A 'Wellbeing Framework' for Aboriginal and Torres Strait Islander Peoples Living with Chronic Disease

This Wellbeing Framework is designed to assist healthcare services to improve the quality of life and quality of care, as well as the health outcomes, for Aboriginal and Torres Strait Islander peoples living with chronic disease. Guided by our National Reference Group, the Framework incorporates not just physical but also social, emotional, cultural and spiritual aspects of health and wellbeing.

Underlying Assumptions

Fundamental to this Wellbeing Framework is also a set of internationally-recognised values and beliefs:

- The ***Declaration of Alma-Ata*** [1], which recognises health as a state of physical, mental and social wellbeing rather than merely the absence of disease, and the right of people to participate in the planning and implementation of their healthcare services.
- The ***United Nations Declaration on the Rights of Indigenous Peoples*** [2], which sanctions cultural integrity and the rights of Indigenous peoples to practice and revitalise cultural traditions and customs.
- The ***Ottawa Charter for Health Promotion*** [3], which advocates for health promotion as a means of enabling people to increase control over, and thereby to improve, their health.
- The vision of the ***National Aboriginal Community Controlled Health Organisation*** [4], which seeks to "deliver holistic and culturally appropriate health and health related services to the Aboriginal community" (p.6).

Other chronic care models rarely addressed or even considered a holistic approach to care, often neglecting to engage with the important roles of culture, family and spirituality in maintaining the wellbeing of Aboriginal and Torres Strait Islander peoples. They have also overlooked how the health of Aboriginal and Torres Strait Islander peoples has been deeply affected by colonisation, including formal policies of segregation and exclusion, as well as forced removal from Country and family which have long-lasting intergenerational effects. The themes, elements and principles contained within this Wellbeing Framework will assist healthcare services to redress some of these important issues.

A Collaborative Approach

The Wellbeing Framework was developed by and for Aboriginal and Torres Strait Islander peoples. Under the guidance of our National Reference Group, a team of researchers including thirteen Aboriginal and Torres Strait Islander health professionals from across Australia came together to undertake this important work. Over 70 community members and healthcare practitioners who provide care to Aboriginal and Torres Strait Islander peoples also reviewed and provided advice prior to release.

