



Australian Government
National Health and Medical Research Council

Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples



INVESTING IN AUSTRALIA'S HEALTH

**A GUIDE FOR HEALTH
PROFESSIONALS**



Australian Government

National Health and Medical Research Council

**STRENGTHENING CARDIAC REHABILITATION
AND SECONDARY PREVENTION FOR
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES**

A GUIDE FOR HEALTH PROFESSIONALS

Endorsed September 2005

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CONTENTS

FOREWORD — A PERSONAL REFLECTION	VII
PREFACE	IX
SUMMARY — KEY POINTS FOR SUCCESS	XI
INTRODUCTION	XV
1 Cardiac rehabilitation and Aboriginal and Torres Strait Islander Peoples	1
1.1 Understanding the barriers	1
1.2 Principles for improving outcomes	3
2 Preparing for a planned hospital admission	7
2.1 Supporting decision-making	7
2.2 Attending hospital for tests	8
2.3 Pre-admission	8
2.4 Providing information	9
Checklist for action	10
3 Hospital care	11
3.1 First impressions	11
3.2 Providing support and information	12
3.3 Discharge planning	14
Checklist for action	16
4 Recovery and rehabilitation	17
4.1 Meeting individual and family needs	17
4.2 Physical activity	18
4.3 Education and discussion	18
Checklist for action	20
5 Secondary prevention	21
5.1 Understanding risk factors	21
5.2 Encouraging continuing use of medications	23
5.3 Maintaining lifestyle change	24
5.4 Continued monitoring of risk factors	25
5.5 Raising awareness in the community	25
Checklist for action	27

6	Organisational support for change	29
6.1	A systematic team approach	29
6.2	Finding ways to support changes in practice	30
6.3	Networks and partnerships	32
6.4	Monitoring and evaluation	32
	Checklist for action	33
	REFERENCES	37
	APPENDICES	41
1	Membership and terms of reference	41
2	Process report	42
	TOOLKITS	51
	Toolkit 1 — Cultural competency	53
	How does an individual develop intercultural expertise?	
	Cultural communication cues	
	Working with cultural mentors	
	Working with interpreters	
	Organisational support for intercultural service delivery	
	Toolkit 2 — Information sheets for patients	61
	What is coronary heart disease?	
	What is atherosclerosis?	
	Is it a heart attack?	
	Heart valve problems	
	Heart rhythm problems	
	What is high blood pressure?	
	Tests for heart problems	
	Procedures for heart disease	
	What happens after hospital?	
	Feeling down after surgery or heart attack?	
	What is cardiac rehabilitation?	
	Medicines for heart problems	
	Getting support or information	
	Tips for a healthy heart	
	Healthy eating for your heart	
	What is cholesterol?	
	Tips for healthy weight	
	Getting active for your heart	

Smoking, substance use and heart health
Alcohol and heart health
Depression and your heart
Stress — why worry?

Toolkit 3 — Materials for health professionals 95

Checklist for pre-admission review
Inpatient mobilisation
Inpatient education
Discharge planning checklist
Checklist for the Aboriginal and Torres Strait Islander Adult
Health Check (Item 710)
Cardiovascular risk assessment
Care plan checklist
Supporting secondary prevention
Cardiac rehabilitation program content
Implementing the guide in different settings
Resources for health professionals

Toolkit 4 — Materials for managers of health organisations 135

Developing a business case
Workforce issues
Using specific Medicare items
Data collection
Consumer and community participation checklist
Resources for managers

FOREWORD — A PERSONAL REFLECTION

It is no secret that Aboriginal and Torres Strait Islander Peoples suffer the worst health in our country.

Since colonisation, drastic changes in lifestyles and diets have resulted in the decline of once healthy circumstances for Indigenous peoples. Sedentary practices and busy workloads contribute to risk factors of life in the 21st century. Aboriginal and Torres Strait Islander Peoples are no exception and also have specific needs in relation to health practices. This guide offers help and hope in the arena of cardiac rehabilitation.

Most Aboriginal and Torres Strait Islander people know of loved ones who have suffered heart problems. For those who inherit a genetic predisposition, the reality of heart disease and rehabilitation is likely to occur somewhere in their lifetime.

We also know that sometimes even outwardly healthy looking people who do the right thing can have heart attacks. This past year I have known two seemingly fit and healthy young Aboriginal men pass on through heart failure. It came as a terrible shock to their families and friends. We asked ourselves “How could two fine athletic men who watched their diets with obsession, loved their sport and exercised daily be struck down so early in their lives?” Unfortunately and sadly, dying young is something many people in our communities have come to accept.

If one is lucky enough to survive, quite often the fear of what will happen after the event is great and the process of recovery is long and arduous. For Aboriginal and Torres Strait Islander people, cultural issues can act as barriers in seeking assistance from health professionals. Hospitals have often been seen as unwelcoming but necessary places for our people. There is much helpful advice on these issues outlined in this guide.

Comprehensive information is essential in improving the health of Aboriginal and Torres Strait Peoples and adds to the growing number of resources. Here practical guidance and lists of additional resources and advice for those practitioners involved in cardiac rehabilitation are also provided. The patient also can learn much themselves.

What is most significant about this guide is that it is structured around the process of cardiac rehabilitation from the diagnosis of heart disease or the occurrence of a cardiac event to secondary prevention and self-management. There have been some positive stories with health education programs being directed at Aboriginal Community Controlled Health Services and many of these are described here.

Health practitioners will benefit from this concise and well thought through guide as to the cultural complexities associated with Aboriginal and Torres Strait Islander Peoples recovering from cardiac problems.

Jackie Huggins AM

Co-Chair Reconciliation Australia

August 2005

PREFACE

Improving the health of Aboriginal and Torres Strait Islander Peoples is a core responsibility of the whole health sector. This guide provides health professionals with practical guidance on improving an important aspect of health. It is one of many small steps towards equitable and appropriate care for Aboriginal and Torres Strait Islander Peoples.

As Co-chairs of the Cardiac Rehabilitation Working Committee of the NHMRC Health Advisory Committee that developed this guide, we are proud to recommend it to all health professionals involved in the care of Aboriginal and Torres Strait Islander Peoples.

The NHMRC recognises that the expertise and knowledge of Aboriginal and Torres Strait Islander health professionals is essential in addressing health inequalities for Aboriginal and Torres Strait Islander Peoples. It is significant that Aboriginal and Torres Strait Islander members made up nearly two-thirds of the working committee. Key organisations were involved from the outset, including the National Aboriginal Community Controlled Health Organisation and the Australian Indigenous Doctors' Association.

The guide is based on available evidence but also on a wide-ranging process of consultation. We listened carefully to health professionals and consumers talking about why Aboriginal and Torres Strait Islander people do not attend cardiac rehabilitation programs and how services could be made more accessible.

The guidance provided here cannot be specific, due to the diversity of the settings in which it will be used and the people that it aims to assist — for example, its audience ranges from Aboriginal Health Workers in small remote communities to specialist staff in large urban teaching hospitals. It considers generic issues around cultural competence and discrimination, while keeping a practical focus on cardiac rehabilitation and secondary prevention. It promotes flexible, multidisciplinary approaches that make use of the skills available in each setting and encourages partnerships and capacity building at a local level.

We hope the guide will be put to practical use by health professionals in their day-to-day work. We trust it will help to improve the uptake and outcomes of cardiac rehabilitation among Aboriginal and Torres Strait Islander Peoples, and through this, the health of Aboriginal and Torres Strait Islander communities across Australia.

Dr Noel Hayman and Dr Mark Wenitong
Co-chairs, NHMRC Cardiac Rehabilitation Working Committee

The Cardiac Rehabilitation Working Committee and the NHMRC are grateful to the many people who shared their stories to help in developing this guide.

SUMMARY — KEY POINTS FOR SUCCESS

The following points are drawn from the guide and summarise key points for health professionals and health managers in different settings.

Cultural competency

Depending on the individual's level of experience, these points will help **non-Indigenous people** working with Aboriginal and Torres Strait Islander Peoples:

- ❖ Reflect on the effects of your own **cultural identity** on your practice, and **respect** people's customs, culture, values, religion, dignity and feelings (eg through cultural safety training)
- ❖ Work collaboratively with and **learn** from Aboriginal and Torres Strait Islander patients, families, interpreters, cultural mentors, Aboriginal Health Workers and other co-workers
- ❖ Wherever possible, involve an **Aboriginal Health Worker or Liaison Officer** in the care of Aboriginal and Torres Strait Islander patients
- ❖ Acknowledge the **importance of family and carers** to Aboriginal and Torres Strait Islander patients, involve them in decision-making and support them in this role
- ❖ Provide Aboriginal and Torres Strait Islander patients with **culturally appropriate** education materials
- ❖ Where possible, provide services to Aboriginal and Torres Strait Islander patients in a setting that is **comfortable** to them

For health professionals in primary care

These points will help you if you are a **GP or allied health professional** working in a primary care setting:

- ❖ Develop **flexible** approaches to providing information to Aboriginal and Torres Strait Islander patients requiring cardiac procedures — involve an Aboriginal Health Worker and family members
- ❖ Talk about the **importance** of cardiac rehabilitation and secondary prevention as soon as heart problems have been diagnosed
- ❖ Put into place **buddying** and/or **mentoring** systems for Aboriginal and Torres Strait Islander patients
- ❖ **Incorporate elements** of cardiac rehabilitation and secondary prevention into existing clinics or group sessions at the health service
- ❖ Explore different ways of getting **health messages** across to Aboriginal and Torres Strait Islander patients as part of brief interventions
- ❖ Develop a **referral network** to assist Aboriginal and Torres Strait Islander patients who require specialist treatment, counselling or social support

- ❖ Get involved in establishing activities for **secondary prevention** (eg heart support groups, walking groups, cooking classes) for Aboriginal and Torres Strait Islander patients
- ❖ Explore **existing networks** within the community that could be drawn on for health promotion activities
- ❖ Establish **links within the community** (eg through Elders or community council) to ensure their involvement in planning, implementing and evaluating health promotion

For health professionals in hospitals

These points will help you if you are a **cardiac rehabilitation coordinator, nurse, allied health professional** who is part of a cardiac rehabilitation team, **cardiac specialist** or **general physician**:

- ❖ **Be aware** that chronic diseases tend to present at much earlier ages among Aboriginal and Torres Strait Islander people
- ❖ Develop **discharge protocols** that consider the needs of Aboriginal and Torres Strait Islander patients, and provide culturally respectful discharge information
- ❖ For Aboriginal and Torres Strait Islander patients, involve an **Aboriginal Health Worker** as a **key member** of the cardiac rehabilitation team
- ❖ Consider providing **outreach cardiac rehabilitation** services to the local Aboriginal Community Controlled Health Service

For managers in health organisations

These points will help you if you are a **manager** in a hospital, Aboriginal Community Controlled Health Service or other organisation providing health services to Aboriginal and Torres Strait Islander people:

- ❖ Clearly **define** the administrative, clinical and educational roles of Aboriginal Health Workers in different settings
- ❖ Develop a specialist education base for **continuing training** and support of health professionals working in cardiac care
- ❖ Have processes for **identifying** Aboriginal or Torres Strait Islander status
- ❖ Ensure **community involvement and control** in planning and implementing programs
- ❖ Develop strategies to assist in **recruiting** and **retaining** Aboriginal and Torres Strait Islander staff — including training and support
- ❖ Wherever possible, ensure that **Aboriginal Health Workers** are involved in the care of Aboriginal and Torres Strait Islander patients and support their access to training in cardiovascular health
- ❖ Take measures to make the organisation more **welcoming** to Aboriginal and Torres Strait Islander patients and support non-Indigenous staff in accessing cultural awareness training

- ❖ Support the development of **culturally appropriate materials** and protocols
- ❖ Ensure **clearly defined management structures** are in place, including routine clinics, treatment protocols, recall systems and clinical guidelines
- ❖ Include data gathering and evaluation to **monitor program outcomes** and **continuously improve** services
- ❖ Establish **partnerships** with other organisations to broaden the range of services that you can provide
- ❖ Explore the viability of using **existing funding sources** (such as specific Medicare items) in your setting

INTRODUCTION

It is well recognised that Aboriginal and Torres Strait Islander Australians experience poorer health than other Australians and have greater difficulty in accessing health services. This is of particular concern in the area of cardiovascular health.

The National Health and Medical Research Council (NHMRC) has developed this guide with the aim of providing health services (including Aboriginal Health Services, hospitals, primary health care workers and Aboriginal Health Workers) with strategies to improve uptake and access to cardiac rehabilitation services. It is hoped that this will help to improve the general health and prevent further cardiac events in Aboriginal and Torres Strait Islander people with heart disease.

Due to the limited evidence available in the area, this guide does not make recommendations, rather summarises existing evidence and lessons learnt from the consultation process that supported the guide's development. It is acknowledged that many of the barriers, principles and strategies in the guide are generic to most health issues affecting Aboriginal and Torres Strait Islander Peoples.

What is cardiac rehabilitation and why is it important?

The World Health Organization defines cardiac rehabilitation as “the sum of activities required to ensure patients the best possible physical, mental and social conditions so that they may resume and maintain as normal a place as possible in the community.”¹

Cardiac rehabilitation describes all measures used to help people with heart disease return to an active and satisfying life and to reduce their risk of further cardiac events such as heart attack.² It includes and complements the care given by GPs and specialists.

Cardiac rehabilitation takes an organised approach, involving physical activity, health education, counselling and behaviour modification strategies. A major component of cardiac rehabilitation is integrating secondary prevention into the long-term care of patients with heart disease, helping to give them the confidence, motivation and skills to make a lifelong commitment to a healthy lifestyle and greater well-being.

Traditionally, cardiac rehabilitation programs included patients with recent cardiac events (eg heart attack or coronary artery bypass surgery). In recent years this has broadened to include patients who have had coronary angioplasty, valvular heart surgery, peripheral vascular disease, chronic stable heart failure and patients with multiple cardiovascular risk factors who have not yet been diagnosed with heart disease.

The National Heart Foundation of Australia and the World Health Organization recommend that all patients with cardiovascular disease are routinely referred to an appropriate cardiac rehabilitation program.^{1,2} Their recommendations are based on findings that three-phase rehabilitation programs provide many short-term and long-term benefits to health and well-being (see boxes in margin).

National Heart Foundation framework for cardiac rehabilitation²

Inpatient

Individual and group counselling is given while the person is in hospital. Topics discussed include:

- ❖ coming to terms with heart disease
- ❖ identifying risk factors
- ❖ suggestions for returning home and to work

Outpatient

Group program combining education, counselling and exercises is given by a multidisciplinary team, within the hospital or at another centre

Secondary prevention

Occurs within the community, and promotes long-term maintenance and support of a healthy lifestyle

Demonstrated benefits of cardiac rehabilitation

- ❖ Long-term reduction in heart disease symptoms
- ❖ Better capacity for exercise
- ❖ Reduced risk factor levels
- ❖ Decreased risk of another cardiac event
- ❖ Lower rates of hospitalisation
- ❖ Lower morbidity
- ❖ Reduced mortality
- ❖ Reduced risk of depression and anxiety
- ❖ Access to expert health professionals
- ❖ Increased opportunity to maximise quality of life
- ❖ Access to information on community resources
- ❖ Earlier return to work
- ❖ Increase in social functioning
- ❖ Development of skills for long-term behaviour change

Although the benefits of cardiac rehabilitation are clear, only a small proportion of people who have experienced cardiac events attend programs.³ Aboriginal and Torres Strait Islander Peoples are even less likely to participate in cardiac rehabilitation programs than non-Indigenous Australians,³⁻⁵ despite being twice as likely to die from heart disease.⁶⁻⁹

Development of the guide

There is considerable activity underway across Australia to improve the cardiovascular health of Aboriginal and Torres Strait Islander Peoples. However, a review of the literature commissioned as part of this project (see page 43) found little evidence specific to cardiac rehabilitation among Aboriginal and Torres Strait Islander Peoples. The review identified a number of barriers to effective practice and a need for practical guidance in the area of cardiac rehabilitation.

To further explore these barriers, consultation workshops were held in Darwin, Townsville and Mt Druitt (Sydney). The workshops involved sessions for health professionals and consumers and were organised through the local Aboriginal Community Controlled Health Service (see page 44). Participants were asked to share their stories and to make suggestions about how cardiac rehabilitation services could be made more accessible to Aboriginal and Torres Strait Islander Peoples. A further workshop was held in Adelaide to test the draft guide.

The result of this process is that the material in this guide is largely based on the experiences of health professionals and consumers at the local level. This is supported by available evidence (much of which is based on findings from other areas such as diabetes and renal disease).

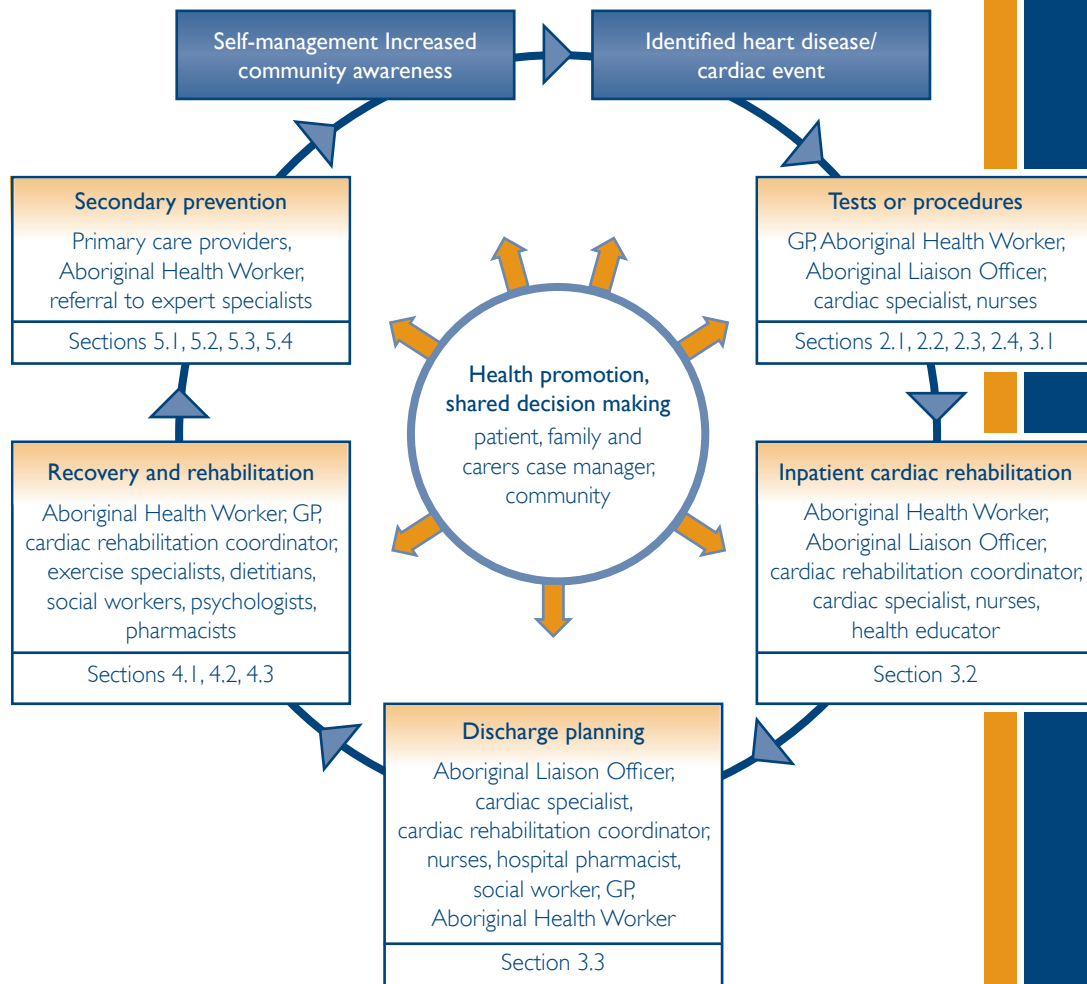
The guide was developed by an expert working committee that included representation from the Aboriginal and Torres Strait Islander health sector, the National Heart Foundation of Australia, the Cardiac Society of Australia and New Zealand, the Royal Australian College of GPs, the Royal Australasian College of Physicians, the National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctors' Association and Aboriginal and Torres Strait Islander consumers (see page 41).

An interactive CD-ROM-based Geographic Information System (GIS) — incorporating maps that integrate the location of cardiac rehabilitation services with Aboriginal and Torres Strait Islander people who have had a cardiac event — is also being developed as part of this project.

Using the guide

This guide is structured around the process of cardiac rehabilitation, from diagnosis of heart disease or the occurrence of a cardiac event to secondary prevention and self-management. Chapter 1 gives the background for activity towards improvement, outlining the barriers to effective practice and giving principles for improving outcomes.

The chart shows the path of cardiac rehabilitation, the health professionals likely to be involved in each phase of care and the sections of the guide that are relevant at each point. Note that participation in cardiac rehabilitation is not necessarily sequential and individuals may access services at different stages and entry points.



Organisational changes to support improved practice are discussed in Chapter 6.

The margins of the guide include information boxes and quotations that give examples to highlight points made in the text. The quotes are drawn from comments made by consumers during the consultation but all names have been changed and any similarity to real people is coincidental.

The guide also includes a toolkit, which provides practical guidance on taking the suggested actions — for health professionals and for managers of health organisations — and lists additional resources.

I CARDIAC REHABILITATION AND ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Whoever wants to reach a distant goal must take small steps
[Saul Bellow]

This chapter outlines the context for activity to improve uptake and outcomes of cardiac rehabilitation among Aboriginal and Torres Strait Islander Peoples. It discusses barriers to effective practice and gives some principles for improving outcomes. This information is relevant to health professionals and managers.

1.1 Understanding the barriers

In order to address the barriers to effective practice, we need to acknowledge and understand them. Consultation for the guide identified a range of barriers to Aboriginal and Torres Strait Islander people attending mainstream cardiac rehabilitation programs (shown in the figure on the following page). Some common themes emerge.

- ❖ **“Not enough black faces”** — Aboriginal and Torres Strait Islander people need to be involved in planning, delivering and evaluating health care. Key barriers to this are lack of training and education in heart health, lack of Aboriginal and Torres Strait Islander people employed in the health system, lack of support and professional recognition in communities and from other health professionals, and insufficient culturally appropriate resources.
- ❖ **Communication and understanding** — cultural factors often not understood and therefore not taken into account in mainstream services include the diversity of Aboriginal and Torres Strait Islander Peoples and culture, the complexity of Aboriginal Lore, the importance of family and community involvement, and a holistic view of health that includes the body, the spiritual, the land and dreaming.
- ❖ **Continuity of care** — the process of cardiac care usually involves many different settings and people. Lack of continuity and linkages between services, in particular between mainstream and Aboriginal services, means that people can fall through the gaps and miss out on important aspects of care. This is made worse when people have to travel long distances to receive care.
- ❖ **Taking the message back home** — it can be difficult to maintain a healthy lifestyle back in the community, where adopting healthy behaviours often has to be less of a priority than meeting basic needs such as food and housing, expectations of health may be low, and there may be strong social pressure not to adopt a healthier lifestyle.
- ❖ **Self-determination and control** — health intervention programs may be implemented without appropriate consultation and community involvement from the outset. Programs are unlikely to succeed unless they build on the leadership provided by community Elders and are adopted as a shared responsibility by the community.

Holistic concept of health¹⁰

“For Aboriginal and Torres Strait Islander Peoples health does not just entail the freedom of the individual from sickness but requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being as well as physical health.”

“You need to have family with you. It’s no good just being around strangers.”

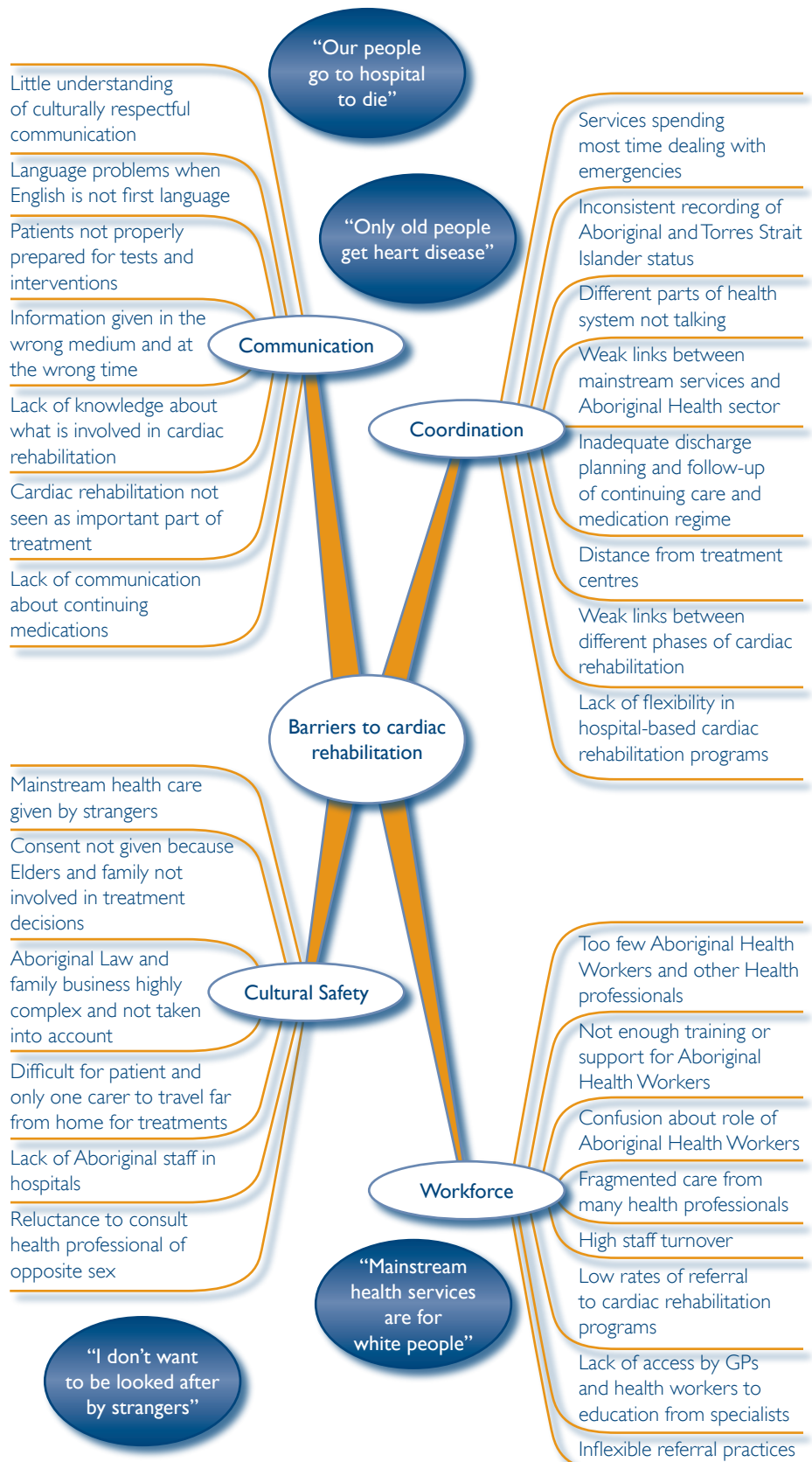
Difficulties with mainstream services¹¹

A major difficulty in rural and remote areas is lack of services, due to distance and lack of transport to regional centres, lack of health professionals and high staff turnover.

But even in regional and urban centres where services exist, Aboriginal and Torres Strait Islander Peoples experience difficulties in accessing mainstream health services and outpatient-based cardiac rehabilitation programs.

Many difficulties relate to lack of flexibility in the structure of traditional hospital-based programs.

Barriers to effective care and rehabilitation among Aboriginal and Torres Strait Islander Peoples



1.2 Principles for improving outcomes

The National Heart Foundation of Australia recommends that:²

- ❖ cardiac rehabilitation services be provided by a multidisciplinary team of health professionals, with one health professional coordinating care
- ❖ in Aboriginal and Torres Strait Islander communities, an Aboriginal Health Worker* be a key member of the cardiac rehabilitation team, supported and encouraged to deliver cardiac rehabilitation in a range of settings
- ❖ cardiac rehabilitation services include and complement the individual care provided by the patient's general practitioner (GP) or cardiac specialist.

