CHRONIC CONDITIONS STRATEGY 2016 TO 2026
WHY A CHRONIC CONDITIONS STRATEGY?

A significant number of Aboriginal and Torres Strait Islander people living in Cape York experience higher rates of chronic conditions and related risk factors when compared to the rest of Queensland. Chronic conditions can be prevented. However, the underlying risk factors are interrelated and are complex to address. Apunipima provides a comprehensive model of care with a focus on empowering communities and families in Cape York to address these underlying risk factors. The Chronic Conditions Strategy 2016-2026 details the organisational approach Apunipima will take to work with Cape York communities in the prevention, treatment, and management of chronic conditions. This strategy reflects current practice, based on research and in line with national and other state approaches. The subsequent Action Plan 2016-2018 outlines how relevant Apunipima teams will coordinate effort and measure progress in addressing the burden of chronic conditions.1

AIM OF THE CHRONIC CONDITIONS STRATEGY

To improve the health and wellbeing of all Aboriginal and Torres Strait Islander peoples living in Cape York by reducing the incidence and impact of chronic conditions. Where ‘health’ refers to the physical, social, emotional and cultural wellbeing of individuals, families and communities. The implementation of the strategy will:

- support better access to primary health care across Cape York communities,
- improve the journey through the health system for the patient
- improve collaboration between teams and with external partners,
- promote more efficient and effective use of health resources,
- support local solutions and responses to identified needs, and
- avoid duplication and fragmentation, and improve consolidated coordination in the prevention and management of chronic conditions.

THE IMPACT OF CHRONIC CONDITIONS IN CAPE YORK

Aboriginal and Torres Strait Islander people living in remote areas experience higher rates of chronic conditions and related risk factors when compared to Indigenous people living in urban or regional areas in Queensland. For example, the prevalence is:

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

STRAIGHT SCOPE

THE STRATEGY WILL TARGET THE FOLLOWING CONDITIONS AND/OR RISKS:

- Cardiovascular Disease
- Type 2 Diabetes
- Airway Diseases
- Kidney Disease
- Mental Illness
- Cancer (associated with common risk factors for other chronic conditions)
- *Rheumatic Heart Disease.4

The approach to chronic conditions described in the Chronic Conditions Strategy can be applied to all chronic conditions, however the conditions above are prioritised for the following reasons:

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

HOW THE CHRONIC CONDITIONS STRATEGY AND ACTION PLAN FITS WITH OTHER GUIDING DOCUMENTS

The Chronic Conditions Strategy and Action Plan will be the basis for how chronic conditions are addressed, support health issues identified through community health plans and align to Apunipima’s first strategic goal of achieving wellness in Cape York communities. The development of the strategy has been guided by state and national planning documents, including Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033, and the Implementation Plan for National Aboriginal and Torres Strait Islander Health Plan 2013-2023. The Chronic Conditions Strategy is one of three strategic documents operationalised using the Apunipima Model of Care, and links to activities outlined in the Social and Emotional Wellbeing Strategy and the Family Health Strategy.
**ACTION AREAS**

**SCREENING AND EARLY DETECTION**

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

**OBJECTIVE:** Increase the proportion of the Cape York population who attend annual health checks and other screening services.

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

**WHY IS THIS ACTION AREA IMPORTANT?**
Culturally appropriate approaches to early detection and follow-up of disease markers result in better health outcomes for families and communities.

**CLINICAL CARE**

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

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

**PRIORITY ACTIVITIES:**
- Enhance Primary Health Care capacity to implement care plan
- Ensure availability of core clinical services for Aboriginal and Torres Strait Islander peoples of Cape York, including specialist and allied health services within community or via referral.
- Regularly review chronic condition management plans
- Conduct brief interventions to address risk factors for chronic conditions
- Provide integrated delivery of multi-disciplinary chronic condition care and ensure evidence-based guidelines underpin the clinical care provided (Chronic Conditions Manual)
- Encourage and support self-care and self-management of chronic conditions
- Provide intensive support to pregnant women with GDM to reduce risk to mother and child of developing T2DM in later life
- Provide the opportunity for families and carers of people with chronic conditions to be involved, informed, supported and enabled

**WHY IS THIS ACTION AREA IMPORTANT?**
Clinical care must be culturally safe, high quality, responsive and accessible to Aboriginal and Torres Strait Islander peoples in Cape York. Frequent ongoing personalised support is needed to encourage self-management of lifestyle risk factors and to prevent chronic conditions.

**EDUCATION & LIFESTYLE MODIFICATION**

A healthy family and community has the knowledge and skills to make healthy lifestyle choices and have control over their own health and wellbeing.

