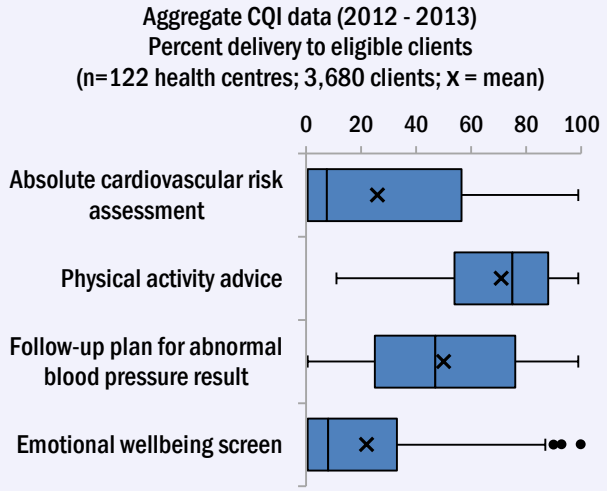
# Chronic Illness (based on feedback from 200+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:

- risk factor measures & enquiry, in particular, absolute cardiovascular risk assessment, healthy weight indicators, tobacco use
- brief interventions & referrals, in particular, physical activity, smoking

### Follow-up planning & action:

- for abnormal findings, in particular, blood pressure, total cholesterol & HbA1c levels (for T2D) – review / adjust medication & continue regular monitoring

### Emotional wellbeing screening & support

### Develop health centre systems:

- more effective links with community & organisational support for CQI systems

### Other specific priorities:

- adherence to evidence-based current treatment guidelines in relation to use of specific medications for clients with chronic illness
- coverage of adult vaccinations, in particular for clients with CKD, CHD, hypertension

## 2. Barriers & Enablers

### Staff recruitment & retention:

- lack of adequate staff numbers, particularly A&TSIHPs & high turnover
- recruitment focused on applicants having acute/emergency background, limited skill mix with respect to chronic illness care
- use of short term contracts limits stability & places additional burden on permanent staff to continually provide orientation & training

### Staff capability (training & development):

- more flexible professional development systems are required (eg inter-/ intra-organisational placements) due to limited time to undertake training outside clinics
- priority competency areas include patient centred care, working effectively in teams, principles of client self-management & principles of population health

### Community capacity/engagement/mobilisation:

- inadequate staff skills/systems to connect with & build capacity of communities

### Embedding CQI systems:

- managers insufficiently trained to support effective use of CQI tools

## 3. Strategies

### Workforce:

- improve induction, training & mentoring programs to increase skills in chronic illness care
- modify roles & career pathways of A&TSIHPs towards patient-centred comprehensive care focus
- introduce workforce measures as KPIs to encourage strategies & actions to improve stability of a qualified workforce (include consideration of adequate staff housing & flexible systems of professional development)
- build cultural capability of PHC staff to develop effective links with communities

### Community development:

- invest in strengthening health literacy & community leadership for CQI
- increase community involvement in the development of service delivery frameworks

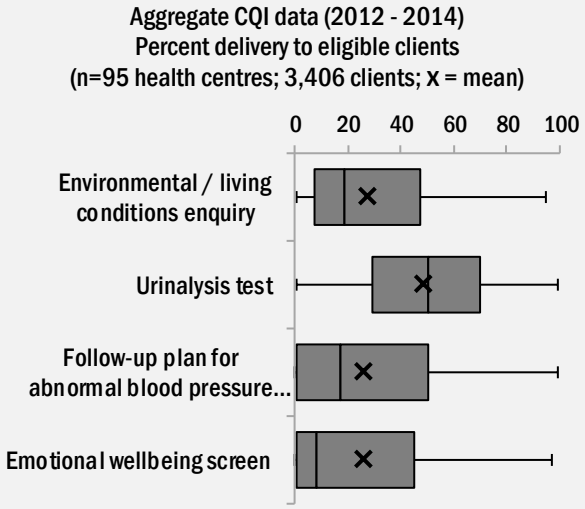
### Health systems:

- develop a CQI culture & practice at all levels (including management) through training & collaborative working

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; CHD – coronary heart disease; CKD – chronic kidney disease; HbA1c - glycosylated haemoglobin; KPI – key performance indicator; PHC – primary health care; CQI – continuous quality improvement; T2D – Type 2 diabetes

# Preventive Health (based on feedback from 75+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:

- risk factor enquiry, in particular substance use, environmental living conditions & family relationships
- absolute cardiovascular risk assessments
- biomedical investigations, in particular urinalysis & lipid profile
- advice on physical activity & nutrition