This approach was supported by health professionals and consumers during the consultation workshops, and by evidence from programs in other areas. While programs and services at the local level vary depending on specific cultural and health needs, most rely on the capacity of Aboriginal and Torres Strait Islander families and communities to work together for better health outcomes, frequently with Elders leading the way.

The following sections outline a set of principles to guide work towards improving uptake and outcomes of cardiac rehabilitation services among Aboriginal and Torres Strait Islander Peoples. Practical application of the principles is described in the following chapters.

Aboriginal and Torres Strait Islander health — a responsibility of the whole health sector

Providing multidisciplinary cardiac rehabilitation to Australia's Aboriginal and Torres Strait Islander population presents considerable challenges. No single solution can be applied, due to the diversity within the population, as well as the need to find approaches that are suitable to remote, rural and urban areas and to take into account cultural matters and staff availability.

Flexible, multidisciplinary approaches are required.² These need to make use of the skills that are available in each setting and take a standardised approach to support system change (eg through consistent recording of Indigenous status and setting up processes for case coordination).

The Indigenous health sector and Indigenous health professionals are best placed to provide cardiac rehabilitation to Aboriginal and Torres Strait Islander people and should be supported to do this. However, not enough Aboriginal and Torres Strait Islander people are employed across all levels of the health sector. Aboriginal Health Workers and Aboriginal Liaison Officers in particular are often fully occupied with social and

* In this guide the term Aboriginal Health Worker includes both Aboriginal and Torres Strait Islander health workers.

Shared responsibility¹²

"Improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use."

"It's not enough just to mean well. You really have to listen to what the people need if you want to make a difference to the health of the community."

What is an Aboriginal Community Controlled Health Service?

An Aboriginal Community Controlled Health Service is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it.

Aboriginal communities operate around 130 Aboriginal Community Controlled Health Services across Australia. These range from large services employing several doctors and a range of health professionals, to small services that rely on Aboriginal Health Workers and/or nurses to provide most primary care services.

Supporting Aboriginal Health Workers

Aboriginal Health Workers need to be given professional recognition and supported to perform their important roles in Aboriginal and Torres Strait Islander health care. This includes appropriate education and training, clearly delineated roles, and the support and respect of their community and other health professionals.

“The nurse came to see me at the community centre and I didn’t have to go back to the hospital. It made a big difference.”

Building links:

- ❖ people who have experienced cardiac events and procedures
- ❖ community representatives
- ❖ primary care services (Aboriginal Community Controlled Health Services, general practices, community health centres, pharmacy)
- ❖ health professionals working in cardiac care in hospitals
- ❖ outreach specialists
- ❖ allied health professionals (dietitians, physiotherapists, occupational therapists, mental health practitioners, counsellors)
- ❖ managers working in health services and hospitals
- ❖ relevant organisations (eg National Heart Foundation, Divisions of General Practice, Australian Cardiac Rehabilitation Association, Cardiac Society of Australia and New Zealand, Diabetes Australia, Kidney Health Australia, National Aboriginal Community Controlled Health Organisation).

acute care. Cardiac rehabilitation is therefore likely to comprise a combination of both Indigenous and mainstream services, with continuing care given by:

- ❖ an Aboriginal Health Worker with the support of a GP and other health professionals (eg cardiac rehabilitation coordinator)
- ❖ an Aboriginal Community Controlled Health Service
- ❖ a GP.

Cardiac rehabilitation is likely to involve health professionals from a number of organisations, such as other primary health care services, hospitals and allied health professionals. Where possible, the patient should be seen by these professionals in a culturally safe environment, such as at the local health service. This could be carried out in a number of ways, for example:

- ❖ the pre-admission nurse from the hospital visits the local health service to review patients scheduled for cardiac procedures
- ❖ an Aboriginal Health Worker teams up with nurses at the hospital to assist with early mobilisation activities and/or discharge planning
- ❖ older patients who have recently had a cardiac procedure are seen by the GP at home and given telephone support through the Aboriginal Community Controlled Health Service
- ❖ the cardiac rehabilitation coordinator from the hospital spends an afternoon each week at the local health service, providing individual and group sessions with an Aboriginal Health Worker
- ❖ an Aboriginal Health Worker provides secondary prevention activities within the health service in collaboration with the GP, bringing in other health professionals (eg dietitian, physiotherapist)
- ❖ a secondary prevention program covering heart disease, diabetes and renal disease is offered by health professionals in the community hall.

Communication and partnerships — a basis for sharing knowledge, understanding and resources

Developing and maintaining links between individuals and organisations involved in cardiac rehabilitation may help to improve continuity and quality of care. At the centre of care are the patients themselves. Learning from the community, and from individuals who have experienced cardiac events and their families and carers, increases health professionals’ understanding of a patient’s stresses and needs.

Partnerships between health organisations allow patients access to a broader range of services than either organisation can provide alone. Such partnerships also help to integrate mainstream and Indigenous health services, so that it is easier for patients to move between the two systems. Knowledge transfer can help organisations to make simple, consistent changes to improve Aboriginal and Torres Strait Islander access to services.

Cultural respect — providing culturally safe health care

Cultural respect is about shared respect and is achieved when the health system is a safe environment where cultural differences are respected.¹² The goal of cultural respect is to uphold the rights of Aboriginal and Torres Strait Islander Peoples to maintain, protect and develop their culture and achieve equitable health outcomes.

Wherever possible, non-Indigenous health professionals should work with an Aboriginal Health Worker or an Aboriginal or Torres Strait Islander cultural mentor to raise their awareness of cultural matters (see box). Further information about cultural competency is given in Toolkit 1.

Sustainability — building change into systems

For improvements in service delivery to be sustainable, they need to be built into the strategic planning of an organisation. Considerations include funding, staffing, training and education, processes to support best practice (such as guidelines and protocols) and ways of monitoring and evaluating practice.

Financial incentives are available to assist health services to improve preventive and coordinated care for Aboriginal and Torres Strait Islander Peoples — specific Medicare items provide for health checks and coordinated care. Building these types of changes into an organisation's strategic planning is discussed in more detail in Chapter 6, with practical guidance for people managing health organisations given in Toolkit 4.

A broader health approach — recognising a holistic view of health

For Aboriginal and Torres Strait Islander Australians, who suffer a far greater burden from chronic diseases such as diabetes, heart disease, kidney disease and depression than other Australians, a broader approach may be appropriate. A whole body, holistic view is more consistent with Aboriginal and Torres Strait Islander concepts of health and illness than considering single diseases or body parts.

A broader health approach addresses chronic diseases such as diabetes, heart disease and kidney disease together. These conditions share many risk factors and their primary and secondary prevention messages about lifestyle are almost the same. This approach can also better take into account depression and other psychosocial factors, and the cultural, environmental and historical risk conditions that place Aboriginal and Torres Strait Islander Peoples at greater risk of the onset and complications of chronic diseases (see Section 5.1).

What is a cultural mentor?

A cultural mentor advises a non-Indigenous person on cultural matters, providing education and support and acting as a contact between the health professional and the community. In many situations more than one mentor is necessary so that individuals are able to work with people of the same gender and age.

“Working with the mentor meant that someone was there to stop me before I made mistakes.”

NSW Aboriginal Vascular Health Program (AVHP)

This NSW Health program has adopted a multi-strategic approach, including service development, Aboriginal workforce development, education and training and resource development.

There are 31 projects underway in urban and rural areas aiming to develop improved models of care. Some projects are looking at alternative methods of cardiac rehabilitation delivery to their communities.

Projects work in partnership with mainstream health services and Aboriginal community controlled health services to improve prevention and management of chronic disease.

The projects were developed according to local resources, service arrangements and priorities. This flexibility allows tailoring to local needs rather than a “one size fits all” model. The central focus of all projects is improving access to treatment, early detection of disease and risk, and referral for care, along with improved support for disease self-management.

2 PREPARING FOR A PLANNED HOSPITAL ADMISSION

Cardiac rehabilitation begins at diagnosis

This chapter discusses the period between diagnosis of heart disease and admission to hospital for planned procedures. It aims to assist primary health care workers in supporting patients with heart disease and in introducing the concept of cardiac rehabilitation at an early stage.

The process of cardiac rehabilitation begins when symptoms of heart disease are identified or sometimes before diagnosis if multiple cardiovascular risk factors are present. This may occur as part of a routine or opportunistic health check, when a patient attends the health service with symptoms such as angina, or when someone experiences a cardiac event such as a heart attack. In most cases, identifying symptoms goes hand in hand with a hospital visit. This may be on a day-case basis for tests to determine the extent of heart disease (eg angiography), a planned admission for a cardiac procedure (eg angioplasty or bypass surgery) or an unplanned admission through the emergency department (presentation at the emergency department is discussed further in Section 3.1).

Going to hospital is stressful for most people and for Aboriginal and Torres Strait Islander people there are additional difficulties. Helping patients to be adequately prepared and supporting them and their families throughout the process is likely to improve outcomes and may increase uptake of cardiac rehabilitation.

2.1 Supporting decision-making

The first step is to help the patient to understand the need for tests and/or procedures. While this may be as simple as explaining how the test or procedure is carried out and why, the process of decision-making may take some time for a number of reasons:

- ❖ Aboriginal Lore and family business are highly complex. The decision may not rest with the individual alone and is likely to involve both family and community members
- ❖ patients may have several reasons not to agree to go to hospital, including denial or disbelief of their diagnosis, fear of leaving family and not returning, limited understanding of the need for procedures, and fear of how they will be treated in hospital
- ❖ attending hospital for tests may be associated with the idea that tests cause the illness or confirm it, and therefore it is better not to have the test at all
- ❖ the distance between many communities and a hospital where cardiac procedures are performed is often huge, in terms of culture as well as kilometers — getting there is often a big step for patients and for family members or carers who go with them.

Important role of family and carers¹³

Aboriginal and Torres Strait Islander people depend on the support of their extended family for their social, emotional and physical well-being. Carers and partners are vital to the patient's health and, where possible, should be actively encouraged to participate in the process of decision-making.

“Everyone in my family has died young, I guess I will too. I won’t go to the hospital, the nurses talk down to you and you can’t leave when you want to.”

What if the family is not available?

Knowing that they will not have to go through the experience alone is likely to make a big difference to patients. Ask them right from the start whether there is someone who can accompany them. If not, see if you can find a community member who has been through the experience to act as a mentor and maybe go with them to the hospital. Another alternative is for two patients with similar conditions to “buddy” each other through the process.

“The doctor thought Charlie had agreed to go to hospital but he’d just nodded that he understood. It took another few months before he said yes. The Aboriginal Health Worker helped the doctor to explain it and then the family said OK.”

Smoking and procedures

One of the important things that is checked before a procedure is whether the person smokes. It is recommended that all patients stop smoking for six weeks before surgery.

Smoking increases the risk of lung problems, heart complications and the need for intensive care. Smoking also slows down wound healing.

For some people, knowing that smoking increases the risk of complications motivates them to quit smoking before the operation. Others, though, keep smoking to help them cope with their anxiety about the procedure.

Patients requiring assistance with quitting smoking can contact Quitline on 13 78 48

“When I got to the hospital they wouldn’t give me the operation after all because I was still smoking. I don’t think I’ll be going back.”

Considering these difficulties will help you to support people as they come to a decision:

- ❖ allow plenty of time for the decision-making process and make sure that the right people are involved from the start: don’t assume that you know who these people are — ask the patient how and where the process should be managed
- ❖ make sure that an Aboriginal Health Worker, Aboriginal Liaison Officer or cultural mentor is available to assist with communicating with patients and their families — for example, to assist doctors to explain procedures, to interpret patients’ understanding of what is happening to them and to answer any questions they may have
- ❖ if there are language problems, it may be necessary to find an interpreter — family members are not always recommended as interpreters as they may not pass on all of the information (see Toolkit 1).
- ❖ the social work department of the hospital can provide advice on accommodation or other social, emotional or practical problems that may arise when patients have surgery away from where they live.

2.2 Attending hospital for tests

After heart disease is diagnosed, most patients have one or more tests to confirm the diagnosis and assess the extent and severity of disease. Tests include ECG, blood tests, angiography, echocardiography (ultrasound), exercise stress tests and blood pressure monitoring.

In most cases these tests need to be performed at the hospital rather than at the Aboriginal health service or by a GP. Clear explanations of why each test is needed and what it involves will help to allay fears. Efforts to make the environment culturally safe and to involve Aboriginal Health Workers or Aboriginal Liaison Officers, as well as the patient’s family and carers, will help to give Aboriginal and Torres Strait Islander patients greater confidence in mainstream services.

2.3 Pre-admission

Once patients have agreed to go to hospital for a procedure and a date has been set, offering pre-admission reviews allows for early identification of problems that may prevent the procedure from going ahead. Regular reviews, preferably conducted on a weekly basis by an Aboriginal Health Worker, are likely to help patients to prepare for the procedure and ensure that they:

- ❖ have not smoked for six weeks before the procedure (see box)
- ❖ have had a dental check if they are to undergo cardiac valve surgery (either repair or replacement).

A final pre-admission check is carried out within a few days of admission. With agreement from the hospital, this may be conducted in the patient’s usual health service or sometimes by telephone. If the pre-admission check is carried out in the hospital, it will assist patients if they are accompanied by an Aboriginal Health Worker or community member.

This may help to avoid communication problems as well as ensure that patients feel more at ease.

Toolkit 3 includes a checklist to assist with pre-admission review.

2.4 Providing information

The earlier in the process that patients are given information about tests and procedures and subsequent rehabilitation, the more time they have to understand and accept their condition and treatment. Accepting a diagnosis of heart disease, the possibility of surgery and the need for longer term lifestyle changes is not easy. The many unknowns associated with the disease, the immediate crisis and the loss of control it brings, fear of death or the idea of physical or emotional limitations may lead to denial, anxiety or depression.

It is important to communicate positively. While the diagnosis will mean changes to the lives of patients and their families, the positive side is that they will be given a second chance through treatment and lifestyle change. This is the beginning of the rehabilitation process. It is also an important opportunity for initiating a commitment to a healthy lifestyle and greater well-being, for all those involved.

Toolkit 2 includes core information on tests and procedures for common heart conditions.

Planning ahead

Pre-admission reviews are a good opportunity to start talking about what will happen when patients leave hospital. This includes who will look after them, what limitations there will be on what they can do, what form of rehabilitation will be necessary and the sorts of lifestyle changes that would be of benefit.

“I didn’t want to leave my home and family for all those tests and the operation.”

Keep it simple

- ❖ Don’t overload people with information — it’s likely that they are already overwhelmed by the diagnosis and the idea of going to hospital
- ❖ Explain in simple terms the risks and benefits of the procedure
- ❖ Use pictures and models to get your message across
- ❖ Ask open-ended questions to check that they have understood — “How do you think the procedure will improve your health?”

Checklist for action

Have you as a health service?	Yes	No
Developed processes for case management for Aboriginal and Torres Strait Islander patients that encompass the process of care from tests and/or procedures to cardiac rehabilitation?		
Developed flexible processes for obtaining informed consent from Aboriginal and Torres Strait Islander patients that involve family members and provision of culturally appropriate information?		
Established a system with the hospital(s) providing cardiac surgery in your area so that pre-admission checks on Aboriginal and Torres Strait Islander patients may be carried out within the health service?		
Developed or adapted culturally appropriate patient education materials on common cardiovascular conditions, tests, interventions, medications and cardiac rehabilitation? (see Toolkit 2)		
Used patient contact in the pre-admission phase to talk about the importance of cardiac rehabilitation?		
Employed or ensured access to an Aboriginal Health Worker to assist you and your Aboriginal and Torres Strait Islander patients?		
Put into place buddying and/or mentoring systems?		
Developed referral networks involving allied health professionals such as dietitians, pharmacists, social workers, physiotherapists?		

3 HOSPITAL CARE

Planning for recovery and rehabilitation starts at admission

This chapter outlines considerations during the inpatient phase of care, including the role of Aboriginal Health Workers and Aboriginal Liaison Officers, support and involvement of family and carers, and discharge planning. Ways of improving linkages between the hospital and other primary care services are discussed in Chapter 6.

Patterns of hospitalisation differ between Aboriginal and Torres Strait Islander Peoples and other Australians. Limited uptake of primary care services means that Aboriginal and Torres Strait Islander patients are more likely to present at the emergency department when symptoms become severe than to seek advice earlier in the course of the disease. Once in hospital, Aboriginal and Torres Strait Islander patients are significantly less likely to undergo procedures such as coronary bypass surgery or coronary angioplasty than non-Indigenous patients.⁴ If a procedure is carried out, Aboriginal and Torres Strait Islander patients are also less likely to be referred to cardiac rehabilitation.³

3.1 First impressions

Whether Aboriginal or Torres Strait Islander patients are admitted to hospital through reception or the emergency department, they are likely to find the situation very stressful, particularly when they are surrounded by strangers. The situation is likely to be worse when patients have had previous bad experiences in hospital, have come on their own or have never been to hospital before.

Making sure that Indigenous status is recorded

By ensuring that all patients are given the opportunity to identify whether they are Aboriginal or Torres Strait Islander, service providers can both better meet patients' needs and improve data collection for monitoring.⁹ It is important to ask people and not just make assumptions. The inquiry may be made verbally and recorded by the provider as part of routine medical history taking at first consultation, or by a receptionist or other staff member. If the patient is presenting to the emergency department and is unconscious or unable to communicate, the inquiry should be made later and Indigenous status noted in the patient's records.

An appropriate question to ask is:

"Are you Aboriginal or Torres Strait Islander?"

Alternatively, the question may be included on a patient self-history or practice record form. The form should use a standard question such as:

Barriers to hospital attendance among Aboriginal and Torres Strait Islander Peoples³

- ❖ Health care given by strangers, with family and community not adequately involved
- ❖ Lack of Aboriginal staff in hospitals (from reception onwards) and patients not given a choice about whether they would prefer to see an Aboriginal staff member
- ❖ Language barriers — English may be the patient's third or fourth language
- ❖ Fear of leaving family and not returning from hospital
- ❖ Institutional racism

"I don't usually ask people whether they are Aboriginal. It doesn't seem polite to me, so I just make a guess based on appearance."

Preferring to wait

"Aboriginal and Torres Strait Islander people often wait over the weekend until our clinic is open rather than going elsewhere, even for emergency problems such as prolonged chest pain or significant injury.

It is common for our doctors to refer significant numbers of patients to the local emergency room because of late presentation."

WuChopperen Health Service, Cairns

Culturally aware care in the emergency department

The Emergency Department Aboriginal Liaison Service at Royal Perth Hospital works with Aboriginal people to provide a more culturally aware service to Aboriginal patients and relatives accessing the emergency department.

By improving awareness and social networks and increasing the involvement and skills of Aboriginal Health Workers, outcomes were improved.

Example of a patient response to the service: “I’ve been to hospital before and no-one gave me this sort of help. It’s also good to have an Aboriginal person helping. It made me feel good.”

“When I went to the hospital with chest pain, they told me it was an anxiety attack, I was too young for it to be my heart. I had a heart attack a few weeks later. My Mum had a bad heart, my sister died in her 40s.”

Support and advice for family and carers

The time that patients spend in hospital is also a difficult time for their family and carers. For some people, this may be their first experience of hospital and others may have had negative hospital experiences themselves. They may need assistance with communication problems, difficulties with administrative processes or reclaiming expenses. This is most appropriately provided by an Aboriginal Liaison Officer or Aboriginal Health Worker.

Are you Aboriginal or Torres Strait Islander?

- ☐ Yes - Aboriginal
- ☐ Yes - Torres Strait Islander
- ☐ Yes – Aboriginal and Torres Strait Islander
- ☐ No

Where possible, people who identify themselves as Aboriginal and/or Torres Strait Islander, should be given the opportunity to see an Aboriginal Liaison Officer or an Aboriginal Health Worker.

Presentation at the emergency department

For patients who have not sought medical help for symptoms of heart disease, their first experience of treatment is likely to be when they are taken to hospital after a heart attack. For Aboriginal and Torres Strait Islander patients admitted through the emergency department, communication difficulties may mean that symptoms are not properly recorded or that accurate diagnosis is difficult. The likelihood of this can be reduced by involving an Aboriginal Health Worker, Aboriginal Liaison Officer or other Aboriginal staff member, where possible.

Chronic diseases tend to present at much earlier ages among Aboriginal and Torres Strait Islander people. To avoid misdiagnosis, health professionals need to be aware of this when considering symptoms in relatively young people. For example, the average age at which Aboriginal and Torres Strait Islander people present with cardiac events may be up to 20 years younger than non-Indigenous patients.¹⁴

3.2 Providing support and information

Support and advice for the patient

After an emergency presentation, patients may be disoriented and distressed. They may not know where they are or how they got there, and have to come to terms with a life-threatening event and a diagnosis of heart disease. Individuals will vary in when and how much they want to be told. By asking questions, you can assess their level of readiness and give information and support accordingly. For example:

- ❖ Would you like me to explain what happened?
- ❖ Would you like to know what we needed to do?

Once they have adjusted to the initial shock, some patients feel that they have been given a ‘second chance’ in life and respond well to information about cardiac rehabilitation as part of their recovery and treatment.

When patients are admitted for planned procedures, they are likely to undergo a final pre-operation assessment. Being accompanied by a “buddy” or Aboriginal Health Worker until they are taken to the operating theatre may help to make the process less frightening. Seeing someone familiar when they regain consciousness in the recovery ward may also reduce anxiety.

Introducing inpatient cardiac rehabilitation

After surgery or emergency admission, patients are likely to feel disorientated. This is not a good time to provide information about cardiac rehabilitation, although reassurance is likely to be appreciated.

Ideally, information and support are given by the cardiac rehabilitation coordinator with the assistance of an Aboriginal Health Worker or Aboriginal Liaison Officer, and the patient's family/carer present.

Topics relevant to inpatient rehabilitation include:²

- ❖ reassurance and explanation of the condition and treatments, including the importance of taking medications as directed
- ❖ psychological issues (eg depression, emotions, sleep disturbance) and social factors (eg family and personal relationships, social support/isolation)
- ❖ explanation of the inpatient mobilisation program (see box)
- ❖ development of an action plan by patient and carer to ensure early response to the symptoms of a possible heart attack
- ❖ the importance of lifestyle change as a follow-up to recovery (including identification of specific risk factors relevant to the patient)
- ❖ how long the patient's activities (eg driving and lifting) are likely to be limited and assistance with daily activities needed
- ❖ the availability of cardiac rehabilitation programs attached to the hospital or closer to the patient's home
- ❖ the patient's preferred mode of cardiac rehabilitation.

If one-on-one introduction of cardiac rehabilitation is inappropriate or not possible, information may be given or reinforced by:

- ❖ providing group sessions on the ward during visiting hours so that family/carers can be involved as well
- ❖ giving patients culturally appropriate written material to read while they are in hospital and discussing it with them before discharge.

In either case, it is important to assess whether the patient has understood that without some form of cardiac rehabilitation, health problems are likely to recur.

Forms for inpatient mobilisation are included in Toolkit 3.

Inpatient mobilisation²

A mobilisation program balances the risks of being active too soon with those of continued bed rest. It also promotes self-confidence.

The program aims for a progressive increase in activity so that the patient can be independent in basic self-care at the time of discharge.

Early mobilisation programs vary according to individual patient need and hospital protocols.

The rate of progress through a program will depend on factors such as other conditions, age, habitual activity and specific medical instructions.

“At the hospital I had to tell my story over and over again to different people.”

Barriers to referral to outpatient cardiac rehabilitation programs include:³

- ❖ absence of a local program
- ❖ failure of attendant doctors to consider referring eligible patients
- ❖ lack of clinician awareness of program availability
- ❖ absence of a dedicated cardiac rehabilitation coordinator with whom to liaise
- ❖ insufficient time to arrange referrals
- ❖ unfamiliarity of clinicians and hospital coronary rehabilitation coordinators with the referral process
- ❖ distance and transport problems
- ❖ inflexible structure of traditional hospital-based programs.

“No-one told us how hard it would be to look after him or what to expect. It was too much for me with him and the kids.”

Aboriginal Health Nurse assists with discharge planning

At Royal Adelaide Hospital an Aboriginal Registered Nurse assists with discharge planning for Aboriginal patients, providing the following services:

- ❖ liaising with the medical practitioner, nurses and Aboriginal Health Workers involved in community-based health care for Aboriginal and Torres Strait Islander People treated at the hospital
- ❖ facilitating continuity of care for Aboriginal and Torres Strait Islander patients
- ❖ providing information to patients and relatives.

3.3 Discharge planning

Effective discharge planning for cardiac patients starts at pre-admission or admission and can help to improve uptake of cardiac rehabilitation. Discharge provides an opportunity to give patients further information on rehabilitation and provide their case manager or local health service with a summary of their progress in hospital.

There are a number of considerations:

- ❖ a range of health professionals will be involved in the subsequent care of the patient (eg cardiac rehabilitation coordinator, dietitian, pharmacist, social worker, physiotherapist) — it is therefore important that as much information as possible about the patient is clearly documented
- ❖ if patients have not already given information on where they will be going when they leave the hospital and who will care for them, this needs to be clarified and measures taken to ensure that they can be adequately cared for after discharge
- ❖ if the patient's Indigenous status has not already been recorded, this needs to be checked with the patient and noted
- ❖ patients may request premature discharge for a range of reasons including the pressure of community obligations.

Providing discharge information

For many Aboriginal and Torres Strait Islander patients, returning home after a cardiac event will be difficult. Many will be young and perhaps feel under pressure to return to work or look after others in the family. Coupled with their immediate disability and fears about their health in the long-term, this can be an extremely difficult time and rehabilitation and lifestyle changes may seem the least of their worries.

Where possible, the patient's case manager (this may be an Aboriginal Health Worker or GP) should be involved in providing information at discharge. If this is not the case, it may be useful to involve the hospital's Aboriginal Liaison Officer to ensure effective communication. Patients need information to help them understand that procedures and medication do not cure heart disease and that they will need to take action to recover and then to maintain health and well-being.

These messages also need to be conveyed to the patient's family or carer, who may not be aware of the level of care that the patient will require. As well as outlining what they can expect from the patient and how to manage at home, this is a good opportunity to provide the family with education on diet and physical activity.

Providing written information can be a good way of reinforcing the verbal information given at discharge, although you need to consider the literacy and communication needs of patients and their families. Discharge information will depend on the reason for admission but may cover:

- ❖ the importance of cardiac rehabilitation as an integral part of treatment to restore health and well-being
- ❖ the need for patients to make contact with their case manager, GP or local health service as soon as possible
- ❖ information about medications and the importance of continuing to take medications as advised
- ❖ the limitations on what patients can and cannot do (eg driving, lifting) — where possible giving specific examples relevant to individuals.

After surgery, patients may also need information covering:

- ❖ the need for them to have someone to assist them with daily activities (eg cooking, washing, cleaning, shopping for food) for at least two weeks after they go home
- ❖ instruction on wound care
- ❖ information on what to expect physically and emotionally, including information on when physical, sexual and usual activities (eg work) can be resumed.

Sample discharge information for patients and family/carers is included in Toolkit 2. A checklist for discharge planning is included in Toolkit 3. The patient may also need information on entitlements for patients and carers and smoking cessation and counselling services.

Coordinating care after discharge

Follow-up of patients after they leave hospital can be challenging, particularly if patients attend a hospital some distance from where they live. Discharge protocols can assist in ensuring that:

- ❖ patients are discharged into someone's care
- ❖ patients have written advice on medications (and wound care if surgery has been carried out) and have understood these instructions
- ❖ patients are given information on cardiac rehabilitation and asked to contact their case manager or local health service as soon as practicable
- ❖ a discharge summary — including details of procedures undertaken, medications at discharge, cardiac rehabilitation undertaken in hospital and patient preferences for further rehabilitation — is sent promptly to the case manager, GP or local health service.

Ideally, contact between patient and case manager or other health professional from the local health service will be made as soon as possible after discharge and an approach to post surgery follow-up and rehabilitation agreed upon.

Consumer participation at Central Yorke Peninsula Hospital, SA

The hospital began an Aboriginal Service Improvement Plan in collaboration with the Aboriginal community in 2002, as part of a project aiming to improve discharge planning processes for older people.

The support of the Aboriginal community was gained through focus group discussions.