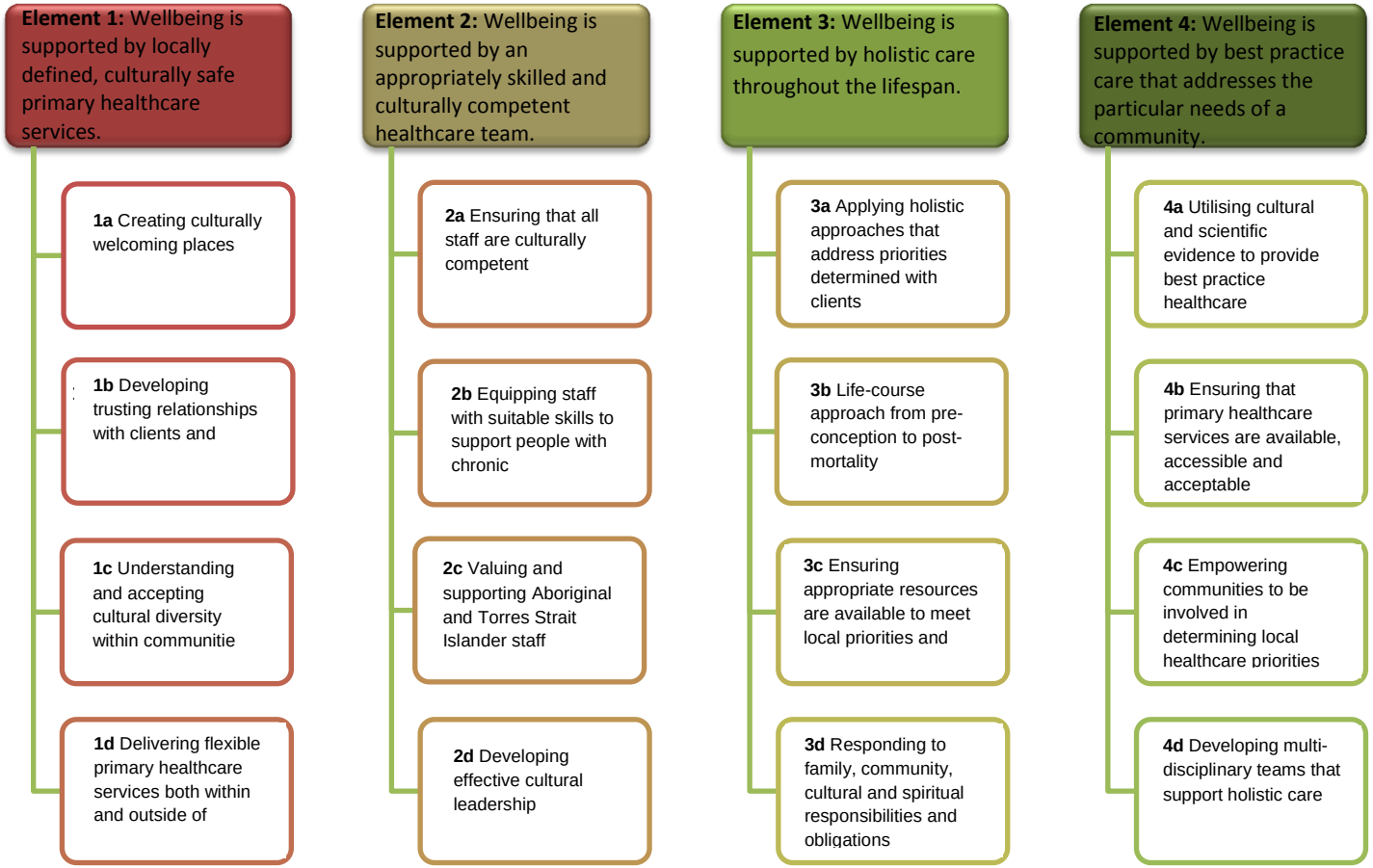
Structure of the Wellbeing Framework

The Wellbeing Framework consists of ***two core values*** that are fundamental to the provision of care for Aboriginal and Torres Strait Islander peoples. It also sets out ***four essential elements*** that can assist primary healthcare services to support the wellbeing of Aboriginal and Torres Strait Islander peoples living with chronic disease. Every element is supported by ***four principles***. Underpinning each principle is a number of practical and measurable ***applications*** that suggest ways in which the principle could be applied or achieved. Primary healthcare services, in consultation with the communities they serve, are encouraged to use the elements, principles and applications included within this Wellbeing Framework to shape their own Wellbeing Model which specifically addresses the needs of their communities.

Wellbeing Framework

Wellbeing is supported by upholding peoples' identities in connection to culture, spirituality, families, communities and Country.

Wellbeing is supported by culturally safe primary healthcare services.



Core Value 1: Wellbeing is supported by upholding peoples' identities in connection to culture, spirituality, families, communities and Country.

Supporting the wellbeing of people in the presence of chronic disease must include upholding people's cultural connectedness and balance with their families, communities, Country, culture and spirituality [5, 6]. For many Aboriginal and Torres Strait Islander peoples, there are complex relationships between natural and spiritual worlds involving interconnections between themselves, their community structures and their environments [7]. Creation beliefs shape people's lives, as well as their spirituality, values, attitudes, concepts, language and relationships to the physical and material world [8]. Often there can be a perception that personal illness or injury is a manifestation of struggles to maintain balance between spiritual, physical and emotional wellbeing and the wider world [9].

Core Value 2: Wellbeing is supported by culturally safe primary healthcare services.

Cultural safety 'involves health providers working with individuals, organisations and, sometimes, [communities]' [10 p. 23]. It extends beyond being aware of or sensitive to cultural differences. It includes a deeper level of interaction and thoughtful practice that ensures safe services, as defined by those who receive services [10, 11]. 'Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' [12 p. 6] or of their families or communities [13].

Element 1: Wellbeing is supported by locally defined, culturally safe primary healthcare services.

Locally defined, culturally safe primary healthcare services can be achieved by creating culturally welcoming space(s) as defined by Aboriginal and Torres Strait Islander communities; by developing trusting relationships between healthcare providers, clients and communities; by understanding and accepting diversity within and between communities; and by offering flexible approaches to the delivery of primary healthcare services that can address the complex needs and accommodate the competing demands experienced by many Aboriginal and Torres Strait Islander people with chronic diseases.