### Follow-up planning & action:

- for abnormal findings, in particular blood pressure, blood glucose levels & lipid profile

### Emotional wellbeing screening & support

### Develop health centre systems:

- appropriate delivery system design with a focus on right skill mix within PHC teams & processes that promote client continuity of care

### Other specific priorities:

- health promotion activities

## 2. Barriers & Enablers

### Staff recruitment & retention:

- lack of adequate staff numbers, particularly A&TSIHPs & lack of access to medical specialists

### Staff capability (training & development):

- insufficient systems to support inter-/ intra- organisational learning
- priority competency areas include patient centred care, teamwork, principles of client self-management (an area where good resources are required), principles of population health & knowledge of service populations

### Community capacity/engagement/mobilisation:

- insufficient systems to enhance community health literacy

### Embedding CQI systems:

- lack of management support for staff to use CQI tools

### Finance & resources:

- insufficient financial resources to support best practice preventive health care

## 3. Strategies

### Workforce:

- more A&TSIHP positions
- improve knowledge & systems to support teamwork, self-management support & patient centred care
- develop skills & knowledge about emotional wellbeing & mental illness

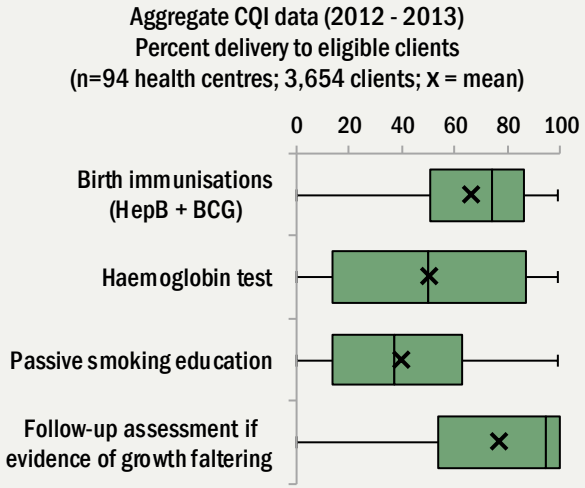
### Health systems:

- develop systems to ensure clients receive relevant follow-up services, including referral or specialised assessment in remote areas
- make effective use of available funding for preventive health assessments & follow-up
- have one clinical information system, rather than multiple systems across providers
- better use of clinical information systems for recall, calculating cardiovascular risk, timely uploading of test results & recording of follow-up actions
- develop systems to enable team based approaches & to promote continuity of care
- adequate & flexible funding to enable resource use according to service priorities

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; PHC – primary health care; CQI – continuous quality improvement

# Child Health (based on feedback from 60+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:

- all scheduled immunisations, in particular, those scheduled at birth & at 2 years & older
- key health measures, including weight, haemoglobin & developmental milestones
- risk factor enquiry, in particular familial use of alcohol, tobacco & other drugs
- brief interventions for child nutrition & development, passive smoking, infection prevention, injury prevention, domestic/social & environmental conditions

### Follow-up planning & action:

- for abnormal findings, in particular developmental delay, anaemia, chronic ear infections, identified risks related to domestic environment, financial situation & food security

### Develop health centre systems:

- more effective links with community & systems to support regional health planning

### Other specific priorities:

- availability of appropriate referral services in remote areas

## 2. Barriers & Enablers

### Staff recruitment & retention:

- lack of adequate staff numbers, particularly A&TSIHPs & to a lesser extent doctors
- inadequate systems to ensure PHC staff have support from experienced staff (limited by high staff turnover)

### Staff capability (training & development):

- insufficient systems to support inter-/ intra- organisational learning
- priority competency areas include working effectively in teams, patient centred care, principles of population health & client self-management, use of CQI tools, best practice guidelines & decision support resources

### Community capacity/engagement/mobilisation:

- insufficient systems to support community health literacy & leadership with respect to quality health care delivery

### Clinical information systems:

- lack of training & support for staff to effectively use information systems for supporting & providing best practice care

## 3. Strategies

### Workforce:

- build staff confidence & skills in areas relevant to practice gaps (including immunisation, community engagement, risk factor enquiry & provision of interventions for children identified at risk). This will require access to experienced, qualified staff & flexibility in training options such as inter-agency rotations & trans-disciplinary work practices

### Community development:

- work with communities to build understanding of child health issues (involve A&TSIHPs)
- identify local child health champions to assist with education & provision of practical support for families to develop strategies to reduce risks to child health