After the group discussions a number of changes were made to increase cultural awareness and make the hospital more welcoming to Aboriginal people:

- ❖ Raising the Aboriginal flag outside the hospital
- ❖ Developing signs in the local language, Narunggan
- ❖ Making cultural awareness training a requirement of employment.

“My brothers and nieces were at the house. But they didn’t help so I just stayed in bed.”

Checklist for action

Have you as a health professional?	Yes	No
Routinely inquired into the Aboriginal or Torres Strait Islander status of all patients if this is not noted in patient records and offered these patients the opportunity to see an Aboriginal staff member?		
Provided Aboriginal and Torres Strait Islander patients with culturally appropriate patient education materials on recovery and rehabilitation from cardiac procedures and with suitable discharge information?		
Acknowledged the importance of family and carers to Aboriginal and Torres Strait Islander patients and involved them in the decision-making process?		
Provided support to your patients' families and carers or referred them to the appropriate staff member within your organisation?		
If working in the emergency department, recognised the different health profile of Aboriginal and Torres Strait Islander patients?		
Supported the development of discharge protocols that take into consideration the needs of Aboriginal and Torres Strait Islander patients?		
Ensured that patient discharge information (including medications) is promptly sent to each patient's GP, case manager (if this is not the GP) or local health service?		
Ensured that your processes complement relevant state-based or local strategies, guidelines and advice?		

A checklist for hospital managers is included at the end of Chapter 6.

4 RECOVERY AND REHABILITATION

The first 6 to 8 weeks — a critical period

This chapter discusses the recovery period after discharge from hospital following a cardiac event or procedure. It outlines key elements of outpatient cardiac rehabilitation and options for program delivery.

Returning home after a cardiac event can be a turning point in a person's life. Education and counselling during this stage can help people:

- ❖ recover from the experience both physically and psychologically
- ❖ have the confidence to return to an active and satisfying life
- ❖ gain the practical skills needed to improve their health.

The journey towards self-management will vary depending on the setting and community. Options may include outpatient, outreach, home-based or GP programs. In many settings, it is also necessary to work with the community to create a supportive environment that will make it easier for people to maintain a healthy lifestyle (see Chapter 5).

The first step in getting people involved in cardiac rehabilitation after a cardiac event is to see them in the health service or clinic. At this point you can talk to patients about what they have been through, discuss their options for cardiac rehabilitation, and explain how you can work together to help them improve their health and well-being. Throughout the process, it is important to monitor patients and refer them to other health professionals and services as required.

4.1 Meeting individual and family needs

Your patients' preferences are likely to vary greatly. The important thing is to offer a program that will get them back on their feet. If possible, offer both individual and group sessions — some people prefer the support and companionship of being in a group, while others may not want to share their stories with other patients. Where there are a limited number of patients with cardiac rehabilitation needs, broader secondary prevention programs can be used to involve patients with different chronic diseases that share risk factors.

To meet individual needs, try to:

- ❖ be constructive and give lots of positive feedback to increase confidence
- ❖ motivate patients and give them the practical skills to become experts in their own health
- ❖ encourage patients to talk (eg ask questions) and other health professionals to listen
- ❖ with each patient, set goals that are appropriate for that person and celebrate small steps towards these goals
- ❖ be realistic – for example, many people need to give up smoking slowly or have to try a number of times before they are able to give up
- ❖ involve family and other community members according to the patient's wishes.

Outpatient cardiac rehabilitation for Aboriginal and Torres Strait Islander Peoples needs to:

- ❖ be integrated into the patient's continuing management and prevention program
- ❖ be part of an approach that provides continuity of care from pre-hospital to ongoing maintenance
- ❖ be given in a culturally safe, familiar and welcoming environment
- ❖ be relevant, enjoyable and supported by infrastructure (eg transport)
- ❖ be positive and affirming, giving people confidence, motivation and practical skills to change their lifestyle and improve their health.

“When I go home everyone will want me to go back on the grog and keep smoking.”

Buddying system

Danila Dilba Health Service in Darwin identified a need for a client advisory group to provide peer support for clients and assist health service staff. In this system, each client has a buddy to help with individual appointments, relieve pressure on Aboriginal Health Workers, and help to build rapport between the client and the different health workers they see at the health service.

Support groups and buddy systems are a good way to help people overcome the fear that heart disease is a death sentence. Talking to others who have been through a major event like cardiac surgery or a heart attack can help to convince people that they can use the experience as a motivator to get a new lease on life. Remember to consider the cultural and kinship laws within your community that may affect buddying and mentoring relationships.

Is exercise safe for everyone?²

Medical assessment is needed before participation in a physical activity program. Patients with a history of the following should not participate in a group exercise program:

- ❖ unstable angina, uncontrolled high blood pressure, severe aortic stenosis or uncontrolled diabetes
- ❖ complicated acute myocardial infarction (within 3 months)
- ❖ untreated heart failure or cardiomyopathy
- ❖ symptoms such as chest discomfort or shortness of breath on low exertion or a resting heart rate over 100 beats/minute.

“Joining the walking group got me out of the house. At first it was hard but the others kept at me to come along.”

Daruk Healthy Heart program

As part of a community-controlled program at Daruk Aboriginal Medical Service at Mt Druitt in Sydney, Healthy Heart workers are involved in screening, referral and case management of community members. Health assessments are made on a drop-in opportunistic basis, through outreach to shopping centres and other community locations and through home-based targeting of ‘at risk’ individuals and families.

The Partners in Health model of chronic disease self-management is used to identify individual health goals and develop care plans in line with these.

The team coordinates physical activity and healthy lifestyle initiatives including aqua-aerobics, walking groups and cooking classes. Increasing community awareness and education is a particular focus.

4.2 Physical activity

Physical activity tones muscles, increases strength and stamina and improves energy levels and spirits. It is also an important factor in reducing body weight and blood pressure. After a cardiac event, physical activity should be gradually re-introduced. You will need to ask patients about their previous levels of physical activity and any barriers that prevented them from being more active. Together you can then work out strategies to increase activity levels.

Whether in a supervised group or an individual program, physical activity sessions should include a warm-up and cool-down period and cater for individual needs and capacities. Patients should start with one or two activities for a short time at low intensity and gradually increase the time spent, the intensity and the variety of activities over several weeks.

The aim should be to build up from low intensity activity to a minimum of 30 minutes of light to moderate physical activity on most, or all, days of the week. A good example of moderate intensity activity is brisk walking at a pace where you are able to comfortably talk but not sing. Other examples include digging in the garden or medium-paced swimming or cycling.

The 30 minutes of exercise per day can be broken up into smaller ‘chunks’ — for example, three 10-minute walks, or one short walk and a longer session in the garden.

Note that *vigorous* physical activity is not recommended for people with coronary heart disease.

4.3 Education and discussion

Cardiac rehabilitation is not just about helping people to recover from surgery or a heart attack, it is also about supporting them to live in a way that will help prevent future heart problems or to manage them well if they occur. This involves providing information and answering questions, offering reassurance and helping patients to get motivated to change.

People have different ways of taking in information — some respond to verbal methods, others to visual information and others need to interact and experience in order to learn. Effective communication aims for a balance between creating a warm and receptive environment and giving the person something to think about and act on. Using appropriate written information (eg adaptations or copies of patient information sheets from Toolkit 2) and other props (eg a model of the heart) may make it easier to get the message across.

There are a number of general topics that may be discussed, including:²

- ❖ the basic anatomy of the heart and what it does, the effects of heart disease and the healing process
- ❖ risk factors for heart disease and why it is so important to reduce risk factor levels in secondary prevention (see Section 5.1)
- ❖ the importance of taking medications as prescribed and of continuing to come back to the health service for review
- ❖ when the patient can resume physical, sexual and daily living activities including driving and return to work (especially if this was not discussed while in hospital)
- ❖ psychological factors such as moods (depression), emotions, sleep disturbance
- ❖ social factors (eg changes in family and personal relationships, lack of social support or a feeling of social isolation)
- ❖ the symptoms of heart problems (eg chest pain, breathlessness, palpitations) and what to do if they occur.

This information should be given by someone who is able to assess whether the patient requires professional counselling or other health services and can make such a referral.²

Discussions should take place in a setting in which patients feel comfortable and in a way that is appropriate to their culture (eg some Aboriginal and Torres Strait Islander patients will feel uncomfortable talking about sex, especially to a person of the opposite gender). Culturally-specific topics that may arise in group discussion include spirituality, health beliefs, traditional healing and bush medicines.

“Some patients don’t want to read a lot of information. Using the heart model is a good way to show them how the heart works.”

Checklist for action

Have you as a health professional?	Yes	No
Established links with hospitals where community members receive treatment for heart disease so that you are notified when they are discharged?		
Considered the model of cardiac rehabilitation that is best suited to your setting?		
Considered setting up a heart support group or buddying system?		
Explored different ways of getting healthy messages across to patients as part of brief interventions?		
Supported the development of a protocol for assessing whether a patient is able to be involved in a physical activity program?		
Provided patients with written advice on cardiac rehabilitation, the importance of physical activity and risk factor management?		
Developed a referral network to assist patients who require specialist treatment, counselling or social support?		
Ensured that your processes complement relevant state-based and local strategies, guidelines and advice?		

5 SECONDARY PREVENTION

Supporting patients to take control of their own health

This chapter talks about ways to support patients to maintain the lifestyle change initiated during the outpatient phase and to self-manage their condition for life. Raising awareness through health promotion can help to reinforce the actions being taken by individuals and may have a beneficial flow-on effect to others in the community.

Secondary prevention beyond the recovery period is important to achieving long-term health benefits. Services offered in this period support behaviours that decrease the risk of future cardiovascular events. From the health professional's perspective, this involves encouraging continued use of medications and monitoring psychosocial and physiological risk factors.

5.1 Understanding risk factors

Risk factors are behaviours and conditions that can increase the risk of a health disorder or other unwanted condition or event. Among Aboriginal and Torres Strait Islander Peoples, risk factors for heart disease include historical, environmental, social, economic, genetic, physiological and behavioural factors (as shown in the flowchart on the following page).¹⁶ While many of these factors cannot be changed, taking them into consideration will help you to develop appropriate management strategies to improve health for Aboriginal and Torres Strait Islander individuals and communities.

Understanding the links between chronic diseases

Risk factors tend to co-exist and be interactive in their effects (for example, for smokers who are obese, the risks associated with smoking may combine with those of obesity so that the health consequences are greater than what would be expected from one of these factors alone).¹⁷

When several risk factors coexist the risk of certain chronic diseases — cardiovascular disease, diabetes, kidney disease — is multiplied (sometimes referred to as global risk). As well, having one of these chronic diseases can predispose to another, for example cardiovascular disease is a common complication of diabetes.

Due to the shared risk factors, messages about health and lifestyle across cardiovascular disease, diabetes and kidney disease are almost the same. A focus on improvement across all risk behaviours is therefore valuable in both preventing and managing these chronic diseases and in a holistic approach to general well-being.

Depression, social isolation and lack of social support are significant risk factors for heart disease. In patients with heart disease, the presence of depression is more likely to lead to poorer outcomes,¹⁸ and they may need more assertive management of their conventional risk factors and attention to the extent to which depression is affecting their adherence to treatment and lifestyle modifications.

Self-management¹⁵

"The principles underlying self-management models are congruent with the Aboriginal holistic view of health and should be encouraged as a way to move forward ... information, guidance and participation are needed from within Aboriginal communities themselves on what they perceive as effective and workable self-management strategies."

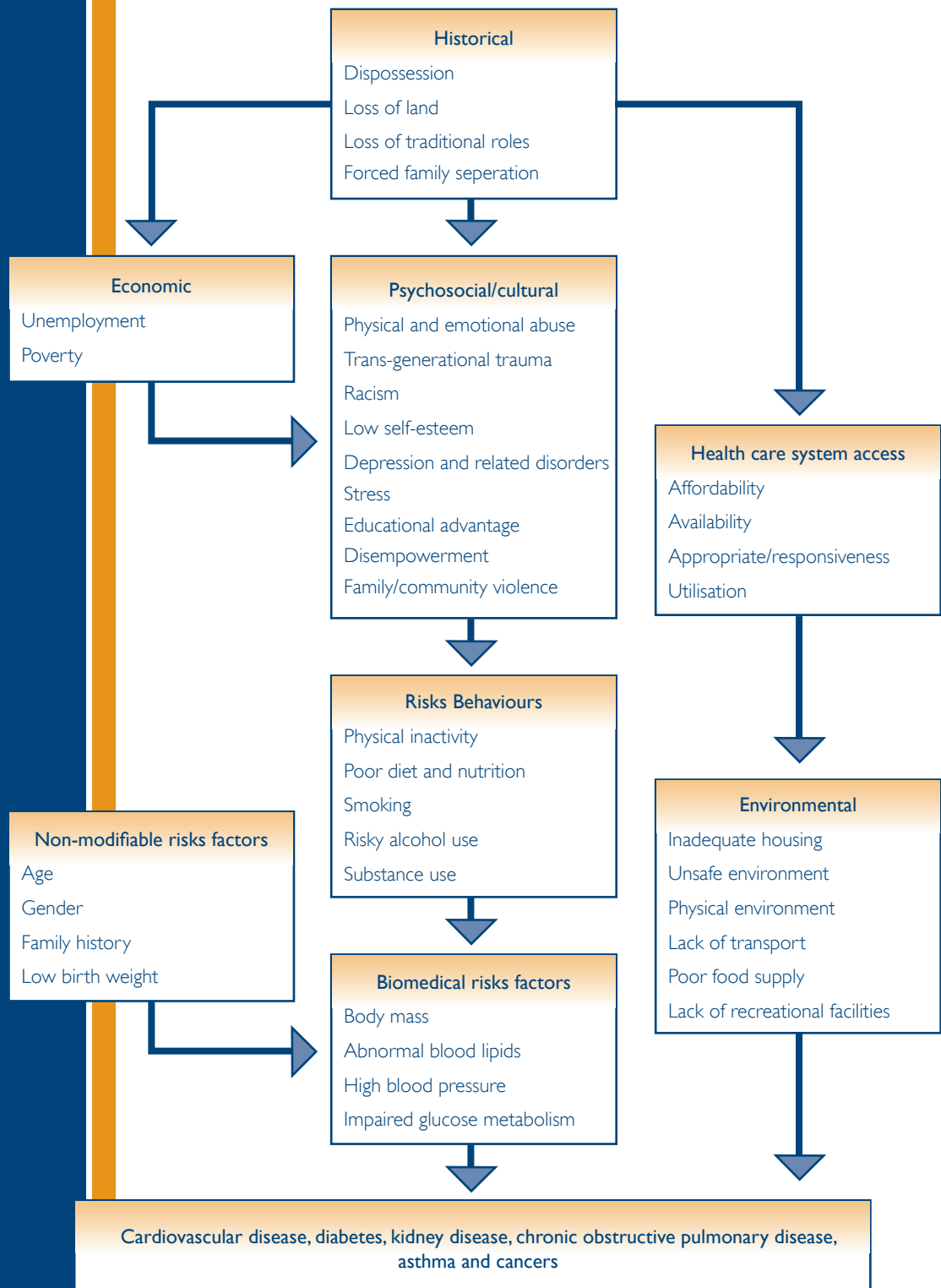
"After the heart attack, Donna gave up the smokes and I was the only one in the house left smoking. She said it felt good after a while and in the end I gave up too. It's better for the kids with no smoke in the house."

Levels of risk behaviours

Results from the 2001 National Health Survey indicated that among Aboriginal and Torres Strait Islander adults:⁸

- ❖ about half were current smokers
- ❖ around two-fifths were physically inactive (in non-remote areas)
- ❖ around two-thirds were overweight or obese
- ❖ of those who consumed alcohol, almost one-third were drinking at risky levels.

Likely factors contributing to cardiovascular disease in Aboriginal and Torres Strait Islander people ¹⁶



Source: Adapted from a flowchart developed through the NSW Aboriginal Vascular Health Program.

This figure shows factors that are likely to contribute to chronic diseases in Aboriginal and Torres Strait Islander people. However, poor health outcomes are themselves a source of continued disadvantage and can contribute to a ‘vicious cycle’ (eg heart disease can lead to further unemployment, disempowerment, further illness and chronic hopelessness).

5.2 Encouraging continuing use of medications

Continuing with prescribed medications is integral to managing heart disease and preventing further events. Managing medications can be difficult for some patients and their carers. There is good evidence that Aboriginal and Torres Strait Islander Peoples have poorer access to medications and the Pharmaceutical Benefits Scheme than other Australians.¹⁹

There are many barriers to accessing and using medications, including limited access to quality medication information and support, socioeconomic factors, transport difficulties, cultural issues, lack of education, and geographical factors. Poorer access is noted regardless of location (eg in urban as well as in rural and remote areas).

Health professionals can support continuing use of medications by:

- ❖ prescribing the correct medication (making use of guidelines such as the National Heart Foundation publication Reducing Risk in Heart Disease. Guidelines for Prevention of Cardiovascular Events in People with Coronary Heart Disease — see Resources section in Toolkit 3)
- ❖ ensuring that hospital discharge medications are recorded (and primary health care staff contact the hospital if this information is not provided)
- ❖ using every clinic visit to talk with patients and their carers about the importance of medications being taken exactly as advised
- ❖ reinforcing messages through allied health staff such as Aboriginal Health Workers
- ❖ using patient information recall systems for reminders
- ❖ providing free medications under Section 100 of the National Health Act (see box)
- ❖ offering patients practical methods of continuing medication use — for example provide them with details on getting financial assistance with medication costs (see box), suggest that they use prompts to remind themselves to take their medicines (eg sticking up a note or having a relative remind them).

“I know what’s bad for my health but there’s no point in doing anything about it.”

Assistance with medications

Under the Pharmaceutical Benefits Scheme Safety Net, people who need a lot of medications in a calendar year are able to get medicines free or at a reduced cost once they have reached a certain threshold for that year.

Under Section 100 of the National Health Act, approved remote area Aboriginal health services are able to provide patients with medicines directly from the health service at the time of medical consultation, without the need for a normal prescription form, and without charge.

People receiving a Centrelink pension may also be eligible for the Pharmaceutical Allowance

“When the pills they gave me ran out I stopped taking them. I don’t have money for any extras.”

Examples of secondary prevention activities

- ❖ Home or community-based walking and/or other physical activity program
- ❖ Linking with cardiac support groups and/or other community-based self-help groups
- ❖ Linking with chronic disease self-management programs
- ❖ Ongoing access to education and discussion sessions as required
- ❖ Individual assessment and referral to appropriate health professionals as required
- ❖ Ongoing care in primary care setting

Get the message across to individuals²⁰

- ❖ When taking a blood pressure reading, share information about the causes and problems of high blood pressure; talk about exercise and good diet as ways to reduce blood pressure
- ❖ Show videos that give suitable information and messages about healthy eating. Take the opportunity to ask viewers if they want to talk about the information in the video
- ❖ Use pictures or models of internal organs to help explain the effects of smoking or drinking harmfully

“The health worker gave a talk in the community centre about heart health. She used a flip chart to tell the story and then some people in the group told their own stories.”

Illawarra Aunty Jean Good Health program²¹

The program was built on the community's capacity to work together for better health outcomes, with the Elders leading the way. The strong relationship between local Elders and Aboriginal Health Workers has given the program its identity and direction.

The pilot project aimed to develop a combined model of health promotion, education and self-management that could support and sustain the development of good health behaviours and strategies for Aboriginal people with chronic and complex care needs.

The emphasis on being part of a team, in a welcoming, safe and fun environment, has contributed to the program's success.

5.3 Maintaining lifestyle change

An important goal for health professionals promoting self-management is to get across the value of changing risk behaviours and maintaining those changes for life.

Behaviour change is hard for everyone but for many Aboriginal and Torres Strait Islander people the will to change is compromised by their social situation and environment. Meeting basic needs such as food and housing may take priority over making changes to improve health and buying medicines. Unhealthy foods are usually easy to obtain, cheap and quickly satisfying (eg chips and soft drinks). As well, family members may not be supportive or may put pressure on the individual to continue drinking too much or smoking. If expectations of health are low, particularly if there is a family history of ill health and early death, things are even more complicated.

Brief interventions by health professionals can help to motivate individuals to change their risk behaviours. A brief intervention involves a range of strategies including advice, referral, motivational interviewing and counselling (see Toolkit 3).

Features of brief interventions make them appropriate for use with Aboriginal and Torres Strait Islander patients in that they are respectful, sensitive and flexible:²⁰

- ❖ the interaction is private
- ❖ the process often involves the patient telling his or her personal story, in his or her own words
- ❖ the process includes sharing knowledge and talking about options — the health professional's role is to be non-judgemental and not forceful or confrontational
- ❖ the patient's decision to change, or not to change, is self-determined.

If patients are not motivated to change, they are unlikely to present for review. Make the most of any opportunity to raise awareness and get people thinking about making changes to improve their health. A good time to share health information as part of a brief intervention is when giving back test results or giving treatment or referral.

Any improvement in risk factors and movement towards the ideal risk factor 'targets' will be beneficial. Risk factor modification should be considered as a total package, so that for example, attention is not diverted from giving up smoking while treating high blood cholesterol and high blood pressure.

More detailed information on risk factor modification among Aboriginal and Torres Strait Islander Peoples is given in the National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples (see resources in Toolkit 3).

5.4 Continued monitoring of risk factors

To effectively self-manage their condition, patients will continue to have physiological and psychosocial risk factors assessed. Some patients will be motivated to return to the clinic for assessment. For patients who do not have this type of motivation, other strategies may be needed, for example:

- ❖ have days at the clinic when patients can attend without an appointment to have weight, blood pressure, blood cholesterol and blood glucose checked
- ❖ opportunistically make these checks when the patient attends for acute care or to renew a prescription for medication.

Providing information on self-management

For many patients, written materials on self-management (eg a care plan) will help them to stay on track. Other patients may need to be given information in more easily accessible formats.

Core information that can be copied or adapted for local use can be found in Toolkit 2.

5.5 Raising awareness in the community

While modifying health behaviours is hard in any setting, in many Aboriginal and Torres Strait Islander communities there is also limited infrastructure to support lifestyle change. It may take community-wide action to make it possible for individuals to make and sustain the changes they need to improve their health. Health promotion within the community can help to raise awareness of the problems caused by chronic disease and what people can do to help themselves — and may also inspire community-led structural changes that will make healthy choices easier (such as changing the types of food available at the local store). Successful strategies can help to improve the health of the whole community.

Sharing information

The following suggestions for sharing information are adapted from the NT Bush Book.²⁰

- ❖ Story telling — Story telling is a traditional way of passing on information in Aboriginal culture. Story telling may be useful for sharing health information and can be a good basis on which to build knowledge and discussion. Individuals may share their personal story on a one-to-one basis (as in a brief intervention), or a health information story may be shared with a group. People can compare stories and experiences, empathise, seek common ground and make individual or collective decisions. Story telling may be through spoken stories, paintings, other visual art forms, dances, songs or a combination of these. Such ways of sharing information may be developed locally for use within the community or adapted from elsewhere.

Get the message across to the community

- ❖ Make a video with people in your community who have recovered from cardiac surgery. Get them to talk about how they have changed their lifestyles. Distribute the video throughout the community.
- ❖ Dietary advice given to individuals at the medical service can be reinforced through demonstrations of cooking healthy food, and putting on a stir fry instead of a sausage sizzle at a community get together.
- ❖ Consider practical ways of attracting people to prevention programs, such as providing transport and healthy lunches. Plan enjoyable activities, and promote a social atmosphere with a focus on health rather than disease.

“They asked us to help with developing a healthy eating program. Even the kids had some good ideas.”

Community involvement²²⁻³¹

Studies in remote Aboriginal communities have shown that planning, implementation and ownership by community organisations is a feasible and effective way to achieve sustainable improvements in healthy behaviours and health-related outcomes, especially in rural and remote areas.

However, variations across communities are to be expected and an approach that works in one community may not be appropriate for another.

Social care planning at Pika Wiya³²

Pika Wiya Aboriginal Medical Service is using the Flinders model of self-management. Staff work one-on-one with patients on their health-related goal setting. Patients then progress to a medical health assessment, which involves other health care workers and culminates in, if patients choose, a formal care plan being agreed between them and their GP.

Staff have found that the social elements and precursors to the formal care plan can be as valuable as the care plan itself in meeting patient needs and assisting them to manage their illness for improved well-being.

Community-based program in the Tiwi Islands^{24, 28}

A renal and cardiovascular intervention using screening and treatment protocols and routine recording of clinical targets achieved improvements in blood pressure and a decrease in renal failure and death.

The roles of Aboriginal Health Workers were clearly defined. Doctors made treatment decisions and modified protocols, but day to day maintenance of the program was by Aboriginal Health Workers and community officers.

The program's success came from:

- ❖ community ownership and control
- ❖ a non-judgmental, non-authoritarian style
- ❖ respect for personal and community perspectives and priorities.

- ❖ Using case studies — Case studies that tell the story of particular people or groups (with permission) may help to raise issues and pass on important information. Suitable case studies may be found locally, or they can be found in journals (such as the Aboriginal and Islander Health Worker Journal) or other publications.
- ❖ Meetings — Whole community meetings may be a good way to make public announcements, but are not necessarily the best way to share health information. Information sharing sessions, however, may take the form of meetings with particular groups. A meeting may be needed to seek permission to proceed with health activities.
- ❖ Reporting back to the community — When you prepare a report for the community, consider what the community wants and needs to know, what you want to say about the project and the best way to say it. Giving feedback on how things are going can help to maintain the momentum of a program.
- ❖ Health days and health weeks — These provide opportunities to raise awareness about health issues, and to share health information, through displays and various activities at the health service or other community setting.
- ❖ Promotional materials — Developing or adapting your own health promotional materials (eg an Aboriginal Health Worker working with medical or nursing specialists) can be an effective way of getting information across in a culturally appropriate way. Ideally, health promotion materials are locally developed and feature local people. Videos and airplay on local TV and radio stations can be effective in augmenting written material and posters.

Working with the community

Working with the community has the potential to address some of the structural and environmental issues that lead to poor health. Health promotion programs can be used to raise awareness and knowledge about health, create supportive environments, strengthen community action and develop individual skills.

- ❖ Community development — Health promotion programs need to be locally relevant to be accessible and suitable to their audience. Community development is based on the idea that local people already know what the issues and problems are and how to solve them. This approach can assist communities to undertake projects in planned and structured ways, recognising the strengths and knowledge of local people and engaging communities in all aspects of development, implementation and evaluation.
- ❖ Using existing networks — You might not have to start from scratch to find opportunities for health promotion in the community. Look beyond the health sector at networks within communities that can be used as forums to get people thinking about lifestyle and health — for example social clubs, church groups, sports groups and school get-togethers.

There are many resources available that can help you to take a community development approach to developing, implementing and evaluating a health promotion program (see Toolkit 3).

Checklist for action

Have you as a health professional?	Yes	No
Provided patients with culturally appropriate written information on risk factor management and the importance of medications?		
Been involved in establishing activities for secondary prevention (eg walking groups, cooking classes)?		
Developed processes for opportunistic health assessments (eg during 'drop in' visits for other reasons, outreach to community locations, home visits)?		
Thought about how to incorporate elements of cardiac rehabilitation and secondary prevention into existing clinics or group sessions?		
Explored existing networks within the community that could be drawn on for health promotion activities?		
Established links within the community (eg through Elders or community council) to ensure their involvement in planning, implementing and evaluating health promotion from the earliest stages?		

6 ORGANISATIONAL SUPPORT FOR CHANGE

Finding ways to build change into practice

This chapter discusses changes to infrastructure that can support and sustain changes in practice. It outlines factors that can be used to support changes in practice, such as specific Medicare items, and highlights the importance of monitoring and evaluation in sustaining change.

Even with the best will in the world, it can be hard to institute and maintain change in a climate of limited funding, low staffing levels, high staff turnover and low patient motivation. Organisations can work around these obstacles and move towards sustainable change by:

- ❖ involving Aboriginal and Torres Strait Islander staff and community members in developing a policy to support cultural competence across the organisation
- ❖ taking a systematic team approach
- ❖ making use of existing structures for funding
- ❖ building communication and collaboration
- ❖ collecting information to identify problem areas and measure change
- ❖ building these factors into strategic planning.