PRINCIPLES

Principle 1a: Creating culturally welcoming places

Culturally welcoming places include physical spaces as well as staff within the facility actively working towards ensuring that Aboriginal and Torres Strait Islander community members feel safe and comfortable [14]. Welcoming spaces are free from discrimination on the basis of differences, including those of race, gender and disability [15], and are reflective of dynamic local community contexts [15, 16].

Principle 1b: Developing trusting relationships with clients and communities

Trusting relationships encourage confidence in primary healthcare services [17-19]. Fundamental to developing trusting relationships is communicating responsively and responsibly and ensuring that people feel respected, valued and cared for when accessing primary healthcare services [14, 19-22].

Principle 1c: Understanding and accepting cultural diversity within communities

Primary healthcare staff should become aware of the diversity both within and between Aboriginal and Torres Strait Islander communities in order to ensure that a wide range of healthcare needs are attended to [13]. Different communities and groups within communities have distinct laws, governance arrangements, kinship structures and ways in which they view and maintain cultural identities [23], which are often overlooked when providing primary healthcare services to Aboriginal and Torres Strait Islander peoples.

Principle 1d: Delivering flexible primary healthcare services both within and outside of healthcare facilities

In order to adequately meet the complex needs and competing demands experienced by some Aboriginal and Torres Strait Islander communities, the provision of primary healthcare services should extend beyond the geographical and temporal constraints frequently applied in conventional primary healthcare settings [24-28].

APPLICATIONS

Applications associated with Principle 1a: Creating culturally welcoming places

Culturally welcoming places may be created by:

- Engaging with Aboriginal and Torres Strait Islander communities to determine what constitutes safe and welcoming healthcare spaces within the local context [13, 14, 16, 19, 45, 47-49]
- Developing resources that assist people to access primary healthcare services [13]

- Ensuring that primary healthcare facilities can be identified as culturally appropriate and welcoming to Aboriginal and Torres Strait Islander people [13], for example by displaying culturally appropriate posters, paintings and artefacts [18, 19, 47]
- Ensuring that protocols acknowledging Country are in place [15]
- Ensuring local Aboriginal and Torres Strait Islander staff are the first point of contact within primary healthcare services [13, 18, 19, 50]
- Ensuring staffing within primary healthcare services reflects an appropriate gender balance [15]
- Being responsive to peoples' diverse understandings and uses of English [13, 36, 44]
- Using interpreters when and where appropriate [13, 44]
- Ensuring that health promotion and information materials within facilities are designed to meet the needs of local Aboriginal and Torres Strait Islander peoples [19]
- Ensuring that healthcare providers are aware of Aboriginal ways

Applications associated with Principle 1B: Developing trusting relationships with clients and communities

Trusting relationships between healthcare providers and clients and their communities may be developed by:

- Ensuring that healthcare providers are aware of Aboriginal and Torres Strait Islander ways of knowing and doing
- Creating opportunities for two-way learning between healthcare professionals and communities [13]
- Scheduling appointments so that there is sufficient time to allow for the development of adequate relationships between clients and healthcare providers [13, 17, 31]
- Allocating appropriate case-loads in order to ensure staff have sufficient time to build relationships with clients [13, 17, 31]
- Developing procedures which ensure that client confidentiality is maintained [14, 45]

Applications associated with Principle 1C: Understanding and accepting cultural diversity within communities

Understanding and acceptance of cultural diversity may be promoted by:

- Involving local communities in the development of culturally safe practices [13, 16, 19, 47-49]
- Seeking the opinions of a variety of locally identified community members to guide the delivery of primary healthcare services [6, 13]
- Encouraging significant input from Aboriginal and Torres Strait Islander peoples into the development of primary healthcare services and resources [6, 13]

Applications associated with Principle 1D: Delivering flexible primary healthcare services both within and outside of healthcare facilities

Flexible service delivery may include:

- Delivering services outside of primary healthcare facilities, including within homes, schools, cultural venues or parklands [13, 20, 24, 25, 33, 44, 45, 51-55]
- Providing services to populations who may be experiencing complex needs, including itinerant, homeless or prison populations [13, 48]

- Using cultural ambassadors or local sporting groups to connect with young people about healthcare and health promotion [13]
- Communicating health messages more broadly through appropriate media [13]
- Identifying and utilising appropriate healthcare electronic applications (apps) [13]
- Offering after-hours phone services [13, 45]
- Providing after-hours clinical services [13, 45]
- Promoting Aboriginal and Torres Strait Islander healthcare through various media, including radio, television, social media and electronic applications [29]

Element 2: Wellbeing is supported by an appropriately skilled and culturally competent healthcare team.