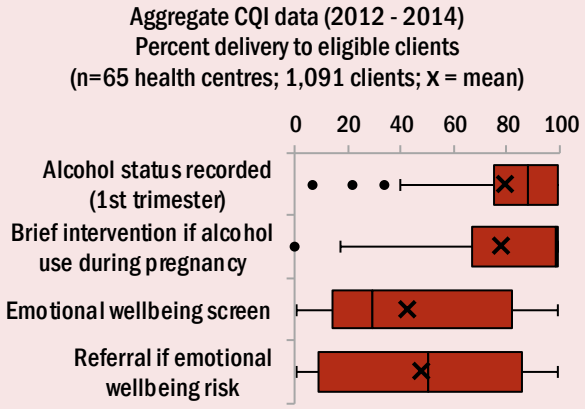
### Health systems:

- aim for less siloed service delivery, better interagency coordination & opportunities for staff across agencies to share relevant knowledge
- improve clinical information systems for sharing records across providers to facilitate follow-up (reminders), completeness of records & efficiency of care
- continue to use CQI processes to identify gaps & the staff skill mix needed in communities

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; PHC – primary health care; CQI – continuous quality improvement

# Maternal Health (based on feedback from 500+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:

- enquiry about smoking, use of alcohol & social risk factors
- provision of brief interventions early in pregnancy regarding smoking & use of alcohol
- post-natal counselling, in particular maternal & infant nutrition, safe environments & passive smoking risks

### Follow-up planning & action:

- availability of appropriate services for referral if social risk evident

### Emotional wellbeing screening & support

### Other specific priorities:

- family wellbeing & family support during pregnancy and at birth
- pre-conception health

## 2. Barriers & Enablers

### Staff recruitment & retention:

- systems to recruit, retain & support A&TSIHPs
- systems to assist experienced staff to support other PHC staff, particularly in times of staff shortage & high turnover

### Staff capability (training & development):

- help staff provide care that respects and responds to patient needs and values
- build capability & support staff to work in partnership with communities
- requires strongly committed staff (including managers) who function effectively in teams, who know maternal health best practice & believe it benefits populations

### Community capacity/engagement/mobilisation:

- systems to support community engagement, capacity & health literacy

### Embedding CQI systems:

- access to best practice guidelines & other decision support resources for maternal care

## 3. Strategies

### Workforce:

- train PHC staff to provide best-practice care for sensitive issues - alcohol use, smoking, social & emotional wellbeing

### Community development:

- work with communities on co-developed & community led health promotion projects about smoking, alcohol use, foetal alcohol spectrum disorder & Sudden Unexpected Death in Infancy risk reduction
- co-develop or adapt local resources with communities to support client education & train PHC staff to use them

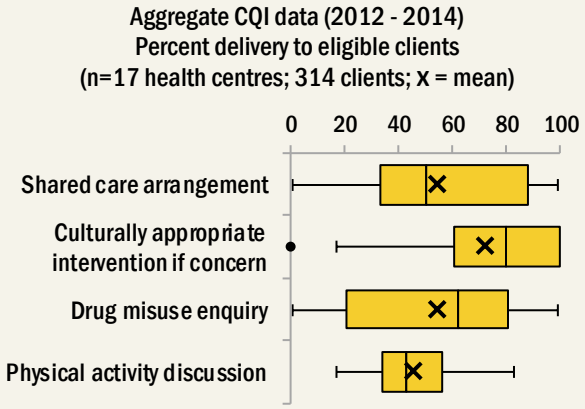
### Health systems:

- develop systems & referral processes to support clinical decision making & continuity of care before, during and after pregnancy (involve A&TSIHPs & midwives)
- support consistent care by embedding care priorities in pregnancy & post-natal checks, quality audits and activities (including prompts in electronic health records & links to resources for staff and clients)
- advocate for healthy food, adequate housing & culturally appropriate local services for referral - particularly social & emotional wellbeing services

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; PHC – primary health care; CQI – continuous quality improvement

# Mental Health (based on feedback from 50+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:
- shared care arrangements & referral
- enquiry about alcohol & drug misuse & provision of brief interventions on tobacco use, nutrition & exercise

### Follow-up planning & action:
- for clients with a deterioration or exacerbation of symptoms

### Develop health centre systems:
- improve organisational culture, support structures & processes that promote high quality care delivery
- develop PHC teams with appropriate skill mix & clear allocation of roles & responsibilities, for example, having psychologists &/or cultural healers
- more effective links with community for service & regional health planning & development of resources

### Other specific priorities:
- access to relevant referral services, particularly in remote areas
- service responsiveness to emerging issues such as drug use