6.1 A systematic team approach

A team approach and commitment from management to improving patient outcomes will benefit an organisation's work with individuals, groups and communities. Teamwork involves coordinating the talents and resources of people with a range of expertise to achieve a common goal — collaborative, cooperative efforts are likely to achieve more than the sum of individual efforts. Each member of the team should have clearly defined day-to-day responsibilities. Team members should meet regularly to share information, learn from each other and plan together. This provides a setting for developing systems for standardised care across the continuum.

Standardising systems

Rather than responding to patient needs in an ad hoc way, having an organised approach will assist continuity of care. This may include:³³

- ❖ structured systems for follow-up and recall — for example triage all patients coming into the clinic and review their need for actions, tests or recalls on the spot
- ❖ guidelines — make sure that practice is consistent with national and state-based guidelines and strategies and that everyone in the team is following them (see Toolkit 3)
- ❖ protocols — these may be developed locally, based on needs identified through the monitoring process
- ❖ supportive information systems (eg decision support software).

Key points for success

- ❖ Define administrative, clinical and educational roles of Aboriginal Health Workers
- ❖ Develop a specialist education base for continuing training and support of health professionals working in cardiac care
- ❖ Ensure community involvement and control in planning and implementing programs
- ❖ Develop strategies to overcome problems of staff turnover and lack of continuing training and support for staff
- ❖ Define management structures, including routine clinics, treatment protocols, recall systems and clinical guidelines
- ❖ Include data gathering and evaluation to monitor outcomes and continuously improve

“The protocols we developed really help us to work in the same way. They make it easier to make decisions too.”

Computerised patient recall systems

Some Aboriginal Community Controlled Health Services, such as Amoonguna Health Service in Alice Springs, are benefiting from the use of computerised patient record systems designed specifically for primary health care providers. The systems provide detailed medical record-keeping, patient recall and statistical data generation in one easy-to-use package and can be customised to suit the needs of the community.

The Office for Aboriginal and Torres Strait Islander Health has prepared a guide³⁴ to assist health services to decide whether they would benefit from this type of software and to select an appropriate package (see Resources list in Toolkit 3).

NSW standards for chronic care³⁶

The NSW Aboriginal Chronic Conditions Area Health Service Standards recognise the importance of the development of individualised training and development plans and career paths for Aboriginal Health Workers.

All local area Aboriginal Health Partnerships are required to develop and implement professional training plans for Aboriginal Health Workers.

Extensive work is also being undertaken at a national level to develop agreed competency-based Aboriginal Health Worker training programs.

“The specialist and I worked together to write a patient brochure on high blood pressure. We got great ideas from some of the patients. I think we all learnt a lot.”

Getting clients on to Medicare

Having and using a Medicare card is central to accessing the services provided in the mainstream health system —visiting a GP, attending the emergency department or purchasing subsidised medicines.

Aboriginal and Torres Strait Islander Peoples use Medicare at only a quarter of the rate of other Australians, even though their overall health needs are around three times higher.^{11,37} This can exclude them from receiving the medical care they need.

The Health Insurance Commission has an information campaign about the benefits of having a Medicare card and an information number specifically for Aboriginal and Torres Strait Islander Peoples — 1800 556 955.

Training and education

Continuing training and education helps to maintain best practice within the organisation. Opportunities for education and training are often limited by time, availability and distance. A number of educational resources for Aboriginal Health Workers are being developed and made available in hardcopy or on the web (see resources section). Other opportunities for specialised training of health professionals include:

- ❖ outreach ‘hands on’ training by specialist nurses and doctors for rural/remote health professionals³⁵
- ❖ multidisciplinary clinical case discussions immediately after patient consultation for GPs, Aboriginal Health Workers and community nurses
- ❖ planning of patient clinical and educational tools by Aboriginal Health Workers together with medical and nursing specialists through an apprentice type of model.

Training resources are listed in Toolkit 3.

6.2 Finding ways to support changes in practice

Health services need to be supported to change the way health care is delivered to Aboriginal and Torres Strait Islander Peoples and to sustain improvements. Basic requirements include mechanisms for accurate identification of Aboriginality, and for ensuring that patients have Medicare cards and use them. Using specific Medicare items can also assist with providing coordinated care for those with complex care needs.

Aboriginal and/or Torres Strait Islander identification

Establishing Indigenous status is important in learning about the patient’s background and for accurate data collection and monitoring. It is also relevant to eligibility for services such as the adult health check (see below). It is important not to assume that a person is or is not Aboriginal or Torres Strait Islander. Practical guidance on establishing Indigenous status is given on page 11.

Using Medicare items

Making use of Medicare items that were specifically developed for preventive health care in Aboriginal and Torres Strait Islander Peoples or for multidisciplinary care of patients with complex care needs can make it more financially viable for services to deliver primary health care matched to the needs of Aboriginal and Torres Strait Islander patients.

Medicare item 710 provides for two-yearly adult health checks for Aboriginal and Torres Strait Islander people aged 15 to 54. In some circumstances parts of these health checks can be carried out by an Aboriginal Health Worker, nurse or other health professional under the supervision of the patient’s doctor.

On 1 July 2005 new Medicare items were introduced to assist with managing patients with chronic medical conditions, including patients needing multidisciplinary care. These items provide improved care planning options for GPs and increase the assistance that Aboriginal

Health Workers and practice nurses can give. They also provide more flexibility in who can provide review services.

Toolkit 4 includes more detailed information on using specific Medicare items.

Case management and coordination

One way of streamlining an individual's care is for a single person within the primary care health sector to coordinate a patient's care and guide them through the process from initial identification of symptoms of heart disease through to cardiac rehabilitation and self-management.

Having a case manager will help to strengthen the linkages between the different phases of cardiac rehabilitation by:

- ❖ enhancing communication between the patient and other health care providers and between the range of health care professionals providing services to the patient
- ❖ reducing the number of times patients need to tell their story
- ❖ ensuring that each health professional involved in the patient's care is aware of any medications being taken and any tests or procedures that have been carried out
- ❖ ensuring that each health professional involved with the patient is aware of steps taken towards self-management.

As discussed, Aboriginal and Torres Strait Islander people are more likely to be comfortable working with Aboriginal health professionals or people that they know. Where staff are available, it is therefore ideal if a patient's care can be managed in their local health service by an Aboriginal Health Worker trained in heart health, in collaboration with a GP and other on-site health professionals with specific expertise. In other cases, the patient's care is likely to be case-managed by a GP or nurse practitioner, working with an Aboriginal Health Worker or cultural mentor as appropriate.

Adult health checks³⁸

"The adult health check for Aboriginal and Torres Strait Islander People is an important Australian initiative that sets an international precedent. The challenge now is for GPs to make use of this rebate. Firstly, they need to understand what comprises an effective preventive health assessment for this population. Secondly, changing practice to align with the evidence requires more than guidelines. Multifaceted strategies are needed, including decision-support systems, clinical audit, feedback, and support from opinion leaders. Bulk-billing for these assessments is critically important given the significant socioeconomic disparity between Aboriginal and Torres Strait Islander People and the broader Australian population."

"I knew I could always call the health worker if I had a problem and she would tell me whether I needed to see the doctor or not."

Making use of Medicare funding

The Townsville Aboriginal and Islander Health Services (TAIHS) Limited, an Aboriginal Community Controlled Health Service, has made use of the Medicare health check for Aboriginal and Torres Strait Islander people aged between 15 and 55 years, carrying out 973 care plans in the six months July–Dec 2004.

An audit of the first 150 care plans suggested that 99% of patients were engaged in brief interventions about smoking, nutrition, alcohol and physical activity. Funding from use of the Medicare item feeds back into secondary preventive activities.

Partnerships improve services at Nunkuwarrin Yunti

At Nunkuwarrin Yunti Health Service in SA, partnerships with a number of organisations increase access for Aboriginal people to a broader range of services including:

- ❖ Royal Australian College of General Practitioners to provide cultural and clinical training for General Practitioner Registrars.
- ❖ Aboriginal Housing Unit to establish cross-referral systems for coordinated care.
- ❖ Royal District Nursing Service to gain access to diabetes educator, palliative care services, post acute care, care for the disabled, and HIV/AIDS care.

“After the program had been running for 12 months we looked at the data we had collected. It showed us that we were making progress but we needed to make some changes to the program.”

Using the PDSA cycle

Fundamental to the process of quality improvement is the “Plan, Do, Study, Act” cycle in which plans and activities are constantly reviewed to assess the degree to which anticipated outcomes have been achieved. The findings of such reviews are then acted upon to inform the development of subsequent plans and strategies. This cyclical approach applies to all levels of operation from service systems to program delivery.

See www.ihl.org for more details.

6.3 Networks and partnerships

Building relationships with other organisations and individuals broadens the capacity of the health service provider, increases access to resources and helps to build networks for referral.

Referral networks

While the Aboriginal Health Worker plays a central role in the care of Aboriginal and Torres Strait Islander patients, there are likely to be constraints on their time and limits to their expertise. Having a network of individuals and organisations that can be called on for information or advice or for specialised services for the patient, will help to ensure that the patient receives the best available care and that the Aboriginal Health Worker’s time is well used. Comprehensive and clearly expressed referral information reduces the need for the patient to repeat details about their condition.

Maintaining links

With high staff turnover and changes in governance, it can be hard to maintain partnerships between services. While it may require the drive of an individual to build goodwill between organisations, continuing the partnership should not rest with individuals. Linkages may be formalised as partnerships (eg through an agreement signed by the CEOs of the organisations). As well, systems need to be developed so that linkages become a standard part of organisational processes, for example through protocols, regular meetings or phone calls, and processes for sharing information.

6.4 Monitoring and evaluation

Monitoring and evaluation are essential to understanding and improving the effectiveness of health service delivery. Program monitoring allows managers to make appropriate decisions on a day-to-day basis and ensures that programs are carried out as designed and altered when necessary. Evaluation enables program managers to understand and demonstrate the results of their work, determine the best strategies for achieving goals and document the lessons learned.

Monitoring comprises any systematic ongoing process of collecting information on outcomes and performance. Evaluation of this information (eg using the PDSA cycle; see box) helps to determine the types and extent of any problems and opportunities for improvement. Regardless of the size of a health organisation or health promotion program, monitoring and evaluation can be effective ways to learn about what you are achieving and feed this information back into the organisation and community.

Toolkit 4 includes more detailed information on the type of data that should be collected and how these can be used to evaluate service delivery.

Checklist for action

Have you as a primary care service manager	Yes	No
Considered potential barriers to Aboriginal and Torres Strait Islander patients accessing your organisation and taken action to address these (eg employing Aboriginal and Torres Strait Islander staff, ensuring availability of appropriate resources, displaying culturally appropriate posters in reception area)?		
Instituted processes to ensure that all patients are asked about their Indigenous status and that this is clearly noted in patient records?		
Taken action to support Aboriginal Health Workers, including clearly delineating roles and providing protocols and guidelines?		
Where Aboriginal Health Workers are not part of the organisation, made enquiries into the availability of individuals to act as cultural mentors?		
Promoted the benefits of having a Medicare card to Aboriginal and Torres Strait Islander patients?		
Considered broadening your approach to care and rehabilitation of Aboriginal and Torres Strait Islander patients with heart disease to address other chronic diseases and the shared risk factors?		
Developed a system so that cardiac rehabilitation and appropriate support can be provided to all Aboriginal and Torres Strait Islander patients following a cardiac event or procedure (this may involve a number of strategies to meet the varying needs of individuals)?		
Developed an Aboriginal and Torres Strait Islander patient cardiac rehabilitation plan?		
Supported the development of systems for using the enhanced primary care items in your organisation?		
Instituted continuous quality improvement processes to review progress and implement changes where appropriate?		
Established a system to measure and monitor cardiac rehabilitation referral rates, attendance rates and health outcomes for Aboriginal and Torres Strait Islander patients?		

Partnership for Aboriginal Care

The Mid North Coast Aboriginal Coordinated Care Trial is a model of coordinated care for Aboriginal communities which builds on partnerships established between Aboriginal Community Controlled Health Services, mainstream health services and other non-government organisations.

Early outcomes of the trial include: improved access to primary care; increased use of Medicare items, health assessments and care planning; strengthened partnerships and community development; and more training and workforce development.

Have you as a hospital manager	Yes	No
Considered potential barriers to Aboriginal and Torres Strait Islander patients accessing your organisation and taken action to address these (eg employing Aboriginal and Torres Strait Islander staff, ensuring availability of appropriate resources, displaying culturally appropriate posters in reception area)?		
Instituted processes to ensure that all patients are asked about their Indigenous status and that this is clearly noted in patient records?		
Considered increasing the number of Aboriginal and Torres Strait Islander staff members?		
Developed strategies to support and retain Aboriginal and Torres Strait Islander staff?		
Supported the development of processes to support family/ carers of Aboriginal and Torres Strait Islander patients and involve them in decision-making?		
Supported the development of emergency department protocols that recognise the different health profile of Aboriginal and Torres Strait Islander patients?		
Developed an Aboriginal and Torres Strait Islander patient cardiac rehabilitation plan?		
Supported the development of discharge protocols that take into consideration the needs of Aboriginal and Torres Strait Islander patients?		
Established a system to measure and monitor cardiac rehabilitation referral rates, attendance rates and health outcomes for Aboriginal and Torres Strait Islander patients?		

Have you as a cardiology or cardiac rehabilitation service manager	Yes	No
Considered potential barriers to Aboriginal and Torres Strait Islander patients accessing your organisation and taken action to address these?		
Considered increasing the number of Aboriginal and Torres Strait Islander staff members?		
Developed strategies to support and retain Aboriginal and Torres Strait Islander staff?		
Where Aboriginal Health Workers are not part of the organisation, made enquiries into the availability of individuals to act as cultural mentors?		
Supported the development of processes to support family/carers of Aboriginal and Torres Strait Islander patients and involve them in decision-making?		
Developed a system so that cardiac rehabilitation and appropriate support can be provided to all Aboriginal and Torres Strait Islander patients following a cardiac event or procedure (this may involve a number of strategies to meet the varying needs of individuals)?		
Developed an Aboriginal and Torres Strait Islander patient cardiac rehabilitation plan?		
Supported the development of discharge protocols that take into consideration the needs of Aboriginal and Torres Strait Islander patients?		
Established a system to measure and monitor cardiac rehabilitation referral rates, attendance rates and health outcomes for Aboriginal and Torres Strait Islander patients?		

REFERENCES

- 1 World Health Organization (1993) Report of Expert Committee on Rehabilitation after Cardiovascular Disease. WHO Technical Report Series No. 831, Geneva.
- 2 National Heart Foundation of Australia & Australian Cardiac Rehabilitation Association (2004) Recommended Framework for Cardiac Rehabilitation. National Heart Foundation of Australia.
- 3 Scott IA et al (2003) Utilisation of outpatient cardiac rehabilitation in Queensland. *MJA* 179: 341–45.
- 4 Cunningham J (2002) Diagnostic and therapeutic procedures among Australian hospital patients identified as indigenous. *MJA* 176: 58–62.
- 5 Shepherd F et al (2003) Improving access to cardiac rehabilitation for remote Indigenous clients. *Aust NZ J Public Health* 27:632–36.
- 6 ABS (2003) Causes of Death 2002. ABS Cat No 3303.0. Australian Bureau of Statistics, Canberra.
- 7 AIHW (2004) Heart, Stroke and Vascular Diseases: Australian Facts 2004. AIHW Cat No CVD 27. Australian Institute of Health and Welfare, Canberra.
- 8 ABS (2001) National Health Survey: Aboriginal and Torres Strait Islander Results, Australia 2001. ABS Cat No 4715.0. Australian Bureau of Statistics, Canberra.
- 9 ABS & AIHW (2003) The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples. ABS Cat No 4704.0; AIHW Cat No IHW11. Commonwealth of Australia.
- 10 National Aboriginal Health Strategy Working Party (1989) National Aboriginal Health Strategy. Australian Government Publishing Service, Canberra.
- 11 Ring I (2000) Townsville Cardiovascular Disease Workshop. James Cook University, National Heart Foundation, National Aboriginal Community Controlled Health Organisation, National Rural Health Alliance and Commonwealth Department of Health and Aged Care.
- 12 Australian Health Ministers' Advisory Council (2004) Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009. Department of Health, South Australia.
- 13 Norris T (unpublished) Draft Standardised Aboriginal Vascular Health Program Assessment and Management Toolkit. Aboriginal Vascular Health Program, Chronic Care Unit, NSW Health Department.
- 14 Couzos S & Murray P (2003) Aboriginal Primary Health Care: An Evidence Based Approach. 2nd Edition. Oxford University Press.
- 15 Wade V et al (2003) Coronary heart disease in Aboriginal communities: towards a model for self-management. *Contemp Nurse* 15: 300–09.
- 16 NSW Health (2003) Facts about Aboriginal Vascular Health. NSW Department of Health, Sydney.

- 17 AIHW (2005) Living Dangerously: Australians with Multiple Risk Factors for Cardiovascular Disease. AIHW Bulletin No 24. AIHW Cat No AUS-57. Australian Institute of Health and Welfare, Canberra.
- 18 Bunker SJ et al (2003) "Stress" and coronary heart disease: psychosocial risk factors. National Heart Foundation of Australia Position Statement Update. MJA 178: 272–76.
- 19 Keys-Young (1997) Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme. Report for the Health Insurance Commission, Canberra.
- 20 Department of Health and Community Services (2002) The Public Health Bushbook. 2nd Edition. Northern Territory Government, Darwin.
- 21 Illawarra Health Aunty Jean's Good Health Team (2004) Participatory Evaluation of the Illawarra Health, Aboriginal Chronic and Complex Care, Pilot Program. Funded by NSW Health Aboriginal Vascular Program.
- 22 Chang AB et al (2000) Asthma management in indigenous children of a remote community using an indigenous health model. J Paediatr Child Health 36: 249–51.
- 23 Rowley KG et al (2000) Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian Aboriginal community. Aust NZ J Public Health 24: 136–44.
- 24 Hoy WE et al (2000) Reducing premature death and renal failure in Australian Aboriginals. A community-based cardiovascular and renal protective program. MJA 172: 473–78.
- 25 Simmons D (2003) Impact of an integrated approach to diabetes care at the Rumbalara Aboriginal Health Service. Intern Med J 33: 581–85.
- 26 Bailie RS et al (2004) A multifaceted health-service intervention in remote Aboriginal communities: 3-year follow-up of the impact on diabetes care. MJA 181: 195–200.
- 27 McDermott R et al (1998) Beneficial impact of the homelands movement on health outcomes in Central Australian Aboriginals. Aust NZ J Public Health 22: 653–58.
- 28 Hoy W et al (1999) Stemming the tide: reducing cardiovascular disease and renal failure in Australian Aboriginals. Aust NZ J Med 29: 480–83.
- 29 McDermott R et al (2003) Sustaining better diabetes care in remote indigenous Australian communities. BMJ 327: 428–30.
- 30 Neilsen G et al (1993) Rheumatic fever and chronic rheumatic heart disease in Yarrabah Aboriginal community, North Queensland: establishment of a prophylactic program. MJA 158: 316–18.
- 31 Mobbs R et al (2003) The chronic disease self management project at Katherine West Health Board Aboriginal Corporation in the Northern Territory. Aust J Primary Health 9: 160–67.

- 32 Sharing Health Care SA (2002) Our Health in Our Hands in Our Region. Project Update December 2002.
- 33 Bailie RS et al (2003) Preventive medical care in remote Aboriginal communities in the Northern Territory: a follow-up study of the impact of clinical guidelines, computerised recall and reminder systems, and audit and feedback. *BMC Health Serv Res* 3: 15.
- 34 OATSIH (2000) Information Systems in Aboriginal and Torres Strait Islander Health Services. A Reference Guide for Services Contemplating the Introduction of a Computer-based Patient Information and Recall System. Office of Aboriginal and Torres Strait Islander Health, Canberra.
- 35 Thomson O'Brien MA et al (1997) Educational outreach visits: effects on professional practice and health care outcomes. *The Cochrane Database of Systematic Reviews* 1997, Issue 4. Art No: CD000409. DOI: 10.1002/14651858.CD000409.
- 36 NSW Health (2005) NSW Aboriginal Chronic Conditions Area Health Service Standards. NSW Department of Health, Sydney.
- 37 Office of Aboriginal and Torres Strait Islander Health (2001) Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians. Commonwealth Department of Health and Aged Care, Canberra.
- 38 Mayers N & Couzos S (2004) Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people. *MJA* 181: 531–32.

APPENDICES

I Membership and terms of reference

Membership, Cardiac Rehabilitation Working Committee

Dr Noel Hayman — Co-Chair (Wakka Wakka and Kalkadoon; Vice-President of the Australasian Faculty of Public Health Medicine, Royal Australasian College of Physicians; Senior Medical Officer Queensland Health, Public Health Physician; member of Health Advisory Committee [HAC])

Dr Mark Wenitong — Co-Chair (Kabi Kabi; Senior Medical Officer, WuChopperen Health Service; Vice-President Australian Indigenous Doctors' Association; Senior Lecturer James Cook University, Faculty of Medicine, Health and Molecular Sciences; member of HAC)

Mr Mick Adams (Yadhiagana with association with Wardaman and Torres Straits, as well as extensions with Warlpiri (Yuendumu), Gurrumaru (East Arnhem Land); National Aboriginal Community Controlled Health Organisation)

Dr Rosemary Aldrich (Public Health Physician and member of HAC)

Mr Gary Christian (Erub, Darnley Island and associations with Mowgoo Village; Consumer representative)

Dr Peter Joseph (Royal Australian College of General Practitioners (RACGP); Provost of the Rural Faculty of the RACGP; member of HAC)

Mr Traven Lea (National Program Manager, Aboriginal & Torres Strait Islander Program, National Heart Foundation of Australia – Brisbane)

Ms Vicki Wade (Noongar from the Kaneang Nation of south-west Perth; NSW Health/Cardiac Nurses Network of Australia and NZ)

Dr Warren Walsh (Cardiac Society of Australia and New Zealand (CSANZ); Chair Indigenous Health Working Group of CSANZ)

Professor Elizabeth Waters (Chair in Public Health, Deakin University, and member of HAC)

Observers

Associate Professor Peter Sainsbury (Sydney South West Area Health Service; member of NHMRC)

Ms Shona McQueen (Office for Aboriginal and Torres Strait Islander Health, Australian Government Department of Health and Ageing)

Ms Emma Rooney (Diabetes and Cardiovascular Health Section, Australian Government Department of Health and Ageing)

Expert advice was also provided to the working committee by Dr Sophie Couzos (Public Health Officer, NACCHO) and Professor Kerin O'Dea (Director, Menzies School of Health Research).

NHMRC Secretariat:

Ms Christine Benger

Technical writers

Ms Elizabeth Hall Ampersand Editorial & Design

Ms Jenny Zangger Ampersand Editorial & Design

Terms of reference

1. Develop information that provides health services including hospitals, primary health care workers and Indigenous Health Workers with strategies to improve uptake and access to cardiac rehabilitation services, and the prevention of further cardiac events for Aboriginal and Torres Strait Islander Peoples, by:
 - Undertaking a systematic review of available literature concerning the structure, delivery, and barriers to uptake of cardiac rehabilitation services to Aboriginal and Torres Strait Islander Peoples in Australia, and Indigenous populations internationally.
 - Mapping cardiac rehabilitation programs, including Aboriginal and Torres Strait Islander Peoples' specific services, with service utilisation by Aboriginal and Torres Strait Islander Peoples and population demographics. This will include conducting an audit of cardiac rehabilitation health service delivery and access, looking at epidemiological data, and the modelling of service utilisation.
 - Consulting widely with community groups and other stakeholders about the barriers to access and uptake of cardiac rehabilitation services by Aboriginal and Torres Strait Islander Peoples.
2. Develop a comprehensive consultation strategy.
3. Develop an implementation and dissemination strategy.
4. Present the document to HAC and Council for issuing.

2 Process report

The NHMRC developed this guide with the aim of providing health services — including hospitals, primary health care workers and Aboriginal Health Workers — with strategies to improve uptake of and access to cardiac rehabilitation services and help to prevent further cardiac events among Aboriginal and Torres Strait Islander people.

The development of the guide was informed by a review of the literature, advice from experts in the area, a series of consultation workshops involving a broad range of health professionals and consumers, public consultation submissions and focus testing with intended users of the guide. The working committee also acknowledges the importance of developing strategies for disseminating and implementing the guide, as detailed in this process report.

Literature review

The literature review was commissioned to examine available evidence — both in Australia and overseas — on the potential barriers to delivery as well as uptake of cardiac rehabilitation services for Aboriginal and Torres Strait Islander Peoples. The objectives of the review were to identify and describe:

- ❖ incidence, prevalence and distribution of cardiac disease and events, including epidemiological factors (eg age, sex, occupation, economic status and identified causal factors) that have influenced this over the past 20 years
- ❖ cardiac rehabilitation services and any other rehabilitation services designed specifically for Aboriginal and Torres Strait Islander Peoples
- ❖ uptake and barriers to access of cardiac rehabilitation services
- ❖ 'best practice model' rehabilitation services, including services with linkages to chronic disease programs that are working well.

Major databases — Australian Bureau of Statistics catalogues, Australian Indigenous Health Infonet, Cochrane Review Library, Health Inequalities Research Collaboration, Primary Health Care Network, and PubMed — were reviewed. References from relevant publications, including government reports, were also examined.

Specific inquiry into socioeconomic differences was not undertaken as it is well recognised that the health disadvantage experienced by Aboriginal and Torres Strait Islander Australians reflects the broader social and economic disadvantages faced by this population group. Indeed, this project emerged from a concern to improve the health status of a disadvantaged socioeconomic group of Australians.

During the literature review, no relevant economic evidence was identified.

No original empirical research was conducted as part of this project.

Expert advice

Opinions and advice were sought from:

- ❖ physicians working in regional and remote Aboriginal and Torres Strait Islander communities and urban settings
- ❖ academics working in regional and remote Aboriginal and Torres Strait Islander communities and urban settings
- ❖ health care workers in urban Aboriginal and Torres Strait Islander health services
- ❖ National Heart Foundation of Australia representatives
- ❖ relevant State health department project managers
- ❖ health care educators.

Consultation workshops

To further explore barriers to Aboriginal and Torres Strait Islander Peoples being involved in cardiac rehabilitation, consultation workshops were held where possible at Aboriginal Community Controlled Health Services in Darwin, Townsville and Mt Druitt in Sydney. Each workshop involved a session for health professionals and one for consumers and was facilitated by a member of the Working Party.

Consumers were recruited from the client base of each of the Aboriginal Community Controlled Health Services and some of the health professionals involved also had experience as patients. Participants were asked to share their stories and to make suggestions about how cardiac rehabilitation services could be made more accessible to Aboriginal and Torres Strait Islander Peoples.

Health professionals participating in these workshops are listed below. Consumer participants are not listed for reasons of confidentiality but their involvement is gratefully acknowledged by the working committee.

Workshop held in Darwin

Ms Carol Jobson	Continuous Improvement Project Manager Danila Dilba Health Service
Ms Chrissie Inglis	Cardiac Educator <i>Healthy Living NT</i> Diabetes Australia NT
Ms Leonie Melbourne	Aboriginal Health Worker Menzies School of Health Research
Ms Sandra Miles	Chronic Condition Self Management Danila Dilba Health Service
Mr Graham Opie	Chief Executive Officer National Heart Foundation

Eight consumers

Workshop hosted by Townsville Aboriginal and Islanders Health Service

Ms Kathy Broad	Cardiac Rehabilitation Coordinator Cairns Base Hospital
Ms Natalie Feeney	Clinical Nurse Cardiac Patient Education Townsville Hospital
Ms Cheryl Hastie	Cardiac Rehabilitation Outpatient Program Townsville Hospital
Mr Brian Hooper	Enrolled nurse Thursday Island Hospital

Ms Beryl Meiklejohn Lecturer Indigenous Health
Centre for Indigenous Health
Education & Research
School of Public Health
Queensland University of Technology

Dr Katie Panaretto Senior Medical Officer
Townsville Aboriginal and Islanders
Health Service

Dr Stuart Ramsay Townsville Aboriginal and Islanders
Health Service

Seven consumers

Workshop hosted by Daruk Aboriginal Community Controlled Medical Service, Mt Druitt

Dr Penny Abbott Daruk Aboriginal Community
Controlled Medical Service

Ms Joyce Davison Heart Aboriginal Health Worker
Daruk Aboriginal Community
Controlled Medical Service

Ms Caroline Harris Project Manager
Aboriginal Vascular Project
Illawarra Health
Unanderra

Ms Stephanie Irwin Cardiac Rehabilitation
Coordinator
Liverpool Hospital

Ms Robyn Speerin Senior Policy Analyst
NSW Health Chronic Care Unit

Ms Jean Turner Project Worker
Aboriginal Vascular Project
Illawarra Health
Nowra Community Health Centre

Mr Robert Zecchin Nursing Unit Manager
Area Cardiac Rehabilitation and Chronic
Care Programs,
Western Sydney Area Health Service,
Westmead Hospital

Five consumers

Public consultation

Public consultation targeting the intended users of the guide took place during April and May 2005 and involved a call for submissions publicised in the Government Notices Gazette and The Weekend Australian. In addition, invitations were forwarded to all professional colleges and known interested parties.