Appropriately skilled healthcare teams are comprised of staff who are culturally competent as well as appropriately skilled and qualified to provide the types of clinical care that are required. Given the crucial role of Aboriginal and Torres Strait Islander staff in linking primary healthcare services with communities, and in the provision of culturally safe care, their particular role needs to be valued. Finally, effective leaders who can ensure that primary healthcare services are responsive to the needs of local communities are essential.

PRINCIPLES

Principle 2a: Ensuring that all staff are culturally competent

Ensuring that all primary healthcare staff are culturally competent may effectively protect the rights and safety of both clients and primary healthcare providers [29, 30].

Principle 2b: Equipping staff with suitable skills to support people with chronic disease

It is important that primary healthcare staff are appropriately skilled and qualified to meet the specific and often complex health needs of the communities they serve. Enhancing the professional development of staff can ensure the currency of clinical skills, as well as encourage retention of staff, thereby supporting continuity of care.

Principle 2c: Valuing and supporting Aboriginal and Torres Strait Islander staff

As a consequence of their cultural understandings and community connections, Aboriginal and Torres Strait Islander staff bring unique contributions to primary healthcare services [17, 31, 32]. It is important to ensure that Aboriginal and Torres Strait Islander staff are not discriminated against, excluded or isolated from other members of the healthcare team [13, 16, 33]. Aboriginal and Torres Strait Islander staff may require further support in managing any additional burden resulting from the dual responsibilities associated with being both healthcare providers and members of local communities [13, 17].

Principle 2d: Developing effective cultural leadership

Effective leaders, whether they sit on governing boards or occupy management positions, will be able to guide and direct the primary healthcare service to ensure that the diverse needs of communities are met and that services remain adequately transparent to maintain the trust of communities.

APPLICATIONS

Applications associated with Principle 2a: Ensuring that all staff are culturally competent

Cultural competency may be developed by:

- Providing regular cultural safety training to all staff members [13, 16, 26]
- Supplementing generic cultural safety training with locally specific face-to-face training [13, 33]
- Involving Elders and other members of local Aboriginal and Torres Strait Islander communities in the development and provision of cultural safety training, and remunerating community members for their contributions to cultural safety training [13, 20, 55]
- Tailoring cultural safety training to the roles and responsibilities of staff members [13, 27]

- Ensuring that all staff are well-informed about local Aboriginal and Torres Strait Islander communities [13, 35]
- Providing local cultural mentors for new staff [13, 49]
- Ensuring non-Indigenous staff can access cultural support from designated Aboriginal and Torres Strait Islander staff members within primary healthcare services [19, 35]
- Providing opportunities for staff to learn from each other [13, 20]
- Ensuring that staff are aware of the important role of Aboriginal Health Practitioners [13, 16]
- Providing opportunities for staff to engage directly with communities [55]
- Utilising previous and current case studies where health service providers have applied cultural competency programs effectively [55]
- Monitoring the progress of staff in cultural competency practice as well as the completion of cultural awareness training [55]
- Ensure cultural competency is supported by appropriate procedures, policies and protocols

Applications associated with Principle 2b: Equipping staff with suitable skills to support people with chronic disease

Equipping staff with suitable skills to support chronic disease may be enhanced by:

- Identifying skilled and respected staff who are clinically competent to ensure evidence-based care is provided [33, 56]
- Developing recruitment policies that ensure that potential staff have sufficient skills, understanding and ability to contribute to the healthcare needs of communities [16, 19, 22]
- Articulating clearly the roles and responsibilities of staff members [13, 14, 26, 33]
- Providing opportunities for staff to debrief with their supervisors [13]
- Rotating staff through remote areas and mainstream primary healthcare services to develop skills and experience [13]
- Providing professional, personal and infrastructure support to staff working in rural and remote areas [33, 42, 56]
- Providing ongoing professional development [20, 33, 44, 45, 56, 57]
- Acknowledging and utilising the skills of staff that have been developed through experience [13, 20]
- Supporting staff to undertake appropriate training and obtain qualifications [13, 22]
- Identifying the needs of staff in order to promote and support their wellbeing, including formal support such as Employment Assistance Programs [14, 27, 55, 58]