**OBJECTIVE:** Increase knowledge and understanding of the risk factors and protective behaviours of chronic conditions, and increase self-efficacy to manage chronic conditions by delivering culturally appropriate information and education sessions to families, small groups and the community.

**PRIORITY ACTIVITIES:**
- Provide group education and skill development sessions on behavioural and lifestyle risk factors (smoking, nutrition, alcohol, physical activity and social emotional wellbeing), and where possible link with existing activities such as community information days/events, community camps and other activities on country
- Deliver healthy lifestyle programs and/or enhance existing programs to provide education and information on risk factors for chronic conditions
- Ensure language and literacy issues are considered in the delivery of health education sessions and information materials
- Develop referral pathways and systems to direct clients to healthy lifestyle programs.

**WHY IS THIS ACTION AREA IMPORTANT?**
Making informed choices is important in reducing risk factors. Group education and healthy lifestyle programs embed knowledge and skill development, encourage self-efficacy
SUPPORTIVE ENVIRONMENTS FOR HEALTHY LIVING

Empower community leadership to develop and adapt policies and infrastructure that can better support a healthier lifestyle.

OBJECTIVE: Increase the number of initiatives implemented in Cape York communities that will create supportive environments for healthy living.

PRIORITY ACTIVITIES:
- Identify local interpretations of current lifestyle risk factors and create alternative local based solutions that uniquely represent the community and environment.
- Assess and prioritise environmental conditions that can be influenced by policy, regulatory or infrastructure initiatives that will identify gaps and address determinants of health in the local environment and will subsequently support healthier lifestyles.
- Advocate for policy, regulatory and infrastructure activities that can influence quit smoking, nutrition, alcohol, physical activity, and social and emotional wellbeing.
- Integrate healthy workplace principles in organisational policies and practices to create a healthy workplace for staff and clients.

WHY IS THIS ACTION AREA IMPORTANT?
Supporting the creation of physical, social, cultural and local policy environments which promote health compliments clinical care efforts. Supportive environments can focus within the primary health care service and on the local community environment.

SOCIAL MARKETING

Culturally appropriate health messages addressing the health needs of the community encourage and empower families and communities to live healthy lifestyles.

OBJECTIVE: Increase community awareness and promote consistent messaging of behavioural risk and protective factors relating to chronic conditions specifically: smoking, nutrition, alcohol, physical activity, and social and emotional wellbeing.

PRIORITY ACTIVITIES:
- Engage communities in the design, development and implementation of social marketing campaigns that target specific population groups and develop culturally appropriate information and resources that complement the mediums used.
- Extend the reach of national and state social marketing campaigns, when appropriate, that promote consistent messages about smoking, nutrition, alcohol, physical activity and social and emotional wellbeing.
- Evaluate social marketing campaigns.

WHY IS THIS ACTION AREA IMPORTANT?
Targeted social marketing campaigns are effective as they can encourage individuals and families to assess their behaviour and support the health messages received.

PARTNERSHIPS, RESEARCH & ADVOCACY

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

OBJECTIVE: Engage in, support and lead activities that aim to influence better health outcomes in Cape York communities.

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

WHY IS THIS ACTION AREA IMPORTANT?
Apunipima must build and facilitate relationships with community, state and national organisations to foster innovative solutions, strong networks, informed and enhanced advocacy and best practice research.
**WORKFORCE PLANNING & DEVELOPMENT**

**OBJECTIVE:** Attract, train and retain an appropriately skilled workforce.

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

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

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**MONITORING, EVALUATION & COMMUNITY FEEDBACK**

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

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

**WHY IS THIS ACTION AREA IMPORTANT?**
Monitoring and evaluation is critical to the development of a robust evidence base that informs policy and practice, resulting in efficient use of resources to achieve improved health outcomes.
DEFINING CHRONIC CONDITIONS

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

Behavioural risk factors include: reducing smoking rates; improving nutrition; reducing gambling; reducing rates of harmful and hazardous alcohol consumption; and, increasing physical activity and social and emotional wellbeing.

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

The social determinants of health include: employment, education, food security, addiction, housing and access to services.

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

HOW WILL PROGRESS BE MEASURED?

Apunipima monitors program performance using three main approaches:

- Monitoring delivery of strategic actions
- Monitoring clinical outputs and outcomes
- Evaluation and research

Short and long-term performance indicators will be measured. Long-term indicators will be measured using National and Apunipima Key Performance Indicators. Short-term measures are detailed in the two-year Action Plan. Apunipima works in partnership with other health and non-health service providers, contributing directly and indirectly to improve health outcomes. Progress against the Action Plan will be communicated every two-years to all teams within the organisation and shared with Cape York communities and partner organisations.

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

REFERENCES