Submissions were received from the following individuals and organisations:

Penny Abbott and Joyce Davidson	Daruk Aboriginal Community Controlled Medical Service, Mt Druitt
Jennifer Ayoub	Physiotherapist Flinders Medical Centre, SA
Kathy Bell	Chief Executive Officer, General Practice and Primary Health Care NT
Nerida Bellis-Smith	Professional Services Director, Dietitians Association of Australia
Kathy Broad	Cardiac Rehabilitation Coordinator, Cairns Base Hospital
Dr Alex Brown	Menzies School of Health Research On behalf of the Australian Indigenous Doctors' Association
David Evans	Health Services Manager, Amoonguna Health Service, Alice Springs
Ms Natalie Feeney	Clinical Nurse, Cardiac Patient Education, Townsville Hospital
Mr Abbas Haghshenas and Prof Maurice Eisenbruch	University of New South Wales
Maura Hopkins	Cardiac Rehabilitation Coordinator Flinders Medical Centre, SA
Chrissie Inglis	Cardiac Rehabilitation Coordinator/Cardiac Educator Healthy Living Northern Territory
Sandy Miles	Danila Dilba Health Service, Darwin
Lynne Portelli	CEO, The Cardiac Society of Australia & New Zealand

Dr Jenny Reath	Aboriginal and Torres Strait Islander Health Projects, RACGP
Dr Lyn Roberts	National Heart Foundation of Australia, National Office
Wendy Scheil	Chair, SA Regional AFPHM Committee 2005
Mereana Senior	Mildura Aboriginal Health Service
Robyn Sperrin	Fairfield Cardiac Rehabilitation and Heart Failure Service, NSW
Janelle Stirling and	Coordinator, Indigenous Health Research Program
Vanessa Clements,	Project Officer, Indigenous Health Research Program Queensland Institute of Medical Research
Leonie Young	CEO, beyondblue

Focus testing workshop

During the public consultation period, a workshop for intended users of the guide was held, hosted by Nunkuwarrin Yunti Health Service in Adelaide. A wide range of health professionals participated in the workshop and were invited to comment on the practicality of the guide and to offer suggestions for ways in which it could be improved.

Facilitators:

Dr Noel Hayman —	Chair (Co-Chair, Cardiac Rehabilitation Working Committee (CRWC)
Traven Lea	(member, CRWC)
Vicki Wade	(member, CRWC)

Opening presenter:

Polly Sumner	(Chief Executive Officer, Nunkuwarrin Yunti)
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Participants:

Dr Anna Aisatullin	Public Health Medical Officer, Nunkuwarrin Yunti, Adelaide
Patricia Bushby	Health Services Manager, Central Site, Derbarl Yerrigan Health Service, East Perth

Susan Cameron	Manager, Aboriginal Health, Flinders Medical Centre, SA
Fiona Coulthard	Sharing Health Care Project Worker, Pika Wiya Health Service, Whyalla, SA
David Evans	Health Services Manager, Amoonguna Health Service, Alice Springs
Colin Graham	Aboriginal Health Council – South Australia
Moirra Hayes	Community Improvements RN, Pika Wiya Health Service, Whyalla, SA
Dr Peter Joseph	GP, member CRWC
Laura Knowles	Aboriginal Liaison Officer, Royal Adelaide Hospital
Monica Lawrence	Cardiac Rehabilitation Health Professional
Dr Depak Naran	Senior Medical Officer, Derbarl Yerrigan Health Service, East Perth
Peter Pangquee	Aboriginal Health Worker, Principal Consultant, Territory Health Services, NT
Jacquie Smith	Cardiovascular Health Unit, National Heart Foundation, SA Division
Caroline Sperber	Aboriginal Liaison Nurse, Royal Adelaide Hospital
Cephas Stanley	CEO, Pika Wiya Health Service, Whyalla, SA
Theresa Williams	Aboriginal Liaison Officer, Flinders Medical Centre, SA
Sandy Wilson	Aboriginal Health Worker, Muna Paiendi, SA

Finalising the guide

The working committee met in July 2005 to consider:

- ❖ the public consultation submissions and their inclusion in the guide
- ❖ the outcomes of the focus testing workshop and how comments received would best be incorporated into the guide.

The guide was then revised accordingly.

Prior to approval by the NHMRC, the guide underwent an independent review process and was assessed against the NHMRC key criteria for assessing information reports. The guide was further refined in response to the reviewer's report.

Dissemination, implementation and review

Dissemination involves making guidelines accessible, advertising their availability and distributing them widely. Multiple dissemination strategies ensure greater coverage than a single strategy.

The dissemination strategy for this guide includes distribution of the document to:

- ❖ Aboriginal Community Controlled Health Services
- ❖ State and Territory health departments
- ❖ individuals and organisations who participated in the consultation process
- ❖ workshop participants
- ❖ relevant professional Colleges.

The guide is also available in PDF and Word formats from the NHMRC website.

Dissemination alone is not enough to change the behaviour of health professionals. Strategies that have been shown to be effective in changing clinicians' behaviour or health outcomes, or both, include:

- ❖ promoting the report through endorsement by clinical groups, as well as conferences, seminars and workshops
- ❖ education
- ❖ monitoring uptake of the report through reminder systems and continuing quality assurance and data feedback.

Members of the working committee are committed to supporting the uptake of the guide and will continue to promote it through organisations such as the Australian Indigenous Doctors' Association, the National Heart Foundation of Australia, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians, the Cardiac Society of Australia and New Zealand, the Australian Cardiac Rehabilitation Association, the Standing Committee on Aboriginal and Torres Strait Islander Affairs and other relevant bodies.

Members will also present the guide at relevant conferences and articles summarising the advice given in the guide and discussing the Geographic Information System (see below) will be submitted to peer-reviewed journals.

It is important that health advice is based on the best available evidence and sits within current policy. For these reasons, this guide will be reviewed in 2010.

Geographic Information System

The NHMRC is developing an interactive CD-ROM-based Geographic Information System (GIS) to be used in conjunction with this guide. The GIS will incorporate maps that integrate the location of cardiac rehabilitation services in Australia with Aboriginal and Torres Strait Islander patients who have had a cardiac event.

TOOLKITS

Toolkit 1 – Cultural competency	53
Toolkit 2 – Information sheets for patients	61
Toolkit 3 – Materials for health professionals	95
Toolkit 4 – Materials for management of health organisations	135

TOOLKIT 1 — CULTURAL COMPETENCY

What is in this toolkit?

This toolkit contains information to assist health professionals who have limited experience in working with Aboriginal and Torres Strait Islander patients to work in a way that is culturally respectful. This, in turn, will help to improve health outcomes among Aboriginal and Torres Strait Islander Peoples. The toolkit contains information on:

- ❖ communicating in a culturally respectful way
- ❖ working with interpreters and cultural mentors
- ❖ supporting intercultural service delivery.

Why should you read and use this toolkit?

Working with people from different cultural backgrounds can be challenging and it is not possible to gain the level of cultural knowledge necessary to communicate safely without assistance. This toolkit aims to assist non-Indigenous health professionals and managers with limited experience in the area to gain an understanding of cultural competency so that they are better able to work with Aboriginal and Torres Strait Islander Peoples.

The toolkit is not meant to replace any form of face-to-face training. It is provided as a starting point, outlining some considerations that may assist individuals and organisations in delivering culturally respectful services. Continuing cultural competency training will support the whole health care team to provide culturally respectful care.

Where can you get more information?

This toolkit summarises information from a number of sources from which more detailed information can be obtained:

- ❖ AHMAC Standing Committee for Aboriginal and Torres Strait Islander Health Working Party (2004) Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004–2009. Department of Health, Adelaide. www.health.sa.gov.au
- ❖ Cass A et al (2002) Sharing the true stories: improving communication between Aboriginal patients and healthcare workers. *MJA* 176: 466–70. www.mja.com.au
- ❖ Department of Aboriginal and Torres Strait Islander Policy (1999) Mina Mir Lo Ailan Mun: Proper Communication with Torres Strait Islander People. Department of Aboriginal and Torres Strait Islander Policy and Development, Brisbane. www.indigenous.qld.gov.au
- ❖ ERA Project (2003) Working with Aboriginal People. A Cultural Guide: For Community-based Health and Home Care Services in Wakefield, Gawler and Mid North Areas of Rural South Australia. SA Dept Human Services, Adelaide. www.health.sa.gov.au

What is cultural competence?

Cultural competence is a set of attitudes, skills, behaviours, and policies that enable organisations and staff to work effectively in intercultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of patients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups.

Cultural competence requires both institutional support for effective intercultural service delivery and individual expertise in intercultural communication

- ❖ Hurley A (2003) Respect, Acknowledge, Listen: Practical Protocols for Working with the Indigenous Communities of Western Sydney. Community Cultural Development NSW Ltd, Sydney. www.ccdnsw.org.au
- ❖ James Cook University School of Medicine (2003) Cultural Mentor Handbook. James Cook University, Townsville. www.racgp.org.au
- ❖ James Cook University School of Medicine (2003) Suggested Guidelines for the Development of Indigenous Cultural Mentors. James Cook University, Townsville. www.racgp.org.au
- ❖ McLennan V & Khavarpour F (2004) Culturally appropriate health promotion: its meaning and application in Aboriginal communities. *Health Promotion Journal of Australia* 15 (3): 237–39. www.healthpromotion.org.au
- ❖ NSW Health (2004) Communicating Positively. NSW Dept of Health, Sydney. www.health.nsw.gov.au
- ❖ Royal Australasian College of Physicians (2004) An Introduction to Cultural Competency. www.racp.edu.au
- ❖ Sharing True Stories: Improving Communication in Indigenous Healthcare. www.sharingtruestories.com
- ❖ WA Department of Indigenous Affairs (2004) Engaging with Aboriginal West Australians. www.citizenscape.wa.gov.au

Additional resources

- ❖ Discipline of Aboriginal Health Studies, University of Newcastle Healing Our Way CD-ROM. See www.themedia.com.au
- ❖ Kokotinna website: www.flinders.edu.au/kokotinna/
- ❖ Royal Australian College of General Practitioners and National Aboriginal Community Controlled Health Organisation Aboriginal health training videos — Doctors in Aboriginal Health, Aboriginal Health Workers, Cross Cultural Awareness' Insight into Aboriginal Community Control. See www.racgp.edu.au

Local resources

List here local resources that may assist in the development of cultural competence (eg training resources, local contacts)

How does an individual develop intercultural expertise?

You can build expertise in intercultural communication by:

- ❖ accessing relevant training courses (eg cultural awareness programs, language courses)
- ❖ locating relevant resources and other sources of information (eg people with expertise relevant to your needs) to help you work more effectively with your Aboriginal and Torres Strait Islander patients and co-workers
- ❖ working collaboratively with and learning from Aboriginal and Torres Strait Islander patients, families, interpreters, cultural brokers, Aboriginal Health Workers and other co-workers — your Indigenous co-workers are experts in how to work effectively within their culture.

Cultural communication cues

With the diversity of Aboriginal and Torres Strait Islander Peoples, there can be no simple set of rules for improving communication. It is suggested that Aboriginal and Torres Strait Islander patients be treated on a case-by-case basis due to the diversity in communities.

The following cues provide a starting point for communicating in a culturally respectful way.¹

Communicating with individuals

- ❖ **Accept** that you are in another social and cultural world
- ❖ **Acknowledge** the experience of two-way learning
- ❖ **Anticipate** barriers in intercultural communication because of the opposing conceptual systems
- ❖ **Be aware of body language**, both your own and that of the other individual
- ❖ **Check** frequently that your message has been understood and that you have understood the other person— asking ‘do you understand’ is not a valid way to assess comprehension (try asking the person to tell you what they think you mean in their own words). To check if your understanding is accurate, summarise what you think the person means
- ❖ **Endeavour** to be open, honest and sincere
- ❖ **Listen** to the other person’s views and take them seriously, keep in mind that your perspectives and concepts may differ
- ❖ **Meet on equal ground** — sitting next to each other or diagonally opposite is non-confrontational and will help the other person feel more comfortable

1. These cues are adapted from Mina Mir Lo Ailan Mun – *Proper Communication with Torres Strait Islander People* and *Working with Aboriginal People. A Cultural Guide: For Community-based Health and Home Care Services in Wakefield, Gawler and Mid North Areas of Rural South Australia*.

- ❖ **Provide** opportunities for people to use their preferred communication style eg ask them to tell their story rather than using question and answer routines, which can be uncomfortable/unfamiliar / ineffective
- ❖ **Recognise** the importance of the family and of family elders
- ❖ **Respect** people's customs, culture, values, religion, dignity and feelings
- ❖ **Understand sensitivities around gender issues** — because of strong gender distinction in Aboriginal and Torres Strait Islander societies, it is more appropriate to discuss certain matters between men or between women
- ❖ **Talk** in a style that is clear, understandable, free of jargon and acronyms — if you must use medical terminology make sure that you explain what it means — and don't use metaphors that are culturally specific eg clock and calendar references to time, quantifying in terms of percentages, grams etc
- ❖ **Wait** — pause times are different across cultures; some people might need a few minutes before they are ready to respond to a request or question or to continue a story
- ❖ **Work** with appropriate interpreters, cultural mentors and/or Aboriginal Health Workers where necessary (see below)

Communicating with communities

Principles for communicating with individuals apply when communicating with community groups. In addition, take the following principles into consideration.

- ❖ **Adopt** a participatory role rather than a controlling role
- ❖ **Allow** time for people to think about ideas and proposals and to discuss them informally among themselves in their own language
- ❖ **Appraise** each meeting or contact as it happens — no two meetings are alike
- ❖ **Build** enduring relationships with community groups
- ❖ **Develop** healthy working relationships with councils, communities, organisations and individuals — promote goodwill and understanding between all parties
- ❖ **Disseminate** information or ideas broadly across all stakeholders in a fair and equitable manner — ensure that no-one is disadvantaged
- ❖ **Dress appropriately** — some people may find exposure of body skin offensive and your dress and appearance play an important role in how communities perceive you
- ❖ **Encourage** participation in discussions, meetings and forums
- ❖ **Expect** resistance to ideas and proposals that are incompatible with Aboriginal and/or Torres Strait Islander values
- ❖ **Familiarise** yourself with the sociopolitical profile of the community in which you are working

- ❖ **Identify** key stakeholders in the community including Chairpersons, Council members, Elders — both men and women, and respected younger people
- ❖ **Promise** only what you can or are capable of achieving
- ❖ **Understand** cultural and community dynamics — stereotyping should be avoided as each community is unique and each has its own individual needs

Communicating with Indigenous health services

The principles outlined above also apply when you are contacting Aboriginal Community Controlled Health Services.

As well, familiarise yourself with the organisation you are contacting and take into consideration its size, staffing and infrastructure. Aboriginal Community Controlled Health Services range from multidisciplinary clinics with a number of clinical and administrative staff to small community clinics run by an Aboriginal Health Worker and a nurse. With the high workload of staff members, the person you need to speak to may be unavailable. If so, explain what you need and ask whom you should contact and when (see margin).

Using appropriate terminology

The use of accurate and non-offensive language is an essential component of Aboriginal and Torres Strait Islander cultural respect and effective communication. Acceptable usage is likely to vary with location. If you are unsure about using a particular term, ask the community with which you are working to identify preferred terms.

Working with cultural mentors

Working with a cultural mentor can provide valuable insight into the culture of the community in which you are working, although it is important to find a cultural mentor that is well matched to the community. To ensure that the situation is acceptable to the health professional, the mentor and the community:

- ❖ local Aboriginal or Torres Strait Islander groups should be fully involved in the selection of the mentor
- ❖ the mentor should be given a clear explanation of the concept and objectives of cultural mentoring
- ❖ the mentor and mentored should be given support and supervision (eg through an Aboriginal or Torres Strait Islander coordinator) including a debriefing mechanism
- ❖ an agreement should be reached on how the mentor will work with the health professional (eg the amount of time to be spent, when and where)
- ❖ the mentor should not be asked for advice on managing an individual situation — in a small community it will be easy for the mentor to recognise who is being discussed, which may place him or her in a difficult situation
- ❖ some form of remuneration could be negotiated.

“I work at the hospital with Aboriginal patients who have had a heart operation. I’d like to talk to someone in your organisation who can help these patients when they leave the hospital. Who should I ask for and when would be a good time to call?”

Aboriginal kinship

The intricate Aboriginal system of classes or skins places everybody in a specific kinship relationship. All of these relationships have roles and responsibilities attached to them.

Kinship influences everyday behaviour and brings with it a set of obligations that need to be met when relating to others. These obligations form a part of Aboriginal Lore.

One important aspect of kinship behaviour is that an individual is allowed to approach and talk to some relatives but not others. These avoidance rules do not mean that these people dislike each other. The rule exists to maintain respect between certain classes of relatives. If two people who are not permitted to speak want to exchange information, they must find a third person to pass it on.

Working with interpreters

If you are not sure whether you can communicate effectively with a patient or family members, you will need to work with an interpreter. If professional interpreters are available they will be able to assist you. In other circumstances an Aboriginal Health Worker, Aboriginal Liaison Officer or other community member could be asked whether they would be an appropriate person to interpret for the patient. It is important to work with someone who is not a close family member, has a good understanding of the patient's language and of English and who has an appropriate kinship relationship with the patient (see box).

Having an interpreter work with you when you meet with a patient does not mean that communication will automatically be without problems. The cultural distance between you and your Aboriginal and Torres Strait Islander patients and interpreters remains. Ways to gain the most benefit from working with an interpreter include:

- ❖ meet the interpreter before the encounter with the patient — you can then explain what you want to achieve and ask about effective communication strategies, check that the interpreter understands the key concepts you will be discussing with the patient/family, learn about the best ways to discuss these and find out if there are any cultural matters you should know about before the interaction
- ❖ set up a discussion between the patient/family and interpreter — this allows the interpreter to learn what the patient/family wants to achieve from the encounter and provides an opportunity for them to inform patients about the role of the interpreter.

When interviewing a patient with the assistance of an interpreter:

- ❖ talk to the patient, not the interpreter, and encourage the patient to talk directly to you (arrange seating to facilitate this)
- ❖ do not speak too quickly (or too slowly) and keep your sentences short: one idea or question at a time — pause frequently and allow sufficient time for translation and/or questions
- ❖ encourage the interpreter to interrupt when clarification or repetition of information is needed
- ❖ don't let the interpreter's presence change your role in the interview — it is not their role to conduct the interview
- ❖ seek the patient's permission if you need to obtain cultural information from the interpreter
- ❖ avoid long discussions with the interpreter — if you need to talk to the interpreter directly then they should explain the nature of the conversation to the patient.

Organisational support for intercultural service delivery

Cultural competence does not just rest with individuals. There needs to be organisational support to ensure that services are provided in a culturally respectful way:

- ❖ actively employ Aboriginal or Torres Strait Islander people to attend the front desk or reception area and any other areas, not only where they are working directly with Aboriginal and Torres Strait Islander patients
- ❖ support non-Indigenous staff in accessing cultural awareness training and include this type of training in orientation programs for new staff
- ❖ identify and address systemic barriers to access to the service by Aboriginal and Torres Strait Islander Peoples
- ❖ ensure systems are in place to monitor and address staff attitudes so that services are provided in a culturally safe manner
- ❖ ensure availability of and support for interpreters and cultural mentors where possible
- ❖ ensure principles of equity and access are written into the service's documentation and are reflected in its culture and actions
- ❖ nominate a care coordinator or case manager to Aboriginal and Torres Strait Islander patients and ensure that this person follows them up at frequent intervals
- ❖ consider the appearance of the front reception area — is there evidence that Aboriginal and Torres Strait Islander People are welcome (eg Aboriginal art on the walls, Aboriginal magazines in the waiting room).

TOOLKIT 2 — INFORMATION SHEETS FOR PATIENTS

What is in this toolkit?

This toolkit contains core information that can be adapted for use as educational materials for patients. Each sheet can be used in the following ways:

- ❖ copy the sheet and decorate the border area in a way that is appropriate to your community before copying it and giving it to patients (pictures to illustrate the messages are a good idea)
- ❖ enlarge the sheet using a photocopier and use it as a poster (illustrated or decorated) in the reception area of your health organisation
- ❖ use the Word version of the sheet (available for download from www.nhmrc.gov.au) and adapt the messages and format so that they are appropriate to your community.

Remember that the information you provide should be reinforced by pictures or demonstrations. In some cases, written information will not be appropriate. Models and sample devices can be obtained (often for free) from companies that produce cardiac medicines or medical technology (eg stents).

Information sheets are provided on the following topics:

Understanding heart conditions

What is coronary heart disease?

What is atherosclerosis?

Is it a heart attack?

Heart valve problems

Heart rhythm problems

What is high blood pressure?

Understanding tests and treatments

Tests for heart problems

Procedures for heart disease

After hospital

What happens after hospital?

Feeling down after surgery or heart attack?

What is cardiac rehabilitation?

Medicines for heart problems

Getting support or information

Secondary prevention

Tips for a healthy heart

Healthy eating for your heart

What is cholesterol?

Tips for healthy weight

Getting active for your heart

Smoking, substance use and heart health

Alcohol and heart health

Depression and your heart

Stress — why worry?

The information sheets have been developed based on information from the National Heart Foundation of Australia and the NSW Aboriginal Vascular Health Program. The information sheet “Healthy eating for your heart” was developed with the assistance of Professor Kerin O’Dea.

Why should you read and use this toolkit?

This toolkit has been developed for use by health professionals working with Aboriginal and Torres Strait Islander patients with heart disease.

Depending on your level of knowledge, the information in this toolkit may help you to better understand cardiovascular disease and cardiac rehabilitation — this will help you to communicate the important points to patients and their families or carers. If you feel that you need more information to improve your understanding of a specific aspect of cardiac care or rehabilitation, talk with other health professionals with expertise in the area or consult relevant resources from the list given in Toolkit 3.

Even if you have extensive knowledge in the area, this toolkit provides an easy way to give consistent evidence-based messages to patients with heart disease.

Where can you get other appropriate resources?

A large range of health promotion materials is available for Aboriginal and Torres Strait Islander Peoples. Some of these are locally focussed, but others are more broadly applicable. Many of these materials are listed in the publications below. Other locally based materials may also be available.

Indigenous Health Promotion Resources: a National Information Guide for Aboriginal and Torres Strait Islander Health Workers (4th edition)

This publication provides a centralised database of health resources and practical assistance to Aboriginal Health Workers. The guide is in an easy to read format and is available free to current subscribers of the Aboriginal and Islander Health Worker Journal while stocks last. Non-subscribers may order a copy by contacting journal@aihwj.com.au.

National Heart Foundation of Australia publications

The Heart Foundation has produced patient information materials that are specific to Aboriginal and Torres Strait Islander patients including:

- ❖ Listen to Your Heart: A Story about Caring for Your Heart (Video)
- ❖ Tobacco Book (booklet and brochure)
- ❖ Heart Story (flipchart)
- ❖ How Smoking Affects Your Family (poster)

These resources are available from www.heartfoundation.com.au.

NSW Aboriginal Vascular Health Program resource guide

A comprehensive list of resources developed specifically for Aboriginal and Torres Strait Islander patients has been compiled as part of the NSW Aboriginal Vascular Health Program. See www.health.nsw.gov.au/living/atsi.html for details on availability.

Understanding heart conditions

What is coronary heart disease?

- ♥ The heart is a muscular pump that needs a constant supply of oxygen. It gets oxygen from blood flowing through arteries on its surface
- ♥ In coronary heart disease the arteries that supply the heart have become narrower and/or harder (atherosclerosis). Sometimes a blood clot may form and block the artery
- ♥ A heart attack is when one of the heart's arteries is blocked by a blood clot. This can damage the heart

Is angina the same as a heart attack?

- ♥ Angina is not a heart attack. When a person with coronary heart disease exercises, or gets angry or excited, the heart works harder and needs more blood flowing to it. Angina is when the arteries are not wide enough to deliver the blood flow needed
- ♥ Angina pain is similar to a heart attack but usually goes away when the person stops doing whatever caused the pain or takes nitroglycerine tablets or spray
- ♥ Sometimes people with diabetes have angina and heart attacks without feeling pain

What is atherosclerosis?

♥ Atherosclerosis is the gradual clogging of the arteries that supply blood and oxygen to heart, brain, kidneys and other vital organs

♥ Atherosclerosis:

- ♥ narrows the inside of the arteries which makes less room for the blood to flow
- ♥ means that less oxygenated blood flows to the cells — this is called ischaemia
- ♥ causes the arteries to become harder and less elastic — hardening of the arteries
- ♥ can affect any artery in the body

What causes atherosclerosis?

♥ The process of atherosclerosis often begins during childhood and adolescence. Certain conditions and behaviours tend to speed up its development including:

- ♥ family history of high cholesterol
- ♥ a diet high in fat and salt and low in fibre
- ♥ being overweight
- ♥ smoking
- ♥ diabetes, especially if uncontrolled
- ♥ insufficient physical activity
- ♥ high blood pressure
- ♥ depression

Is it a heart attack?

You don't have to be having chest pain to be having a heart attack

It may be a heart attack if there is:

- ♥ Pain or discomfort in the centre of the chest lasting more than 10–15 minutes AND/OR
- ♥ Pain in one or both arms, the shoulders, the throat and/or the bottom jaw

There may also be:

- ♥ Sweating
- ♥ Shortness of breath
- ♥ A sick feeling in the stomach
- ♥ Dizziness
- ♥ Feeling generally unwell

What to do

- ♥ The person should seek medical attention straight away
- ♥ If the hospital is too far, call a doctor, nurse or Aboriginal Health Worker
- ♥ Use an ambulance if possible — call 000 (triple zero)
- ♥ The sooner the person gets treatment the less damage there will be to the heart

Heart valve problems

How do heart valves work?

- ♥ Your heart has a number of one-way valves. If these valves become damaged or narrower than usual, they don't work properly. They can leak and slowly weaken the heart, causing heart failure

What causes heart valve problems?

- ♥ Heart valve problems can be caused by rheumatic fever. It is important to treat rheumatic fever as early as possible

What are symptoms of heart valve problems?

- ♥ Heart failure can cause shortness of breath, tightness in the chest, a feeling that you can't keep up with exercise or get your wind

What can be done?

- ♥ Treatment options include medications to prevent heart failure and surgery to repair or replace the faulty valve

Heart rhythm problems

The heart has its own electrical system to control its pumping. This system keeps the heart beat regular. Sometimes problems occur and help is needed to get the heart beat back to normal.

- ♥ **Defibrillator:** This is a machine that delivers a controlled electric shock or series of shocks to the heart to return it to its normal rhythm. These machines are carried in some ambulances and located in hospitals and some clinics.
- ♥ **Implantable defibrillators:** In some cases a small defibrillator may be placed in a person's chest to check the heart's rhythm and give an electric shock when it is needed.
- ♥ **Pacemakers:** An artificial pacemaker is a small electrical device used to stimulate the heart to beat. Each year, thousands of Australians have these devices placed in their body to help the heart beat normally. The pacemaker's batteries usually last for 10 years or more before needing to be replaced.

What is high blood pressure?

Blood pressure (BP) is the pressure of the blood against the walls of the arteries

High blood pressure causes you to get sick and have health problems:

- ♥ Heart disease
- ♥ Stroke
- ♥ Kidney disease or failure
- ♥ Eye problems

What causes high BP?

- ♥ Family history
- ♥ Being overweight
- ♥ Eating too much fat or salt
- ♥ Drinking too much alcohol
- ♥ Getting little or no exercise
- ♥ Kidney problems
- ♥ Cigarette smoking

What can be done to help manage high BP?