## 2. Barriers & Enablers

### Staff recruitment & retention:
- inadequate numbers of mental health & wellbeing staff
- systems to recruit, retain & support staff, in particular A&TSIHPs

### Staff capability (training & development):
- systems to enable staff access to advice & support from experienced colleagues & mental health professionals
- help staff understand mental health and wellbeing needs of service population
- build awareness, knowledge and skills in culturally appropriate, patient-centred mental health & wellbeing care

### Finance & resources:
- insufficient financial resources to support best practice mental health care including PHC facilities of adequate size, design & condition
- insufficient resources to support access to referral services

## 3. Strategies

### Workforce:
- employ more Aboriginal & Torres Strait Islander mental health care staff, improve understanding of mental health from a community perspective & build cultural competency
- train staff in asking questions about alcohol & drug use, & educating clients in the health effects of misuse
- increase staff awareness of shared care & referral options

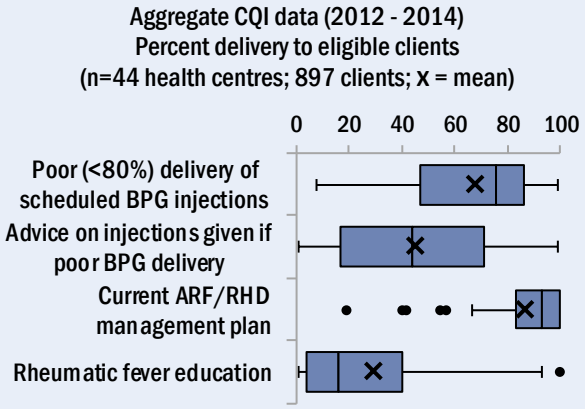
### Community development:
- include family members in clients' care & treatment
- work with community to combat normalisation of excessive alcohol & drug use

### Health systems:
- improve communication (ideally one information system) across services & between acute & primary care teams to coordinate case management, especially following suicidal ideation & attempts
- build multi-disciplinary teams & co-locate services to avoid the stigma of a 'mental health service', increase recognition of the central role of mental health wellbeing in PHC
- embed CQI strategies that highlight links between best practice & client outcomes

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; PHC – primary health care; CQI – continuous quality improvement

# Rheumatic Heart Disease (based on feedback from 500+ stakeholders)

## 1. Priority Evidence - Practice Gaps




### Delivery & recording of key aspects of care:

- provide at least 80% of planned BPG injections to clients who have been prescribed injections
- recording of current BPG prescriptions, planned frequency of injections in health summaries & clinic master charts
- disease management planning
- recording of ARF diagnoses (included suspected ARF)
- delivery & recording of rheumatic fever education to clients, families & communities

### Follow-up planning & action:

- actively follow-up clients who have missed BPG injections
- improve provision of interventions for clients who have ARF despite adequate BPG injection delivery

### Other specific priorities:

- educate communities & seek their involvement in advocating for secondary prophylaxis compliance

## 2. Barriers & Enablers

### Staff recruitment & retention:

- staff shortages, in particular A&TSIHPs, resulting in limited time to focus on holistic care

### Staff capability (training & development):

- insufficient systems to support inter-/ intra- organisational learning
- priority competency areas include patient centred care & to a lesser extent, team work & self-management support
- build capacity of PHC teams to develop partnership links with community

### Finance & resources:

- insufficient financial resources to support best practice ARF/RHD care

### Embedding CQI systems:

- support for staff to interpret CQI data, plan & implement strategies for improvement

### Community capacity/engagement/mobilisation:

- enhance community health literacy & expectation for quality care

## 3. Strategies

### Workforce:

- educate staff on the importance of the injection schedule to manage ARF/RHD and best practice guidelines
- train staff in social determinants of health and patient-centred care
- establish a dedicated staff role with responsibility for RHD care

### Community development:

- provide community, patient and family education on the importance of receiving injections – for example, one on one education, family focus groups, broader community education such as films in local language

### Health systems:

- establish a national data base of ARF/RHD patients to support BPG injection provision & disease management
- strengthen regional programs & partnerships to enable care for patients who move across jurisdictional boundaries
- improve resources & systems for follow-up of patients who require BPG injections, provide flexible options for BPG delivery including outreach & use of interpreters
- use CQI approaches & data to inform planning & service delivery

A&TSIHP - Aboriginal & Torres Strait Islander Health Practitioners; ARF – Acute Rheumatic Fever; BPG - benzathine penicillin G; PHC – primary health care; CQI – continuous quality improvement; RHD – Rheumatic Heart Disease