- ♥ Have your BP checked regularly
- ♥ Keep to a healthy weight
- ♥ Exercise regularly
- ♥ Drink less alcohol
- ♥ Do not smoke
- ♥ Take your medications

Understanding tests and treatments

Tests for heart problems

Sometimes tests are needed to learn more about how well your heart is working.

- ♥ **Angiography:** A coronary angiogram (or angiography) shows whether the arteries in the heart are badly clogged and how well the heart is pumping. A small tube is inserted into an artery in the arm or leg and guided towards the heart. Dye is injected through the tube and pictures are taken as the dye moves through the heart and arteries
- ♥ **Electrocardiogram (ECG):** An ECG is a reading of the heart's electrical impulses. Special leads are placed on the chest, arms and legs to produce a picture of the electrical impulses on a long strip of paper or a small television screen. This picture can show whether you are likely to have heart disease
- ♥ **Echocardiography:** This test uses ultrasound waves that come from a small hand piece placed on the chest. The waves bounce back to give a picture of the inside of the heart
- ♥ **Exercise stress test:** This test shows whether the blood supply is reduced in the arteries that supply the heart. Your heart rate is monitored while you walk on a treadmill. As you walk faster, your heart must pump more blood
- ♥ **Blood tests:** Your blood offers many clues about your heart health. Blood tests can show whether you have high levels of "bad" cholesterol or even if you've had or are likely to have a heart attack
- ♥ **Chest X-ray:** A picture that shows the heart, lungs and ribs

Procedures for heart disease

If the arteries supplying blood (and oxygen) to your heart become clogged or narrow, you may need a procedure to improve blood flow to your heart.

- ♥ **Angioplasty and stents:** Angioplasty improves the blood flow to the heart without the need for heart surgery. It uses a special balloon (plasty) to open a blocked artery at the point where it is narrow. A wire cage called a 'stent', is usually placed in the artery once it has been widened. This helps to keep it open.
- ♥ **Bypass surgery:** This operation creates a detour for the blood flow to bypass narrowed areas in the arteries, allowing blood to get to the heart muscle. The bypass is made from a piece of blood vessel from either the chest or arm, or from leg veins.

After hospital

What happens after hospital?

After you leave the hospital you need to:

- ♥ Contact your clinic about your continuing care, including cardiac rehabilitation
- ♥ You can also contact the clinic if you have any questions or need support
- ♥ Continue taking any medicines that you were given in hospital
- ♥ Follow any wound care instructions you were given in hospital
- ♥ Follow any activity guidelines that you were given in hospital
- ♥ Look forward to getting back to your favourite activities with time

See your doctor or Aboriginal Health Worker if you have:

- ♥ Angina-type pain (chest, arm, neck, jaw, back)
- ♥ Shortness of breath that is new or increasing
- ♥ Severe or increasing tiredness
- ♥ Dizziness or feeling faint
- ♥ Irregular heart beats or pounding fast heartbeat

Feeling down after surgery or heart attack?

Many people feel anxious or depressed after a heart attack or heart surgery. These feelings may be due to many reasons including being worried that you're going to have another heart attack, being afraid of dying, fear that you are not making progress or that the operation was not successful. You may also be worried about going back to work.

These fears and changing emotions are normal and a natural reaction to what you have been through. It often helps to have family and friends around you. You will probably have good days and bad days. However, most people start to feel better as time passes, as they get back into their usual routine and the anxiety starts to lessen.

How do I know if I'm depressed?

If you experience tiredness, irritability, difficulty with sleeping, find it difficult to concentrate, cry or feel tearful on a regular basis, lose interest in things you normally enjoy or you start to lose your temper easily, it may be a sign of depression.

Depression and anxiety can also cause physical symptoms, which are sometimes very similar to the symptoms of coronary heart disease, including tiredness, chest pain, breathlessness and palpitations. Your symptoms may vary from day to day.

What can I do?

- ♥ Talk to family and friends or someone who has been through the same experience
- ♥ Talk to your Aboriginal Health Worker or doctor
- ♥ Take part in cardiac rehabilitation

What is cardiac rehabilitation?

Cardiac rehabilitation can help you if you:

- ♥ Have heart problems, such as angina or heart failure, or have had a heart attack
- ♥ Have had bypass surgery or a valve replacement
- ♥ Have an implanted defibrillator
- ♥ Have had a balloon catheter (angioplasty), a stent or other cardiac procedure

Cardiac rehabilitation helps you to:

- ♥ Feel better faster, emotionally and physically
- ♥ Get stronger
- ♥ Learn how to reduce stress
- ♥ Become confident to care for your health and return to former activities
- ♥ Reduce the risk of further heart problems
- ♥ Live longer

Cardiac rehabilitation involves learning about:

- ♥ Your heart problem, its causes and treatments, and how you can manage it
- ♥ How to exercise for heart health
- ♥ How to change your lifestyle to lower the chance of future problems

Cardiac rehabilitation may involve many different health professionals, such as Aboriginal Health Workers, doctors, nurses, exercise specialists, dietitians, social workers, psychologists and pharmacists. You and your family are an important part of the team

Medicines for heart problems

There are many different types of heart medicines. Some are taken for a short time or course, others are taken for the rest of your life. For some you need to have the amount of medicine in your blood monitored.

Heart medicines are important because they:

- ♥ Reduce the risk of having a heart attack or of heart failure
- ♥ Help control the rhythm of the heart
- ♥ Help to control blood pressure or cholesterol
- ♥ Help remove excess water from your body

For the medicines to do their job:

- ♥ Take them at the same time each day
- ♥ Never take less or stop taking the medicine without talking to the doctor or Aboriginal Health Worker
- ♥ Do not wait until the medicine runs out before you get more
- ♥ Be careful not to miss a dose and don't take more than one dose at a time without talking to a health professional first
- ♥ Never take someone else's medicine

Talk to your Aboriginal Health Worker, doctor or pharmacist if:

- ♥ You think that the medicines are causing side effects
- ♥ You need help with the costs of medicines
- ♥ You need help remembering to take them

Getting support or information

Your clinic will usually be able to provide you with an explanation of your heart condition, any procedures that you have had and information on lifestyle choices that will help you to stay well

There are also other organisations that you can contact for support or information for the cost of a local call

♥ For questions about heart health, call the National Heart Foundation's Heartline 1300 36 27 87

(Monday to Friday 8:30am to 6:30pm Eastern Standard time)

♥ If you are feeling depressed and need to talk to someone straight away call:

♥ Lifeline — 13 11 14

♥ Lifeline's Just Ask Mental Health Information Line
1300 13 11 14 (rural areas only, Monday to Friday
9am to 5pm EST)

♥ Mensline Australia — 1300 78 99 78

♥ For help with quitting smoking call the
Quitline — 13 78 48

Secondary prevention

Tips for a healthy heart

- ♥ Don't smoke
- ♥ Enjoy healthy eating
- ♥ Drink less alcohol
- ♥ Be more active
- ♥ Keep your blood pressure under control
- ♥ If you have diabetes, keep blood sugar within normal limits
- ♥ Keep cholesterol level within normal limits
- ♥ Lose your extra body fat (especially belly fat)
- ♥ Try to relax and stress less
- ♥ Take any medicines that have been prescribed for you
- ♥ Have regular health check ups
- ♥ Be involved in healthy activities you enjoy every day
- ♥ Be involved in your community in any way you can

Healthy eating for your heart

- ♥ Eat a variety of foods from the different food groups, including:
 - ♥ plenty of vegetables (all kinds, fresh is best), pulses (eg baked beans, salad beans, lentils) and bush tucker
 - ♥ medium amounts of bread, cereals, rice, pasta, noodles (try to use wholegrain products that are low in sugar and fat)
 - ♥ include:
 - fruit (two serves a day)
 - fish, lean meats (trimmed of fat), chicken (skinned), bush tucker and reduced fat dairy products
 - small amounts of polyunsaturated or monounsaturated oils and fats (eg olive oil, canola oil and margarine)
- ♥ Drink plenty of water (soft drinks, fruit juices and alcoholic drinks are all fattening)
- ♥ Try not to eat too many foods that are high in fat such as:
 - potato chips/crisps
 - take-away foods
 - salted nuts
 - processed meats
 - gravy powder

What is cholesterol?

Cholesterol is a white waxy fatty substance. It is made in the liver and released into the blood.

There are different types of cholesterol:

- ♥ 'Good cholesterol' — This is called HDL (or high-density lipoprotein). It mops up the bad cholesterol and protects you against heart disease. The more you have the better.
- ♥ 'Bad cholesterol' — Also called LDL (or low-density lipoprotein) it leads to fatty stuff building up in artery walls, which can lead to heart problems.

How to lower your cholesterol

- ♥ Keep a healthy weight
- ♥ Cut down on animal fats such as fatty meat, chicken skin, butter, cream and cheese
- ♥ Eat more fibre (fruit, vegetables, cereal, baked beans)
- ♥ Be active
- ♥ Be a non-smoker
- ♥ Take your medicines as advised
- ♥ Exercise regularly
- ♥ Keep control of diabetes
- ♥ Have your cholesterol level checked once a year

Tips for healthy weight

Being overweight or very overweight (obese) is bad for your health and for your heart. It makes it more likely that you will have serious health problems:

- ♥ Heart disease
- ♥ High blood pressure
- ♥ Stroke
- ♥ High cholesterol
- ♥ Diabetes
- ♥ Bone disease
- ♥ Cancer

Why is having a 'fat belly' BAD?

People come in many shapes and sizes. People with a 'pot belly' are more likely to have health problems, even if their arms and legs are skinny. Measuring your waist shows how much extra fat you are carrying around your belly.

- ♥ Men — aim for a waist measurement of 94cm or less
- ♥ Women — aim for a waist measurement of 80cm or less

Eating tips for a healthy body and healthy heart

- ♥ Eat a variety of foods
- ♥ Have low fat food
- ♥ Eat at least 5 serves of vegetables a day
- ♥ Eat smaller portions of food
- ♥ DO NOT SKIP BREAKFAST

Getting active for your heart

Why get active?

- ♥ Regular physical activity makes the heart stronger
- ♥ Being active also makes you feel better
- ♥ Physical activity helps to control your weight and blood pressure

How to get active?

- ♥ Talk to your doctor or Aboriginal Health Worker before you start
- ♥ Aim for 30 minutes of exercise every day
- ♥ Start by taking a walk with a friend for 5 minutes on flat ground — if you can comfortably talk, the exercise is not too strong for your heart
- ♥ Build up by adding 5 minutes a week until you are walking 30 minutes a day
- ♥ You don't have to do the whole 30 minutes in one go, try three 10-minute walks
- ♥ Then try other activities, like swimming or gardening, playing sports, dancing, games or fishing as well
- ♥ Remember to drink water when exercising
- ♥ Wait 1 hour after a meal before you exercise
- ♥ Don't exercise in the heat of the day

Smoking, substance use and heart health

Smoking overworks the heart and reduces its oxygen supply, makes clots in the blood vessels more likely and increases the risk of changes to the heartbeat

Some good reasons to quit now

- ♥ Better health
- ♥ Save money
- ♥ Food tastes better
- ♥ Have more energy
- ♥ Live longer
- ♥ Better health for your family

Tips on quitting

- ♥ Pick a date to stop
- ♥ Don't try to give up before stressful events (eg job interview)
- ♥ Get your family to support you
- ♥ Plan for upcoming events like a party where others will be smoking
- ♥ Have someone to talk to
- ♥ Get help with patches or gum
- ♥ Call the Quitline 1 3 78 48 (cost of a local call)

Other substances

Don't replace one problem with another — chewing tobacco, bush tobacco (pituri) and petrol or glue sniffing also have a damaging effect on your health

Alcohol and heart health

What does drinking do to your heart?

- ♥ Alcohol raises your blood pressure. The more you drink, the more likely you are to have high blood pressure
- ♥ Over time, heavy drinking can weaken your heart so that it is not able to pump blood through your body as well
- ♥ Even a few drinks can affect your heart rate, blood pressure and how well blood is pumped through your body — this can be a problem if you already have heart disease

Some good reasons to quit or ease up now

- ♥ Alcohol makes it harder to control your weight, so giving it up will help you to lose weight
- ♥ Alcohol can make it harder to get on with family and friends
- ♥ No more feeling crook after drinking
- ♥ You'll have more money and reduce your medical costs

Depression and your heart

People who experience depression are more likely to develop heart disease, so it is important to look after your mind as well as your body

What is depression?

It is normal to feel sad every now and then. But when you are feeling sad or down for a long time — more than two weeks — or it happens for no reason, then you may be depressed. Depression ranges from mild to serious.

These are some signs of depression

Remember you do not have to have all of these

- | | |
|--|--------------------------------------|
| ♥ Waking up sad | ♥ Feeling sad most of the day |
| ♥ Being agitated and angry | ♥ Crying all the time |
| ♥ Not sleeping | ♥ Changes in appetite |
| ♥ Not being able to get to sleep | ♥ Feeling like “giving up” |
| ♥ More bad thoughts than good thoughts | ♥ Feeling lonely |
| | ♥ Waking up early |
| | ♥ Losing interest in things you like |

What can be done about depression?

It is no shame if you have depression and need to take medicine for it. The tablets today are safe.

- ♥ Talk to someone about it and get help
- ♥ Talk to your Aboriginal Health Worker
- ♥ Talk to your doctor or clinic staff
- ♥ Talk to the mental health team
- ♥ Talk to a counsellor or psychologist

Stress — why worry?

What is stress?

- ♥ Stress is how people react to events that happen in their life, family, community, work and relationships
- ♥ Everyone thinks and feels differently about things, so stress affects people differently
- ♥ Stress can be good as it tells our bodies to slow down

Stress can lead to unhealthy habits such as:

- ♥ Drinking too much alcohol
- ♥ Fighting with your people
- ♥ Smoking or taking drugs
- ♥ Being angry or depressed

Signs of stress can be physical and mental:

- ♥ Faster heart beat
- ♥ Quicker breathing
- ♥ Tension
- ♥ Going to the toilet more often
- ♥ Tight feeling in your stomach
- ♥ Irritable or having fights
- ♥ Not sleeping
- ♥ Being restless
- ♥ Crying
- ♥ Eating too much or not enough

What can I do about stress?

- ♥ **Step 1: Identify** — Find out your responses to stress, what is causing the stress
- ♥ **Step 2: Do** — Do something about it: give yourself time out; talk to someone; do some exercise or relaxation
- ♥ **Step 3: Act** — If you still feel stressed or worried you need to act now. Get help from colleagues, friends, Aboriginal Health Workers or clinic staff
- ♥ **Step 4: Think** — Think about the experience to learn about your stress patterns and what helps you to feel better or worse

TOOLKIT 3 — MATERIALS FOR HEALTH PROFESSIONALS

What is in this toolkit?

This toolkit provides additional information and materials for health professionals to assist them in putting the advice given in the guide into practice. The toolkit is aimed at health professionals in primary care and hospital settings who are working with patients who have experienced cardiac events or procedures. The tools are grouped by the stage of the patient's care to which they apply:

- ❖ preparing for a planned hospital admission
- ❖ hospital care
- ❖ care planning and secondary prevention
- ❖ cardiac rehabilitation, including how this guide can be implemented in various settings.

Resources that may be of use to health professionals involved in cardiac rehabilitation for Aboriginal and Torres Strait Islander patients (such as national and State-based guidelines) are also provided.

Preparing for a planned hospital admission

This section includes a checklist for pre-admission review in the primary care setting – This allows early identification of problems that may prevent a planned procedure from going ahead.

Checklist for pre-admission review

Smoking

It is essential that the patient has stopped smoking for six weeks before the surgery. This is because the risks of surgery are greatly increased if the patient is a smoker.

- ☐ Has the patient been advised of the need to stop smoking six weeks before the procedure?
- ☐ Has the patient stopped smoking? Date: / /

Dental health

- ☐ Has the patient been advised of the need for a dental health check?
- ☐ Has the patient had a dental health check? Date: / /

Systems health review

- ☐ Has an assessment of the patient's health been conducted?

Mental health

- ☐ Has the patient's mental well-being been assessed?

Social health

- ☐ Is someone available to assist the patient with daily activities (cooking, cleaning, washing, shopping) after discharge from hospital?
- ☐ If not, have alternative arrangements been made?
- ☐ Does the patient have dependents who will require care while he or she is in hospital?
- ☐ If so, have arrangements been made?

Education

- ☐ Has the patient and family/carer been provided with information about the planned procedure?
- ☐ Has the patient and family/carer been given information about limitations on activity after the procedure?
- ☐ Has the patient and family/carer been given information about cardiac rehabilitation?

Support

- ☐ Has the Aboriginal Liaison Officer at the hospital been contacted?
- ☐ If the patient has to travel a considerable distance for the procedure, has the State/Territory patient transport assistance scheme been contacted to determine whether support is available under the scheme?
- ☐ Have accommodation and transport for the patient's family/carer been organised and financial assistance sought where possible?

Hospital care

This section includes:

- ❖ forms for inpatient mobilisation and education after a cardiac event, from the National Heart Foundation (2004) *Recommended Framework for Cardiac Rehabilitation*, to assist in starting cardiac rehabilitation as soon as possible after a cardiac event
- ❖ a checklist for discharge planning, to help you ensure continuity of care in the transition from hospital to the community

Inpatient mobilisation

The mobilisation program can usually be commenced when the patient is clinically stable.

Program for:.....

Date commenced:...../...../.....

This mobilisation program is to help patients return to an activity level that allows them to be independent. Ward staff will regularly review and guide progress through stages 1–6. These stages do not necessarily correspond to days. In some situations, stages may be notional and mobilisation may be achieved in a single day. Individual assessment of progress should occur on a regular basis.

When doing any of these activities, symptoms such as chest pain, shortness of breath, fast heart rate and feeling dizzy or unwell should be reported to a nurse immediately.

Stage	Physical Activity	Date achieved	Comment
1	To the shower in a wheelchair. The nurse will shower patient while they remain seated. Go out to the toilet in the wheelchair. Sit out in a chair for meals. Do arm and leg exercises as shown.		
2	To the shower in a wheelchair. The nurse will shower patient while patient remains seated. Go out to the toilet in the wheelchair. Sit out in a chair for meals. Do arm and leg exercises as shown. Walk slowly for 1–2 minutes twice a day		
3	Patient to shower on their own while seated on the wheelchair. Walk to the toilet as necessary. Sit out in the chair as often as patient wishes. Walk slowly for 2–3 minutes twice a day.		
4	Shower. Walk at an easy pace for 3–4 minutes twice a day. In addition, patient may walk around room as much as they like.		
5	Shower. Walk for 4–5 minutes twice a day. Climb one flight of stairs with the supervision of the nurse or physiotherapist.		
6	Shower. Walk for up to 10 minutes twice a day. Climb two flights of stairs with the supervision of the nurse or physiotherapist.		

Inpatient education

Program for:.....

Date commenced:...../...../.....

Details of patient education should be documented in the patient's medical records. It is recommended that the health (medical) professional responsible for addressing a particular topic sign for that topic when completed.

If a topic is not applicable this point should be recorded. For short-stay patients (1–2 days) the emphasis will be on discharge planning and follow-up.

Topic	Discussed	Resources provided	Action/ comment required	Sign/Date
❖ Explanation of the cardiac condition, treatment, procedures and recovery				
❖ Psychological and social implications of the illness including: — return to work — driving — social support — effect on mood (eg depression, anxiety)				
❖ Explanation of the Inpatient Mobilisation Program				
❖ Management of symptoms in hospital				
❖ Medications (stressing the importance of ongoing concordance with prescribed medications)				

Topic	Discussed	Resources provided	Action/comment required	Sign/Date
Risk factor modification: ❖ Smoking ❖ Nutrition goals: — blood cholesterol — weight management targets — alcohol consumption guidelines ❖ Physical activity goals: — establishing a pattern of regular activity — resumption of lifestyle activities — resumption of sexual activity ❖ Blood pressure goals				
❖ Wound care (where applicable)				
❖ Management of chest pain or discomfort post discharge ❖ Outpatient cardiac rehabilitation discussed and referral made				

Other comments:

On discharge the patient to sign:

I.....have participated in discussion of the topics as outlined above

Signature:.....Date:...../...../.....

Patient comments:

Discharge planning checklist

- ☐ Has a discharge summary been provided to the patient's case manager (eg Aboriginal Health Worker or GP)?
- ☐ Has the patient been given and understood information about changes to his or her medications?
- ☐ Has the patient been given and understood information about wound care?
- ☐ Has the patient been given information about limitations to daily activities and when normal activities may be resumed?
- ☐ Is someone available to assist the patient with daily activities?
- ☐ Has the patient been provided with information on cardiac rehabilitation, including the availability of any programs in his or her local area?

Care planning and secondary prevention

This section includes:

- ❖ a checklist for carrying out the Aboriginal and Torres Strait Islander Health Check, which lists the information you need to collect to meet the requirements for Medicare item 710
- ❖ explanation of how to use the information gathered in the Health Check to determine a patient's cardiovascular risk
- ❖ a care plan checklist that aims to assist practitioners in the delivery of services and enable them to meet the requirements for Medicare items at the initial consultation and for ongoing review
- ❖ information that may assist with the secondary prevention phase

Checklist for the Aboriginal and Torres Strait Islander Adult Health Check (Item 710)

Patient's surname:

Other names:

Patient contact details:

Alternative contact details:

DOB: / / Age:

Dr:

Date/s check provided:

Patient gender: Male/Female

Patient consent: Date: / /

Previous health check Date: / /

Identification: Aboriginal
 Torres Strait Islander
 Aboriginal and Torres Strait Islander

Pre check

- ☐ Explanation of check and likely benefits to patient
- ☐ Verbal or written consent given by patient
- ☐ Personal details (name, age, gender) and contact details

Other items recommended for collection

- ☐ Alternative contact details
- ☐ Obtain and examine previous patient records

History

- ☐ Patient medical history and current health problems
- ☐ Risk factors
- ☐ Family medical history
- ☐ Medication usage (including OTC and prescribed)
- ☐ Immunisation status (refer to current schedule)
- ☐ Sexual and reproductive health
- ☐ Physical activity, nutrition and alcohol, tobacco or other substance use
- ☐ Hearing loss
- ☐ Mood (depression and self-harm risk)
- ☐ Family relationships (is the patient a carer or cared for by others?)

Other items recommended for collection if indicated

- ☐ Social support and networks
- ☐ Work status (eg paid/unpaid, CDEP, in training or education)
- ☐ Environmental and living conditions
- ☐ Other history as considered necessary by the practitioner or collector

Examination of the patient

- ☐ Measurement of blood pressure, pulse rate and rhythm
- ☐ Measurement of height and weight to calculate BMI
- ☐ Oral examination (gums and dentition)
- ☐ Ear and hearing (otoscopy)
- ☐ Urinalysis (dipstick) for protein/urea

Other items recommended if indicated

- ☐ Measure waist circumference for central obesity
- ☐ Whisper test
- ☐ Reproductive and sexual health examination
- ☐ Trichiasis check
- ☐ Skin examination
- ☐ Visual acuity (recommended for people over 40)
- ☐ Other examinations considered necessary by the practitioner

Investigations as indicated

- ☐ Fasting blood sugar and lipids (lab-based test on venous sample)
- ☐ Random blood glucose
- ☐ Pap smear
- ☐ STI testing (urine or endocervical swab for chlamydia/gonorrhoea especially for those aged 15–35 years)
- ☐ Mammography (schedule appointment/refer directly) (if eligible)
- ☐ Other investigations considered necessary by practitioner and in accordance with current recommended guidelines

Intervention

- ☐ Assess patient's risk factors
- ☐ Discuss results of check with patient

Other items recommended as indicated

- ☐ Discuss risk factors with patient
- ☐ Provide preventive health advice
- ☐ Provide intervention activity:
 - initiation of treatment
 - referral
 - education, advice or assistance
- ☐ Other interventions considered necessary by practitioner

Care planning

- ☐ Documentation of simple strategy of good health for patient
- ☐ Record of health check kept on file
- ☐ Offer patient a written report about the health check, with recommendations about matters covered by the health check, and a simple strategy for good health of the patient.

Recommended

- ☐ Register patient for two-yearly reminder of check

Cardiovascular risk assessment

Risk assessments should be provided at the primary care level by health practitioners with appropriate training, infrastructure support, systems for follow-up and systems that improve quality.

When the assessment is carried out as part of a two-yearly health check, the doctor must have a personal consultation with the patient, perform all of the medical components of the check, review patient information and communicate their recommendations to the patient. However, an Aboriginal Health Worker, nurse or other qualified health professional may:

- ❖ take or update the patient's personal information and contact details and get the patient's consent to proceed with the check
- ❖ take or update the patient's medical history
- ❖ collect information as part of the examination (eg take blood pressure, pulse rate and rhythm, height and weight and calculating BMI).

How is the risk assessment carried out?

The risk assessment involves:

- ❖ History — The first stage of the assessment involves reviewing the patient's family history (if known) and risk behaviours. It is important that patients do not feel interrogated or judged while questioning takes place. Open-ended questions are a good starting point eg What history of heart problems is there in your family? How do you feel about your smoking? What foods would you eat on an average day? What kind of sport or other outdoor activities do you like?
- ❖ Physical assessment — The physical assessment gathers information on the patient's weight, level of obesity and central obesity and blood pressure.
- ❖ Biochemical tests — Additional biochemical tests may be used to assess levels of blood cholesterol and blood glucose.

Putting it all together

Once the information described above has been gathered, it can be used to determine the patient's risk of cardiac events.

In non-Indigenous patients, the risk of the patient having a cardiovascular event over a given period of time — the absolute risk — is usually calculated using risk tables or electronic decision support tools that are based on a study carried out in the United States, the Framingham Study.

The risk equations used in these tools may have limited applicability to Aboriginal and Torres Strait Islander Peoples as they do not take into account the impact of diabetes and obesity in this group. As well, the age groups used in the tables are based on life expectancy in non-Indigenous Australians. At present there are no validated tools for cardiovascular risk assessment in Aboriginal and Torres Strait Islander Peoples.

Care plan checklist

Care planning is increasingly used as a tool in managing patients with chronic or complex conditions, at the initial consultation and also to monitor progress and review medical management and lifestyle changes. To ensure that services are properly provided and as a requirement for Medicare benefits to be made, GPs must keep a written record of a health assessment and a care plan and the patient must be offered a copy of the record.

Practitioners may find the easiest way to ensure these requirements are met is by using an appropriate form suited to their needs. The Royal Australian College of General Practitioners has developed proformas for health assessments and care plans, which have been adapted for local use by many Divisions of General Practice.

Proformas developed for local requirements should support practitioners in the delivery of services and enable them to meet the requirements for the Medicare items. A checklist that covers the basic elements for a care plan is given below.

- ☐ Reminder to check for previous and current care plans (should not duplicate another active care plan)
- ☐ Patient's name
- ☐ Patient's consent to care plan service and sharing of information with other service providers
- ☐ Evidence of biopsychosocial assessment of patient and their chronic and complex care needs as documented by identification of needs and goals
- ☐ Management goals, agreed to by patient (may be covered by agreement to the care plan)
- ☐ Assessment of the treatment the patient will require as documented by tasks
- ☐ Specify medical and care personnel that can provide the above treatment
- ☐ Evidence that other health providers have been involved and contributed to the plan eg signature, identification of ongoing care and services to be provided by members of the team
- ☐ Review date
- ☐ Patient (and, if appropriate and with the patient's agreement, the patient's carer) to be offered a copy of the plan
- ☐ Carer details (if the patient has a carer)

Supporting secondary prevention

As well as care planning, there are many resources and programs developed to assist health professionals in primary care to support patients to take control of their health and self-manage their heart disease for life. Details of the resources mentioned can be found in the resources list on the following pages.

The information given below is based on material developed for the NSW Aboriginal Vascular Health Program.

Brief interventions

Brief interventions are short conversations in which the health professional provides education and counselling on a particular topic, such as smoking cessation or alcohol consumption. Generally a topic can be covered in one to four sessions, each session lasting from a few minutes to an hour. There are six key ingredients to a brief intervention, summarised by the acronym FRAMES:

Feedback — provide patients with feedback on the risks for heart problems based on their current risk factors

Responsibility — tell patients that no one else can make them change or make them decide to change. What they do about their risk behaviours is up to them

Advice — advise patients to change their risk behaviours (eg stop smoking, reduce alcohol intake, increase physical activity etc)

Menu of strategies — offer patients a variety of strategies from which to choose to change their risk behaviour

Empathy — a warm reflective and understanding style of delivering brief intervention is more effective than an aggressive, confrontational or coercive style

Self-efficacy (eg patients' motivation, skills and confidence to manage their condition) — encourage patients to rely on their own resources to bring about change and to be optimistic about their ability to change.

The importance of these elements in enhancing effectiveness has been supported by further review. Goal setting, follow-up and timing are also important to the effectiveness of brief intervention:

Goal setting — negotiate a goal with the patient and if possible put this in writing as a contract signed by the patient — make sure that the goal is specific and has a timeframe

Follow-up — follow-up on the patient's progress and provide ongoing support — follow-up may take the form of telephone calls, repeat visits or repeat assessments or tests

Timing — it is important to assess the patient's readiness to change when beginning an intervention and to match the intervention techniques to the patient's stage of change.

Stages of change

The Stages of Change model can be used in the assessment and management of risk behaviours — smoking, poor nutrition, alcohol consumption and physical inactivity. According to the model, individuals engaging in new behaviour (such as giving up smoking) move through a series of stages. Determining the stage of change the patient is at and adapting management accordingly will improve the chance of achieving a successful outcome.

Sharing Health Care guidelines

These chronic condition self-management guidelines, developed by the RACGP, promote a generic, patient-centered approach to self-management, based on the Stages of Change theory. Guidance and tools are provided for general practitioners and allied health professionals on working with patients to promote self-management of complex and chronic conditions.

Stage	Role of health professional
Pre-contemplation Individuals in this stage have no desire to change and are not even considering changing their behaviour in the next six months	Consciousness/awareness raising Discuss with the patient the health problems associated with the unhealthy behaviour and the feasibility of giving up.
Contemplation The individual has the intent or is considering making a change to his or her behaviour within the next six months	Motivation Help the patient recognise the benefit of change
Preparation The individual is ready to make a behaviour change within the next month	Barrier identification Assist the patient to identify barriers that may make the change more difficult and how these can be dealt with successfully
Action This stage is the first six months after the behaviour change has occurred	Planning Develop an action plan with the patient and monitor closely
Maintenance This stage starts six months after the action stage and can last for several years	Follow-up and support Organise routine follow-up and discuss the possibility of relapse. If relapse occurs support the patient in further attempts to change behaviour

The stages of change model and its use in self-management is covered in the RACGP guidelines *SNAP A Population Health Guide to Behavioural Risk Factors in General Practice and Sharing Health Care: Chronic Condition Self-Management Guidelines*.

The SNAP framework

The SNAP (Smoking, Nutrition, Alcohol, Physical activity) framework aims to support GPs in decreasing levels of common risk behaviours. The framework represents a system-wide approach to behavioural risk factor identification and management, also acknowledging the importance of socio-economic factors. The initiative targets consumer awareness of the links between behavioural risk factors and chronic disease and highlights the role of the GP as an agent for supporting behavioural change.

Implementing the guide in different settings

Cardiac rehabilitation program content

The table below gives a summary of the content of a cardiac rehabilitation program as recommended by the National Heart Foundation of Australia.

Inpatient	Outpatient	Secondary prevention
Mobilisation and resumption of activities of daily living See under “Hospital care” in this toolkit	Low or moderate intensity physical activity program <ul style="list-style-type: none"> ❖ Minimum of 6 sessions, weekly or twice weekly, including warm-up and cool-down period, and catering for the individual needs and capacities of each patient ❖ Written guidelines for resumption of daily activities, including home walking program, and aiming at an accumulation of 30 minutes or more of light to moderate physical activity on most, or all, days of the week ❖ Individual review of physical activity program at each contact 	Regular physical activity
Basic information, education and counselling <ul style="list-style-type: none"> ❖ Reassurance and explanation of cardiac condition, treatment and procedures ❖ Psychological issues eg mood (depression), emotions, sleep disturbance ❖ Social factors eg family and personal relationships, social support, social isolation ❖ Explanation of the inpatient activity (mobilisation) program. ❖ Management of symptoms eg chest pain, breathlessness, palpitations ❖ Medications ❖ Identification and modification of risk factors ❖ Wound care (if applicable) ❖ Resumption of physical, sexual and daily living activities (including driving and return to work) ❖ Discharge planning, including referral to outpatient program 	Education, discussion and counselling <ul style="list-style-type: none"> ❖ Basic anatomy and physiology of the heart ❖ Effects of heart disease, the healing process, recovery and prognosis ❖ Risk factors for heart disease and their modification for secondary prevention ❖ Skills for behaviour change and maintenance ❖ Resumption of physical, sexual and daily living activities including driving and return to work ❖ Psychological issues eg mood (depression), emotions, sleep disturbance ❖ Social factors eg family and personal relationships, social support, social isolation ❖ Management of symptoms eg chest pain, breathlessness, palpitations ❖ Medications ❖ Investigations and procedures ❖ Cardiac health beliefs and misconceptions 	Supporting concordance with goals of medical therapy, including medications <ul style="list-style-type: none"> ❖ Coordinated chronic disease management including ongoing individual medical care ❖ Monitoring of risk factors (lipids, blood pressure etc) Support for maintenance of behaviour change (remain smoke free, regular physical activity, healthy eating etc) <ul style="list-style-type: none"> ❖ Communicate with treating doctor and/or primary care provider ❖ Heart support and/or other community-based groups ❖ Ongoing access to education and discussion sessions as required ❖ Home or community-based walking and/or other physical activity program ❖ Individual assessment and referral to appropriate health professionals as required ❖ Telephone follow-up ❖ Ongoing care in general practice setting
Discharge planning Referral to outpatient program	Referral to secondary prevention program	

Implementing the guide in different settings

Ideally, cardiac rehabilitation programs for Aboriginal and Torres Strait Islander patients are delivered by a multidisciplinary team of health professionals, coordinated by the patient's case manager (Aboriginal Health Worker or GP) or by a cardiac rehabilitation coordinator, with services being provided in the patient's local health service.

However, the reality is that many health services lack the infrastructure or access to specialists, allied health professionals, counselling and other multidisciplinary teams to provide a full cardiac rehabilitation program. Where these resources are available there may still be problems in providing programs that are accessible to Aboriginal and Torres Strait Islander patients.

The guide includes a great deal of information on providing cardiac rehabilitation in a culturally respectful way. This tool uses a stepwise approach and fictional scenarios to outline how you can use this information to develop an implementation plan for your setting.

- 1 **Read** Chapters 1-6 of the guide.
- 2 **Relate** the information to your setting:
 - ❖ Which **health professionals** are available to become involved in providing cardiac rehabilitation (both within your health service and in the local area)?
 - ❖ What **services** are available that could be adapted to provide elements of cardiac rehabilitation (eg existing group sessions or clinics, visits by heart health experts)?
 - ❖ What **resources** are available (patient information [written and pictorial] on heart disease, cardiac rehabilitation and secondary prevention; and education/training resources for health professionals)?
 - ❖ Is there any **funding** available to set up new services/programs or incorporate elements of cardiac rehabilitation into existing services?
 - ❖ Are the practices of your health service **respectful of the culture** you serve?
- 3 **Develop** a plan for your organisation:
 - ❖ Look at the checklists at the end of each chapter and think about which processes are already in place and which need to be set up.
 - ❖ Look at the toolkits and decide which ones apply to your situation:
 - Are there people in the health service with limited experience in working with Aboriginal and Torres Strait Islander Peoples who would benefit from reading Toolkit 1? Is cultural safety training available?
 - Which information sheets in Toolkit 2 are relevant to your patients? How can they be adapted and illustrated so they best suit your patients and your setting? What other patient

information resources do you have? Do you need to get hold of some visual props, such as a model of the heart or samples of cardiac devices?

- Can the checklists and forms in the earlier sections of Toolkit 3 be incorporated into existing processes to assist with pre-admission review, care planning and secondary prevention?
- Which resources in the list at the end of Toolkits 3 and 4 would be useful to get copies of or borrow?
- Do you need to prepare a business case (as described in Toolkit 4) to obtain funding for cardiac rehabilitation services?
- Can existing structures (eg specific Medicare items [described in Toolkit 4]) be used to provide funding for extra services?
- Have you thought about ways to build local capacity, increase access to resources and help to build networks for referral through relationships with other organisations and individuals?

Remote settings

Health professionals in remote settings are likely to already have many demands on their time and abilities. However, there are ways in which Aboriginal Health Workers and nurses in remote areas can work cardiac rehabilitation into the services they provide without greatly increasing their workload or stretching resources, as illustrated by this scenario.

Scenario — making cardiac rehabilitation possible in a small remote community

The health service in a small remote community is run by an Aboriginal Health Worker and a nurse. Neither have had any experience in cardiac rehabilitation but there are now four community members who have had cardiac events and a number of people in the community have multiple risk factors for cardiovascular disease. Both members of the health service are fully occupied with providing acute care so have no time to attend training courses or to provide extra services. The area's GP is only able to visit once every two weeks and cardiac surgery is carried out in another state.

The health professionals read this guide to find out what is involved in cardiac rehabilitation. While there are many areas that are beyond their expertise, they realise that they can play an important role in secondary prevention of further cardiac events in the patients who have had procedures. As a first step, they decide to make the most of clinic visits to raise awareness and get their patients thinking about making changes to improve their health. They also decide to set up a small group, hoping that family members will also attend. The limited number of people interested, combined with kinship issues, means that the planned group does not go ahead and another way of getting the message across needs to be tried.

The health service is run on a “walk-in” basis and the health professionals decide to set aside one afternoon a fortnight for matters related to cardiovascular health. They talk to the community Elders about what they consider would be an appropriate approach. Then they use Toolkit 2 to put together some information sheets about cardiovascular risk factors and obtain a model of a heart from a pharmaceutical company. They also make posters and put them up around the health service explaining that from now on every second Wednesday “belongs to the heart”. They contact patients who have identified risk factors as well as the patients who have had cardiac events and explain that they will be available to answer questions and will be providing a healthy afternoon tea.

Regional settings

There are many regional settings where elements of cardiac rehabilitation are available, although these are likely to be in mainstream organisations. Aboriginal and Torres Strait Islander patients are more likely to become involved in cardiac rehabilitation programs if they are offered in settings where they feel comfortable, such as their local clinic or community centre. Health professionals working within Aboriginal Community Controlled Health Services can provide some of these services, and health professionals from other organisations can assist by providing services in alternative settings.

Scenario — Providing cardiac rehabilitation at the Aboriginal Community Controlled Health Service

The cardiac rehabilitation coordinator (CRC) recently employed by the area health service in a regional area has had reasonable success so far in setting up a cardiac rehabilitation program, running a few groups a week as well as visiting individuals. She has developed good networks with most of the GPs in the area and they are referring patients to the program. The hospital is also referring patients to her and numbers of people enrolled in the program are rising. Although there is a large Aboriginal population in the area none of them are attending, despite the fact that the CRC visits all patients in the cardiology ward and initiates discussion about the program.

The CRC approaches the local Aboriginal Community Controlled Health Service and learns that no cardiac rehabilitation program is being offered by the service. The GPs from the service agree to refer patients and the CRC puts up some posters around the health service to let people know that the program exists. Over the next few weeks enrolment in the program continues to rise but no Aboriginal people attend. The CRC then reads a copy of the guide and learns about some of the barriers to Aboriginal people attending mainstream services.

Still determined to involve this group of patients, the CRC has a close look at the material in Toolkit 1 and then goes back to the Aboriginal health service and talks to a few of the Aboriginal Health Workers. She asks if she can run an information session at the health service and eventually does this together with two Aboriginal Health Workers.

The CRC is surprised that she ends up learning from the patients as much as the other way around. As a group they decide to make a video to tell people about cardiac rehabilitation and they do this over the next few weeks. The CRC uses the information in Toolkit 2 to help the community members with the messages but it is the patients who do the talking and come up the wording.

The video is run in the waiting area of the health service and the CRC starts coming down to the service to talk to patients when they come in for other reasons. After a while she is able to start a group that she and one of the Aboriginal Health Workers run from the health service.

Urban settings

In urban settings patients are likely to have access to outpatient programs provided by a hospital and to other structured cardiac rehabilitation programs. However, these programs are not usually developed specifically around the needs of Aboriginal and Torres Strait Islander patients. If the patient is unwilling to attend a hospital-based program, aspects of outpatient rehabilitation can be provided in a more appropriate setting (such as the Aboriginal Community Controlled Health Service). Alternatively, hospital-based programs can take steps to provide a culturally safe environment for their Aboriginal and Torres Strait Islander patients.

Scenario — Mainstream services meeting Aboriginal needs

A large teaching hospital has been running outpatient cardiac rehabilitation programs for some time. Aware of the number of Aboriginal and Torres Strait Islander patients attending for cardiac procedures, the hospital management has employed an Aboriginal Liaison Officer. His role is mostly to provide transport to members of the Aboriginal community so that they can attend the outpatient program. The program is run by a non-Indigenous health professional and there are few other Aboriginal or Islander staff members at the hospital. Numbers of Aboriginal and Islander patients attending the program remain low and few complete the full program.

When a member of hospital management reads the guide, she realises that the experience of Aboriginal and Islander patients at the hospital could be improved and that this might also improve attendance at the cardiac rehabilitation program. She uses Toolkit 4 to prepare a business case for more funding for cardiac rehabilitation and lobbies for employment of more Aboriginal and Islander staff, particularly Aboriginal Liaison Officers and staff in the reception area. She pushes for a revision of the Aboriginal Liaison Officer job description so that it includes assisting patients while they are in the hospital, and makes a case for involvement of Aboriginal Health Workers in some aspects of the cardiac rehabilitation program. A protocol is also developed for assisting the families and carers of patients from remote areas.

Resources for health professionals

This list of resources aims to assist health professionals in increasing their understanding of aspects of cardiac care and rehabilitation and in accessing existing guidelines. Before using a specific guideline, health professionals should check with their health authority on preferred guidelines in their State/Territory

Resources for health professionals

Cultural competency

See Toolkit 1.

Aboriginal and Torres Strait Islander health

- ❖ Australian Bureau of Statistics and Australian Institute of Health and Welfare (2003) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. www.aihw.gov.au
- ❖ Australian Institute of Health and Welfare (2004) *Heart, Stroke and Vascular Diseases Australian Facts 2004*. www.aihw.gov.au
- ❖ NSW Health (2003) *Facts about Aboriginal Vascular Health*. NSW Health Department, Sydney.

Cardiac rehabilitation for Aboriginal and Torres Strait Islander Peoples

- ❖ Chalmers E (2001) Improving access to cardiac rehabilitation for remote Indigenous clients. *6th National Rural Health Conference Proceedings 2001*. pandora.nla.gov.au/tep/10767
- ❖ Lea T (1999) *Report on GP-based Cardiac Rehabilitation, Outreach Program for Aboriginal and Torres Strait Islanders*. Townsville Division of General Practitioners, Townsville.
- ❖ National Heart Foundation of Australia (1999) *Summary of Aboriginal and Torres Strait Islander Townsville Cardiovascular Disease Workshop October 1999*. www.hearfoundation.com.au
- ❖ Shepherd F et al (2003) Improving access to cardiac rehabilitation for remote Indigenous clients. *Aust NZ J Public Health* 27: 632–36.

Primary health care

- ❖ Couzos S & Murray R (eds) (2002) *Aboriginal Primary Health Care: An Evidence-based Approach*, 2nd Edition. Oxford, Sydney.
- ❖ Department of Health and Community Services (2002) *The Public Health Bushbook*, 2nd Edition. NT Government, Darwin.
- ❖ Australian Journal of Primary Health Special Issue (2003) *The Management of Chronic Disease in Primary Care Settings* Vol 9, Nos 2&3.
- ❖ Central Australian Rural Practitioners Association (2003) *CARPA Standard Treatment Manual*, 4th Edition. www.carpa.org.au
- ❖ National Aboriginal Community Controlled Health Organisation and the Chronic Disease Alliance of Non-Government Organisations (in press) *National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples*. Royal Australian College of General Practitioners and Australian Government Department of Health and Ageing.
- ❖ Queensland Health & the Royal Flying Doctor Service (Queensland Section) (2003) *The Primary Clinical Care Manual*, 3rd Edition. Queensland Health, Brisbane.

Guidelines and other professional guidance

Cardiac rehabilitation

- ❖ Australian Cardiac Rehabilitation Association (1999) *A Practitioner's Guide to Cardiac Rehabilitation*.
- ❖ Giannuzzi P et al (2003) Secondary prevention through cardiac rehabilitation: Position paper of the Working Group on Cardiac Rehabilitation and Exercise Physiology of the European Society of Cardiology. *European Heart Journal* 24: 1273–78.
- ❖ Goble AJ & Worcester MUC (1999) *Best Practice Guidelines for Cardiac Rehabilitation and Secondary Prevention*. Department of Human Services, Melbourne. www.health.vic.gov.au/nhpa/card-resc.htm
- ❖ New Zealand Guidelines Group (2002) *Best Practice Evidence-based Guideline: Cardiac Rehabilitation*. www.nzgg.org.nz
- ❖ National Heart Foundation of Australia & Australian Cardiac Rehabilitation Association (2004) *Recommended Framework for Cardiac Rehabilitation*. www.heartfoundation.com.au
- ❖ National Heart Foundation of Australia (2002) *Nutrition Recommendations for Cardiac Rehabilitation*. www.heartfoundation.com.au
- ❖ National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2003) *Reducing Risk in Heart Disease. Guidelines for Prevention of Cardiovascular Events in People with Coronary Heart Disease*. www.heartfoundation.com.au
- ❖ Queensland Health (undated) *Outpatient Cardiac Rehabilitation Best Practice Guidelines for Health Professionals*. www.health.qld.gov.au
- ❖ Scottish Intercollegiate Guidelines Network (2002) *Cardiac Rehabilitation – A National Clinical Guideline*. www.sign.ac.uk

Manuals for Aboriginal Health Workers

- ❖ National Heart Foundation (2000) *Heart Story*. Territory Health Services, Alice Springs.
- ❖ National Heart Foundation of Australia & Derbarl Yerrigan Health Services (2002) *Heart Health Manual: A Resource for the Certificate in Cardiovascular Health for Aboriginal Health Workers*.
- ❖ Queensland University of Technology and National Heart Foundation of Australia (1997) *Promoting Heart Health: An Educational Resource Manual for Rural and Remote Health Workers*.

Risk assessment

- ❖ National Vascular Disease Prevention Alliance (2004) *Consensus Statement for the Prevention of Vascular Disease*. www.heartfoundation.com.au
- ❖ National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2003) *Reducing Risk in Heart Disease: Guidelines for Preventing Cardiovascular Events in People with Coronary Heart Disease*. www.heartfoundation.com.au
- ❖ New Zealand Guidelines Group (2003) *The Assessment and Management of Cardiovascular Risk*. www.nzgg.org.nz

Psychosocial risk factors

- ❖ *Beyond Blue* website – www.beyondblue.org.au
- ❖ Bunker SJ et al (2003) “Stress” and coronary heart disease: psychosocial risk factors. National Heart Foundation of Australia Position Statement Update. *MJA* 178: 272–76.

Physiological risk factors

High blood pressure

- ❖ NHFA (2004) *Hypertension Management Guide for Doctors*. www.heartfoundation.com.au

Cholesterol

- ❖ Haq IU et al (1995) Sheffield risk and treatment table for cholesterol lowering for primary prevention of coronary heart disease. *Lancet* 346: 1467–71.
- ❖ National Heart Foundation of Australia (2001 and 2002 addenda) *Lipid Management Guidelines*. www.heartfoundation.com.au
- ❖ National Heart Foundation of Australia (2002) *Lipid Management Guidelines — 2001. Addendum October 2002*. www.heartfoundation.com.au

Diabetes

- ❖ NHMRC (2001) *Evidence Based Guidelines for the Management of 2 Diabetes Mellitus*. www.nhmrc.gov.au/publications
- ❖ NHMRC (2001) *Evidence Based Guidelines for Type 2 Diabetes: Primary Prevention, Case Detection and Diagnosis*. www.nhmrc.gov.au/publications

Risk behaviours

- ❖ Royal Australian College of General Practitioners (2004) *SNAP A Population Health Guide to Behavioural Risk Factors in General Practice*. www.racgp.org.au

Cigarette smoking

- ❖ Guideline Development Group (2004) *Smoking Cessation Guidelines for Australian General Practice. Practice Handbook 2004 Edition*. www.quitnow.org.au.

- ❖ New Zealand Guidelines Group (2002) *Guidelines for Smoking Cessation*. www.nzgg.org.nz
- ❖ National Aboriginal Community Controlled Health Organisation (2002) *Tobacco — Time for Action: National Aboriginal and Torres Strait Islander Tobacco Control Project*. www.naccho.org
- ❖ National Heart Foundation *Tobacco Book* series. National Heart Foundation NT.

Nutrition

- ❖ Bear-Wingfield R (1996) *Sharing Good Tucker Stories: A Guide for Aboriginal and Torres Strait Islander Communities*. Commonwealth Department of Health and Family Services, Canberra.
- ❖ NHMRC (2000) *Nutrition in Aboriginal and Torres Strait Islander Peoples*. An Information Paper. www.nhmrc.gov.au/publications
- ❖ NHMRC (2003) *Dietary Guidelines for Australian Adults*. www.nhmrc.gov.au/publications

Alcohol

- ❖ Aboriginal Drug and Alcohol Council (forthcoming 2005) *Alcohol and Your Health: Australian Alcohol Guidelines for Indigenous Communities*.
- ❖ Brady M (1998) *The Grog Book: Strengthening Indigenous Community Action on Alcohol*. Commonwealth Department of Health and Family Services, Canberra. (revised edition forthcoming in 2005)
- ❖ Brady M & Hunter E (2003) *Talking about Alcohol with Aboriginal and Torres Strait Islander Patients*. Funded by the Office for Aboriginal and Torres Strait Islander Health.
- ❖ Brady M (ed)(1995) *Giving Away the Grog: Aboriginal Accounts of Drinking and Not Drinking*. Commonwealth Department of Human Services and Health, Canberra.
- ❖ National Drug and Alcohol Research Centre (2003)
 - *Guidelines for the Treatment of Alcohol Problems*
 - *Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals*
 - *Treating Alcohol Problems: Guidelines for Hospital Staff*
 Prepared for the Australian Government Department of Health and Ageing, Canberra. www.health.gov.au
- ❖ NHMRC (2001) *Australian Alcohol Guidelines: Health Risks and Benefits*. www.alcoholguidelines.gov.au
- ❖ NHMRC (2003) *Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults*. www.obesityguidelines.gov.au.
- ❖ Territory Health Services (1998) *Living With Alcohol: A Handbook for Community Health Teams*, Living with Alcohol Program, Territory Health Services, Darwin.

Physical activity

- ❖ AustRoads (2003) *Assessing Fitness to Drive*.
www.austroads.com.au/aftd.html
- ❖ Australian Government Dept of Health and Ageing (1999) *National Physical Activity Guidelines for Australians*. www.health.gov.au

Management of cardiovascular disease**Self-management**

- ❖ Royal Australian College of General Practitioners (2002) *Sharing Health Care: Chronic Condition Self-Management Guidelines*
 - *Desktop Guide for Nurses and Allied Health Professionals*
 - *Desktop Guide for General Practitioners*
 - *Summary for Nurses and Allied Health Professionals*
 - *Summary for General Practitioners*
- WA Research Unit of the RACGP. www.racgp.org.au

Medications

- ❖ National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2003) *Reducing Risk in Heart Disease: Guidelines for Preventing Cardiovascular Events in People with Coronary Heart Disease*. www.heartfoundation.com.au

Antiplatelet agents

- ❖ Hung J (2003) Aspirin for cardiovascular disease prevention. Medical Issues Committee of the National Heart Foundation of Australia. *MJA* 179: 147–52.
- ❖ National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2000) Management of Unstable Angina [supplement]. *MJA* 173: S65–88.

ACE inhibitors

- ❖ American Heart Association (2001) AHA/ACC Guidelines for preventing heart attack and death in patients with atherosclerotic cardiovascular disease: 2001 Update. *Circulation* 104: 1577–79.
- ❖ Gibbons RJ et al (2003) ACC/AHA 2002 guideline update for the management of patients with chronic stable angina - summary article: a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines. *Circulation* 107: 149–58.

Beta-blockers

- ❖ American Heart Association (2001) AHA/ACC guidelines for preventing heart attack and death in patients with atherosclerotic cardiovascular disease: 2001 Update. *Circulation* 104: 1577–79.

- ❖ National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (2002) *Guidelines on the Contemporary management of the Patient with Chronic Heart Failure in Australia*. www.heartfoundation.com.au

Anticoagulants

- ❖ Hankey G (2001) Non-valvular atrial fibrillation and stroke prevention. National Heart Foundation of Australia. Position statement. *MJA* 174: 234–39.
- ❖ American Heart Association (2001) AHA/ACC guidelines for preventing heart attack and death in patients with atherosclerotic cardiovascular disease: 2001 Update. *Circulation* 104: 1577–79.

Patient education materials

See Toolkit 2.

Patient support

Patient accommodation and travel schemes

All States and Territories have patient accommodation and travel schemes (PATS) that reimburse a proportion of out-of-pocket expenses for patients having to travel long distances. Since conditions vary, the websites for each of the State schemes are provided below.

- ❖ NSW Isolated Patients' Travel and Accommodation Scheme
www.health.nsw.gov.au/policy/hsp/iptaas/office.html
- ❖ Victorian Patient Transport Assistance Scheme
www.health.vic.gov.au/agedcare/services/guide/two.htm
- ❖ Queensland Patient Travel Subsidy Scheme
www.health.qld.gov.au/services/community/ptss
- ❖ SA Patient Assistance Transport Scheme
www.rah.sa.gov.au/country/pats.htm
- ❖ WA Patients' Assisted Travel Scheme
www.fcs.wa.gov.au/_content/concessions_guide/health.html
- ❖ Tasmania Patient Travel Assistance Program
www.dhhs.tas.gov.au/hospitals/patienttravel/
- ❖ Northern Territory Patient Assistance Travel Scheme
www.nt.gov.au/health/hospital_svs/pats/toc.shtml
- ❖ ACT Interstate Patients' Travel Assistance Scheme
www.canberrahospital.act.gov.au/main.htm

Aboriginal Hostels Limited

Aboriginal Hostels Limited is a company that provides temporary accommodation to Aboriginal and Torres Strait Islander people. It has established a network of hostels across Australia and currently operates 48 of its own hostels and funds 83 community hostels.

Aboriginal Hostels Limited operates from a central office in Canberra and eight regional offices around Australia. Regional offices are in Perth, Darwin, Cairns, Brisbane, Sydney, Melbourne, Adelaide, and Alice Springs. Contact details for these offices can be obtained from www.ahl.gov.au.

Community development

- ❖ Hawe P et al (1990) *Evaluating Health Promotion: a Health Worker's Guide*. MacLennan and Petty, Sydney.
- ❖ Commonwealth Department of Health and Aged Care (2001) *Better Health Care. Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*. www.health.gov.au

Local contacts

Use the table below to keep a record of relevant contacts.

Cardiac rehabilitation program	
Cardiac support group	
Cardiologist	
Counsellor	
Dietitian	
Exercise group	
Hospital	
Mental health worker	
Physiotherapist	
Ambulance	
Cardiology team	
Aboriginal Liaison Officer	

TOOLKIT 4 — MATERIALS FOR MANAGERS OF HEALTH ORGANISATIONS

What is in this toolkit?

This toolkit contains information to assist people managing health organisations to support the provision of appropriate cardiac rehabilitation services for Aboriginal and Torres Strait Islander Peoples. The toolkit contains information on:

- ❖ preparing a business case to obtain funding for cardiac rehabilitation services
- ❖ workforce issues
- ❖ using specific Medicare items
- ❖ monitoring and evaluation
- ❖ assessing the organisation's involvement of consumers and community.

Toolkit 1 on cultural competency also provides important information for improving service delivery to Aboriginal and Torres Strait Islander Peoples.

Developing a business case

Once the need for the provision of cardiac rehabilitation services to Aboriginal and Torres Strait Islander patients has been identified within your organisation, structures will need to be put into place to support this service delivery. Additional funding may be required. To gain approval and/or resourcing from higher level management and funders you will need to develop a business case that outlines:

- ❖ the importance of cardiac rehabilitation
- ❖ the need for culturally respectful cardiac rehabilitation services for Aboriginal and Torres Strait Islander patients
- ❖ the type of changes that will be made to service delivery under the proposed business plan (eg employment of an Aboriginal Health Worker, establishment of a cardiac rehabilitation nurse position, provision of an outpatient rehabilitation program)
- ❖ other funding mechanisms that will be used to support these changes (eg specific Medicare items).

The business case should provide sufficient information for those approving the resources to be able to clearly assess the proposed project in terms of improved health outcomes and financial viability.

Before you start developing a business case, you will need to:

- ❖ obtain agreement to proceed with the development of the business case from senior management and/or your funder
- ❖ obtain agreement on the scope of the business case
- ❖ read the sample business case and instructions below and gather the required information.

A brief sample business case is provided below, along with instructions on what to include in each section and suggestions on how the information in the guide might be used to support the case (given in italics). Note that the example is based on a small organisation and that the scale of the organisation and of the funding required will have an influence on the level of detail required in the business case.

A template for a business case is also provided. This can be copied as it is or adapted to local needs using the Word version available on the NHMRC website.

This tool has been developed based on information provided in Department of Premier and Cabinet, Tasmania (2002) PM 902 *Small Project Business Case Template & Guide*. Version 1.0. www.projectmanagement.tas.gov.au/pm_templates/pm002_902_menu.htm

Project title:	Improving Aboriginal access to cardiovascular secondary prevention in a mainstream service
Organisation:	Gilbert Health Service
For submission to:	Area Health Service, State Health Department
Prepared by:	Melanie Louis
Date:	11 May 2005
Executive summary	<i>If your business case is quite long and detailed (ie more than 10 pages), it is helpful to provide a short summary (ie 1–2 pages)</i>
Introduction <i>Briefly describe the background to the problem, what has been done to address it in the past and the rationale for developing the business case at this particular time</i>	<p>Secondary preventive activities as part of a cardiac rehabilitation program are important in improving health outcomes. Aboriginal people are less likely to attend cardiac rehabilitation programs although they are more likely than non-Indigenous people to die from heart problems. Barriers to Aboriginal people attending mainstream services have been identified.</p> <p>Since the establishment of a phase-3 cardiac rehabilitation program (secondary prevention) at the Gilbert Health Service, the hospital has referred all patients who have had a cardiac event or procedure to the service. While Aboriginal patients are passing through the hospital system, they are not presenting to attend the program. Until now, no action has been taken at this health service to address the lack of uptake. No Aboriginal-specific initiatives addressing cardiac rehabilitation are currently underway in the region.</p>
Overview <i>Outline the vision and objectives of the project and how these relate to organisational and systemic objectives</i>	<p>The vision for this project is that in three years time:</p> <ul style="list-style-type: none"> ❖ numbers of Aboriginal patients attending Gilbert Health Service will have increased ❖ a substantial number of these patients will attend the service for annual health checks ❖ an Aboriginal Health Worker will be employed by the service to coordinate prevention activities for Aboriginal patients ❖ a part-time dietitian will be employed by the service ❖ partnerships will exist between the service, the regional hospital, the Wonga Aboriginal Cooperative and the local Divisions of General Practice. <p>The project aims to improve long-term outcomes among Aboriginal patients who have experienced cardiac events by addressing the barriers to these patients accessing our service. After initial start-up funding, the project will be sustained by utilisation of existing funding mechanisms under Medicare.</p> <p>The objectives of this project are in accord with the Area Health Service's vision of improving cardiovascular outcomes among Aboriginal people and improving Aboriginal access to services; with the State health department's goal of addressing cardiovascular disease through prevention; and with national objectives of improving Aboriginal cardiovascular health and increasing cultural competency across the health sector.</p> <p>These objectives also comply with the World Health Organization and National Heart Foundation recommendations that all people who have experienced a cardiac event be involved in a cardiac rehabilitation program.</p>

Project title:	Improving Aboriginal access to cardiovascular secondary prevention in a mainstream service
<p>Business case</p> <p><i>Set the scene for the business case and describe its purpose. The purpose is generally to:</i></p> <ul style="list-style-type: none"> ❖ <i>define the business need or problem in detail</i> ❖ <i>analyse options</i> ❖ <i>identify costs, benefits and risks.</i> ❖ <i>put forward a proposal to senior management for approval to proceed with the project, or to the funding source for approval for funding for the project.</i> 	<p><i>To set the scene, include information from Sections 1.1 and 1.2 of the guide outlining barriers to Aboriginal and Torres Strait Islander Peoples accessing mainstream services and principles for improving outcomes. Information from other chapters may also be of relevance — for example as this sample business case focuses on secondary prevention, information from Chapter 5 of the guide could also be included here.</i></p> <p>The purpose of this business case is to:</p> <ul style="list-style-type: none"> ❖ <i>evaluate current processes for providing secondary prevention activities to Aboriginal patients who have experienced a cardiac event or procedure</i> ❖ <i>compare the current processes with those in other health services, making particular note of projects that have evaluated results</i> ❖ <i>analyse options for the improvement of current processes and determine preferred methodology, business processes framework, supporting technology and implementation strategy</i> ❖ <i>fully document the preferred option in terms of direct and recurrent costs, stakeholder requirements and involvement, and risk/benefit assessment</i> ❖ <i>request the Area Health Service to consider the business case and approve appropriate funding for the project to proceed.</i>
<p>Sponsor</p> <p><i>List any individuals or organisations sponsoring the development of the business case</i></p>	<p>This business case has the support and sponsorship of Wonga Aboriginal Cooperative.</p>
<p>Situational assessment and problem statement</p> <p><i>Clearly establish the benefit to the organisation from the proposed project, including:</i></p> <ul style="list-style-type: none"> ❖ <i>a description of the relevant environmental conditions</i> ❖ <i>an assessment of how the business needs are currently being met or not met</i> ❖ <i>an analysis of the gap between the current situation and the stated objective(s).</i> 	<p>As discussed there are currently no health organisations in the region providing cardiac rehabilitation services specifically for Aboriginal patients. Gilbert Health Service has a history of developing programs to support patients with chronic diseases to be able to self-manage their conditions but these programs are not being taken up by local Aboriginal community members. Discussions with the Wonga Aboriginal Cooperative have suggested that there is support from the Aboriginal community for appropriate services to be provided at the service.</p> <p>The service has the infrastructure to support the provision of secondary prevention activities. To extend these services to the Aboriginal community would involve addressing barriers to access as outlined above.</p> <p>As well as improving health outcomes in the region, the proposed project would increase the health service's client base. While start-up funding would be required, increasing the number of patients undergoing health checks under Medicare item 710 would also increase funding to the service and help to sustain the changes in practice.</p>
<p>Assumptions underlying this business case</p> <p><i>Describe any assumptions that have been made in developing the business plan</i></p>	<p>This business case is based on the following assumptions:</p> <ul style="list-style-type: none"> ❖ <i>that the planned measures will encourage Aboriginal people to attend activities offered at Gilbert Health Service</i> ❖ <i>that an Aboriginal Health Worker and a dietitian will be available for employment at the service</i> ❖ <i>that the hospital will refer Aboriginal patients to the service for secondary prevention activities.</i>

Project title:	Improving Aboriginal access to cardiovascular secondary prevention in a mainstream service		
Analysis of options <i>Identify options then analyse the pros and cons and direct and indirect costs for each option. This section should provide a brief description of these and may best be displayed in a table.</i> <i>The example given here is simplified but shows a way in which the information could be presented.</i>	Pros	Cons	Costs
	Option 1: Retain the current situation		
	No additional infrastructure	No increase in Aboriginal patients	No additional costs
	Option 2: Employ Aboriginal Health Worker		
	Likely increase in Aboriginal patients	Need remains to address other barriers	Wages
	Option 3: Address barriers to Aboriginal access to health service and develop Aboriginal-specific secondary prevention project		
	Likely increase in Aboriginal patients Improved health outcomes	Changes in practice required to include Medicare item 710	Capital purchases Implementation strategy
Implementation strategy <i>The information provided here will form the basis of the project's business plan if the project proceeds. Group the information under the given headings</i>	Target outcomes/benefits <ul style="list-style-type: none"> ❖ Improved health outcomes for local Aboriginal people who have experienced cardiac events and/or procedures ❖ Improved health outcomes in the local Aboriginal community through flow-on effect of secondary prevention messages ❖ Partnerships between the Gilbert Health Service, Wonga Aboriginal Cooperative and Elizabeth Hospital ❖ Increased client base for Gilbert Health Service Outputs <i>(list deliverables)</i> <ul style="list-style-type: none"> ❖ Patient and community education materials ❖ Hospital-community interface protocol ❖ Project report 1 (12 months) ❖ Project report 2 (24 months) ❖ Evaluation report (36 months) Stakeholders <i>(list those to whom outputs will be delivered and a short description of how each will use each output to generate target benefits)</i> <ul style="list-style-type: none"> ❖ Wonga Aboriginal Cooperative — dissemination of education materials through the Cooperative will broaden participation and awareness ❖ Elizabeth Hospital — use of the hospital-community interface protocol will improve integration of services and communication between organisations ❖ Area Health Service — dissemination of the evaluation report will assist in sharing of lessons learned with other health services Related projects <i>(list dependent on or interdependent projects)</i> The Gilbert Health Service's Healthy Ageing through Self-Management project, targeting the general population, has similar goals to those of the proposed project. The project's methodology will be adapted in collaboration with representatives of Wonga Aboriginal Cooperative.		

Project title:	Improving Aboriginal access to cardiovascular secondary prevention in a mainstream service
	<p>Work Plan <i>(outline project phases, areas of work and key milestones)</i></p> <p>Project establishment (month 1 - month 6)</p> <ul style="list-style-type: none"> ❖ Work with members of Wonga Aboriginal Cooperative to: ❖ establish a project team ❖ make changes to reception area so that it is more welcoming to Aboriginal patients ❖ start selection process for cultural mentor(s) to work with the service's general practitioners ❖ start selection process for an Aboriginal Health Worker ❖ raise awareness of project within the Aboriginal community <p>Stage 1 (month 7 – month 12)</p> <p>The project team to:</p> <ul style="list-style-type: none"> ❖ start recruiting patients to the project through hospital and community visits ❖ employ an Aboriginal Health Worker ❖ with Aboriginal Health Worker, develop recall system for Aboriginal patients ❖ initiate an Aboriginal adult health check clinic operating out of the health service one day per week —schedule longer appointments ❖ initiate data collection. <p>Stage 2 (month 13 – month 24)</p> <ul style="list-style-type: none"> ❖ Promote adult health check and continue with weekly clinic ❖ Commence evaluation ❖ Employ part-time dietitian ❖ Initiate Healthy Weight program <p>Stage 3 (month 25 – month 36)</p> <ul style="list-style-type: none"> ❖ Continue all initiatives from previous stages ❖ Continue evaluation and develop evaluation report <p>Resources <i>(outline budget and resources, noting when these are required)</i></p> <p><i>As this business case is a sample only, information concerning budget and resources is not available. Relevant information for this fictional case would include anticipated revenue from use of Medicare item 710, costs of employing the Aboriginal Health Worker and dietitian, production costs for educational materials etc.</i></p> <p>Project management <i>(describe how the project will be managed)</i></p> <p><i>Outline the proposed:</i></p> <ul style="list-style-type: none"> ❖ project governance model (who is responsible for what) ❖ <i>quality plan (standards and methodology and a checklist of things to verify that the outputs have been delivered, eg the meeting schedule, project monitoring arrangements, structure/format of reports)</i> ❖ <i>organisational change management plan</i>
Appendices	<p><i>Include as appendices any detailed information that would break the flow of your discussion. This is most likely to be necessary in business cases for more comprehensive projects.</i></p>

Project title:

Organisation:

For submission to:

Prepared by:

Date:

Executive summary

Introduction

Overview

Business case

Sponsor

**Situational assessment and
problem statement**

**Assumptions underlying this
business case**

Analysis of options

Pros

Cons

Costs

Option 1:

Option 2:

Option 3:

Implementation strategy

Target outcomes/benefits

Outputs

Stakeholders

Related projects

Work plan

Resources

Project management

Appendices

Workforce issues

Information in this tool is adapted from ERA Project (2003) Working with Aboriginal People. A Cultural Guide: For Community-based Health and Home Care Services in Wakefield, Gawler and Mid North Areas of Rural South Australia. SA Dept Human Services — www.health.sa.gov.au

The recruitment of Aboriginal and Torres Strait Islander staff into the health sector is crucial if progress is to be made in addressing Aboriginal and Torres Strait Islander health and well-being. The success of recruitment is likely to depend on a number of factors such as availability, the culture of the organisation and retention strategies as outlined below.

Culturally competent workplaces and staff that adopt culturally respectful practices (see Toolkit 1) are evidence of good retention practice. Positive workplace retention principles include:

- ❖ orientation and regular and positive debriefing opportunities regarding work and community issues
- ❖ recognition and respect of significant cultural events and practice that can reflect flexible work practice
- ❖ acknowledgement and celebration of good work
- ❖ supportive team approaches in preference to working in isolation.

Strategies for supporting the retention of staff include:

- ❖ mentoring schemes — a comprehensive mentoring program can enhance staff training and development and improve staff motivation because they feel supported and valued, leading to increased output and enhanced service delivery. Mentoring can improve communication, performance management and career planning. It can also support strategic and succession planning, making a valuable contribution to both the recruitment and retention of staff
- ❖ peer shadowing — when individuals are able to observe peers in other workplaces for short periods of time, they are provided with reflective feedback and can use the acquired knowledge for self growth and professional development. Peer shadowing provides an opportunity to learn from others and develop insights into different environments, systems, work practices, cultural traits and values while learning new ways and approaches to service delivery
- ❖ ongoing training — there is a range of accredited certificate, diploma, associate degree and degree courses available for Aboriginal Health Workers at tertiary and non-tertiary educational settings, including courses and training programs designed to address specific health issues such as cardiac rehabilitation. However, difficulties with funding and access have been identified. Organisational support for ongoing training both increases the capacity of the health service and improves staff retention.

Using specific Medicare items

Use of Medicare item 710 by some Aboriginal Community Controlled Health Services has already resulted in greater use of the Medicare and Pharmaceutical Benefits schemes by Aboriginal and Torres Strait Islander patients. Using this and other Medicare items can gain funding and improve outcomes but may not be feasible in all settings.

Medicare item 710

The Aboriginal and Torres Strait Islander adult health check should generally be undertaken by the patient's 'usual doctor'. This means the doctor (or a doctor working in the medical practice or health service) who has provided most of the services the patient has had in the past 12 months and/or who will provide most of the services for the patient in the next 12 months.

The information collection component of the assessment may be completed by an Aboriginal Health Worker, nurse or other qualified health professional where:

- ❖ the patient's medical practitioner has initiated the collection of information by a third party, after the patient has agreed to the Adult Health Check and has agreed to a third party collecting information for the assessment
- ❖ the patient is told whether or not information collected about them for the health check will be retained by the third party
- ❖ the third party acts under the supervision of the practitioner.

The other components of the health check must include a personal attendance by the medical practitioner.

Within the general practice or primary health care service a number of organisational and structural issues could be considered in order to facilitate effective implementation of the Aboriginal and Torres Strait Islander Adult Health Check item. These include:

- ❖ clearly defining roles of individuals within the health team who will be undertaking elements of the health check and follow-up
- ❖ ensuring all members of the health team who are involved in undertaking the health check understand the elements of the health check, and are given adequate information to undertake their role, including cultural awareness training as appropriate;
- ❖ timing health check appointments so that components of the health check can be undertaken by appropriate staff — some health checks may require more than one visit to complete
- ❖ use of formal (ideally electronic) recall and reminder systems to ensure follow-up of patients
- ❖ use of standard protocols and evidence-based guidelines for screening, follow-up, referral and treatment
- ❖ continuous quality improvement processes to review progress and implement changes where appropriate
- ❖ availability of appropriate resources for patients.

Medicare chronic disease management items

There are six chronic disease management Medicare items.

Preparation of a GP Management Plan (Item 721)

- ❖ Provides a rebate for a GP to prepare a management plan for a patient with a chronic or terminal condition (including patients who have multiple chronic conditions and multidisciplinary care needs).
- ❖ Recommended frequency is once every two years, supported by regular review services.
- ❖ The GP (who may be assisted by an Aboriginal Health Worker or practice nurse) assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these in the GP Management Plan.

Review of a GP Management Plan (Item 725)

- ❖ Provides a rebate for a GP to review a GP Management Plan.
- ❖ Aboriginal Health Worker or other can assist.
- ❖ Recommended frequency is once every six months; can be earlier if clinically required.
- ❖ Involves reviewing the patient's GP Management Plan, documenting any changes and setting the next review date.

Coordination of Team Care Arrangements (Item 723)

- ❖ Provides a rebate for a GP to coordinate the preparation of Team Care Arrangements for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers.
- ❖ In most cases the patient will already have a GP Management Plan in place but this is not mandatory.
- ❖ Recommended frequency is once every two years, supported by regular review services.
- ❖ Involves a GP (who may be assisted by an Aboriginal Health Worker or practice nurse) collaborating with the participating providers on required treatment/services and documenting this in the patient's Team Care Arrangements.

Coordination of a Review of Team Care Arrangements (Item 727)

- ❖ For patients who have a current Team Care Arrangement and require a review of their Team Care Arrangement.
- ❖ Recommended frequency is once every six months; can be earlier if clinically required.
- ❖ Involves the GP (who may be assisted by their Aboriginal Health Worker or practice nurse) collaborating with the participating providers on progress against treatment/services and documenting any changes to the patient's Team Care Arrangement.

Contribution to a multidisciplinary care plan being prepared by another health or care provider (Item 729)

- ❖ For patients who are having a multidisciplinary care plan prepared or reviewed by another health or care provider (other than their usual GP).
- ❖ Recommended frequency is once every six months; can be earlier if clinically required.
- ❖ Involves the GP (who may be assisted by an Aboriginal Health Worker or practice nurse) collaborating with the providers preparing or reviewing the plan and including their contribution with the patient's records.

Contribution to a multidisciplinary care plan being prepared by another health or care provider for a resident of an aged care facility (Item 731)

This is for patients in residential aged care facilities and is otherwise the same as item 729.

Further information

- ❖ Further information about Medicare item 710 is available from: www.health.gov.au/epc
- ❖ Information on the chronic disease management items is available from: www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

Data collection

Data collection provides information on services provided. Following are some examples of the types of information that can be collected to inform improvements to service delivery in various settings.

Primary health care

- ❖ Number of Aboriginal and Torres Strait Islander employees across the organisation
- ❖ Number of Aboriginal and Torres Strait Islander patients undergoing cardiovascular risk assessment
- ❖ Patients referred to/involved in programs to improve risk behaviours
- ❖ Patients treated for cholesterol, blood pressure, diabetes
- ❖ Patients referred for intervention

Hospital

- ❖ Number of Aboriginal and Torres Strait Islander employees across the organisation
- ❖ Number of Aboriginal and Torres Strait Islander patients attending
- ❖ Number of Aboriginal and Torres Strait Islander patients seen by an Aboriginal Liaison Officer
- ❖ Cardiac intervention rate among Aboriginal and Torres Strait Islander patients compared with total cardiac intervention rate
- ❖ Discharge summaries provided to patient and case manager

Outpatient rehabilitation program

- ❖ Number of patients referred
- ❖ Proportion of patients completing program
- ❖ Changes in risk behaviours
- ❖ Subsequent cardiac events
- ❖ Mortality

Data Set Specification for collection of cardiovascular data

The National Health Data Committee has recommended a Data Set Specification for the collection of cardiovascular data (CV/Data). This data set is not mandated for collection but is recommended as best practice. The definitions used in the cardiovascular data are designed to underpin the data collected by health professionals in their day-to-day practice.

Examples of cardiovascular data elements include:

- ❖ Sociodemographic elements such as:
 - Person identifier
 - Sex
 - Date of birth
 - Date of referral to rehabilitation
 - Date of diagnosis
 - Country of birth
 - Indigenous status
 - Postcode
 - Preferred language
 - Living arrangements
 - Labour force status
 - Carer availability
- ❖ Risk factor indicators such as:
 - Alcohol consumption
 - Blood pressure
 - Total cholesterol
 - Physical activity sufficiency status
 - Diabetes status
 - Smoking status

For the complete details of definitions relating to these data elements and a guide to their use see National Health Data Committee – Data Set Specification Cardiovascular Disease, 2003. This is available online at www.aihw.gov.au.

Performance indicators for outpatient programs

It is recommended that evaluation of the program and patient outcomes be incorporated into the cardiac rehabilitation process. Comprehensive program evaluation requires assessment of process, impact and outcome. Process evaluation measures the program strategies/activities, impact evaluation measures the objectives, and outcome evaluation measures the goal. Ideally both qualitative and quantitative approaches are used.

Examples of process evaluation indicators include:

- ❖ program reach
- ❖ number of people attending
- ❖ number of people attending as proportion of those eligible
- ❖ number of eligible people referred
- ❖ proportion of people who complete the program
- ❖ participant satisfaction
- ❖ proportion of program discharge summaries sent to GP or other primary care provider.

Examples of impact evaluation indicators include:

- ❖ assessment of risk factors at the completion of the program (eg lipid levels, blood pressure and tobacco use)
- ❖ physical activity status using objective clinical measures or self-report tools
- ❖ assessment of quality of life, self-efficacy, physical and psychosocial functioning
- ❖ links established with follow-up services.

Examples of outcome evaluation indicators include:

- ❖ maintenance of behaviour change
- ❖ risk factor profiles in the longer term
- ❖ quality of life
- ❖ morbidity (ie occurrence of subsequent events)
- ❖ mortality rates can also be measured, however, this would be beyond the means of most programs.

Consumer and community participation checklist

Information in this tool is from National Resource Centre for Consumer Participation in Health (2004) Information Series — Consumer Participation: Questions for Health Care Organisations — www.participateinhealth.org.au

Changing the questions you ask, or changing the way you ask the questions, is part of the process of changing the culture of your organisation. The following questions will help you to assess your organisation's capacity and willingness to involve consumers and the community in planning and development of services. Note that the term “consumer” is used here to represent patients, their families and carers and the community.

Questions for the organisation to ask itself

- ❖ What is management and staff commitment to consumer participation?
- ❖ What is the level of commitment of the organisation to change?
- ❖ Do we really want consumer participation? Are we willing to pay for it?
- ❖ Are we really prepared to commit the time, energy, patience and resources to making consumer participation work?
- ❖ What are the attitudes of staff and management towards consumers and consumer participation? What are the attitudes of staff to various groups of consumers?
- ❖ Do we know why we want to involve consumers? (What do we expect to gain?)

Questions for the organisation to ask when planning consumer involvement

- ❖ What aspects of the organisation's history may have an effect on consumer participation? How will this be addressed?
- ❖ Do we know who our consumers are?
- ❖ How do consumers want to participate in our organisation?
- ❖ What do consumers want from the organisation?
- ❖ In what ways are the organisation's structures alienating for consumers? (administrative, management, overall structure, service delivery, discharge/follow-up, relationships with other organisations etc) How can we make changes to improve these structures?
- ❖ How will the organisation accommodate circumstances that could make it difficult for consumers to participate effectively? (eg meeting times, stress of meetings, health etc)
- ❖ What staff and financial resources will be available?
- ❖ How will we support consumers who provide their time and expertise to the organisation?
- ❖ How will the organisation cover attendance costs? (eg hire of equipment, transport, [including reimbursement of expenses] childcare, room hire, etc) What will be the confidential process for discussions about reimbursement?
- ❖ What kinds of skills will be required by consumers and staff to do this work and how can the organisation support consumers and staff to work together?
- ❖ How will what consumers say be listened to and acted on by management?
- ❖ How will we make the organisation more open to ideas initiated by consumers?
- ❖ What opportunities will there be for consumers to discuss consumer issues on their own?
- ❖ What are the staff concerns? How can they be addressed both practically and financially?
- ❖ Are there bridges that need to be built to foster collaboration? How will goodwill be maintained?
- ❖ What will be the timetable for each step of the way?
- ❖ How will the organisation continue to reach out to consumers? How will the organisation reach out to people who are not getting the service?
- ❖ How will the organisation communicate to its consumers and potential consumers about the changes that have occurred due to consumer participation?
- ❖ How will the organisation respond if consumer participation flags, or attendance drops?

Evaluation questions

Ideally, evaluation questions should be asked along the way so that you are identifying and addressing issues as you go.

- ❖ How can we tell if the processes used are working?
- ❖ How have consumers been involved?
- ❖ What do consumers say about their experience of being involved?
- ❖ What has the organisation and staff learnt so far and what needs to be changed to improve participation processes?
- ❖ What changes have been implemented as a result of consumer participation and consumer–staff collaboration?
- ❖ Have changes that consumers wanted to see been implemented?
- ❖ Have the consumer representatives persisted or have they gone away after a few meetings?

Resources for managers

Cultural competency

See Toolkit 1.

Training

See Toolkit 3.

Information systems

- ❖ Office for Aboriginal and Torres Strait Islander Health (2000) *Information Systems in Aboriginal and Torres Strait Islander Health Services. A Reference Guide for Services Contemplating the Introduction of a Computer-based Patient Information and Recall System*. www.health.gov.au

Data collection

- ❖ Australian Institute of Health and Welfare Data Set Specification – Cardiovascular disease (clinical). *National Health Data Dictionary 2003*. Version 12. www.aihw.gov.au

Medicare

- ❖ Health Insurance Commission Medicare toolkit for Aboriginal and Torres Strait Islander health services — www.hic.gov.au/providers/resources/programs_services/indigenous

Aboriginal and Torres Strait Islander access line: 1800 556 955

- ❖ Enhanced Primary Care Information kit — www.health.gov.au/epc

Strategies and policy documents

- ❖ Department of Health and Ageing (2004) *National Strategy for Heart, Stroke and Vascular Health in Australia*. Commonwealth Department of Health and Ageing, Canberra.
- ❖ National Aboriginal and Torres Strait Islander Health Council (2004) *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013, Context*. Commonwealth of Australia; Canberra.
- ❖ National Aboriginal and Torres Strait Islander Nutrition Working Party (2001) *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000–2010: Summary*. National Public Health Partnership. www.nphp.gov.au
- ❖ NSW Health (1997) *Improving Cardiac Care and Outcomes. New South Wales Policy Standards for Cardiac Rehabilitation*. www.health.nsw.gov.au

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) was established in 1936 and is now a statutory body within the portfolio of the Australian Government Minister for Health and Ageing, operating under the *National Health and Medical Research Council Act 1992* (NHMRC Act).

The NHMRC advises the Australian community and the Australian Government, and State and Territory governments on standards of individual and public health, and supports research to improve those standards.

The NHMRC Act provides four statutory obligations:

- to raise the standard of individual and public health throughout Australia;
- to foster development of consistent health standards between the states and territories;
- to foster medical research and training and public health research and training throughout Australia; and
- to foster consideration of ethical issues relating to health.

The NHMRC also has statutory obligations under the *Prohibition of Human Cloning Act 2002* (PHC Act) and the *Research Involving Human Embryos Act 2002* (RIHE Act).

The activities of the NHMRC translate into four major outputs: health and medical research; health policy and advice; health ethics; and the regulation of research involving donated IVF embryos, including monitoring compliance with the ban on human cloning and certain other activities.

A regular publishing program ensures that Council's recommendations are widely available to governments, the community, scientific, industrial and education groups. The Council publishes in the following areas:

- | | |
|--|---|
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| • Blood and Blood Products | • Human Cloning and Embryo Research |
| • Cancer | • Indigenous Health |
| • Cardiovascular Health | • Injury including Sports Injury |
| • Child Health | • Men's Health |
| • Clinical Practice Guidelines – Standards for Developers – Topics | • Mental Health |
| • Communicable Diseases, Vaccinations and Infection Control | • Musculoskeletal |
| • Diabetes | • NHMRC Corporate documents |
| • Drug and Substance Abuse | • NHMRC Session Reports |
| • Environmental Health | • Nutrition and Diet |
| • Ethics in Research–Animal | • Oral Health |
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