Applications associated with Principle 2c: Valuing and supporting Aboriginal and Torres Strait Islander staff

Valuing and supporting Aboriginal and Torres Strait Islander healthcare staff may be achieved by:

- Actively encouraging recruitment and retention of Aboriginal and Torres Strait Islander Health Workers and staff members, and ensuring equity in salaries and remuneration packages [55]
- Including Aboriginal and Torres Strait Islander staff in setting primary healthcare priorities and in decision making within the primary healthcare service [16, 33]
- Responding to cultural, spiritual, family and community obligations of Aboriginal and Torres Strait Islander staff [13, 38]

- Ensuring that Aboriginal and Torres Strait Islander staff are provided with support to assist in managing any additional responsibilities associated with being both members of local communities and of primary healthcare teams [17, 31]
- Encouraging and supporting Aboriginal and Torres Strait islander staff to meet their career goals [13, 16, 55]
- Recognising Aboriginal and Torres Strait Islander healthcare staff as an integral part of a multi-disciplinary team

Applications associated with Principle 2d: Developing effective cultural leadership

Effective leadership may be developed by:

- Supporting local community members to actively guide and govern local primary healthcare services [17, 33]
- Facilitating opportunities for Aboriginal and Torres Strait Islander people to take up leadership positions [13, 27]
- Employing leaders who are able to establish and implement clear strategies based on agreed-upon goals [6, 28, 44, 49, 59, 60]
- Establishing reporting systems which ensure transparency [16, 44]
- Establishing a succession plan to ensure sound future leadership [6, 44]

Element 3: Wellbeing is supported by holistic care throughout the lifespan.

An integrated cycle of care recognises that people's healthcare needs extend beyond the physical body. For Aboriginal and Torres Strait Islander peoples, healthcare needs may be closely bound to their spiritual, family, cultural, community and Country connections. An integrated cycle of care also acknowledges that people's needs differ according to where they are within their life-course. Ensuring that appropriate resources are available is also essential to meeting the often complex needs of Aboriginal and Torres Strait Islander clients.

PRINCIPLES

Principle 3a: Applying holistic approaches to address priorities determined with clients

Applying an holistic approach [18, 20, 28, 34, 35] includes addressing the physical, spiritual, social, emotional, psychological and cultural aspects of people's health [6]. Primary healthcare providers must be aware of and, where possible, support people to address and work toward overcoming socio-economic disparities [27, 28, 36, 37]. This may include providing opportunities for healing from trauma and stress, as well as addressing the social and cultural determinants of health as part of chronic disease care [13, 38].

Principle 3b: Life-course approach from pre-conception to post-mortality

A life-course approach considers healthcare needs and priorities according to life stages [13]. In Aboriginal and Torres Strait Islander communities, a life-course approach extends from pre-conception to post-mortality [16, 27, 32]. The development of risk factors for chronic diseases is influenced by parents' health prior to conception as well as during pregnancy [6]. Likewise, the ongoing responsibilities for people who have passed, together with higher rates of morbidity and mortality, can result in an increased burden of unresolved grief, loss and trauma [14, 24].

Principle 3c: Ensuring appropriate resources are available to meet local priorities and needs

Resources include guidelines, assessment tools and measures, and information that support the provision of healthcare to meet the specific needs of communities. Ideally, resources that are specific to local communities should be used or developed. However, where these are not available, it may be necessary to utilise or adapt generic resources to suit local contexts.

Principle 3d: Responding to family, community, cultural and spiritual responsibilities and obligations

Primary healthcare providers need to understand and be willing to respond appropriately to people's range of cultural responsibilities, including family and kinship obligations [13, 20, 39, 40]. Wellbeing for Aboriginal and Torres Strait Islander peoples is closely connected to Country and cultural practices, as well as to the maintenance and application of traditional knowledge [6]. It is therefore important not only to respond appropriately to the diversity of healthcare needs, but also to respect cultural and social conditions at a local level [5, 13, 27, 41, 42].

APPLICATIONS

Applications associated with Principle 3a: Applying holistic approaches to address priorities determined with clients

Applying holistic approaches that address needs and priorities as determined with clients may be achieved by:

- Identifying and responding to needs and priorities determined with clients [14-16, 38, 45, 52]
- Encouraging and supporting people to be involved in the management of their healthcare [13, 37, 61]
- Being prepared and having the capacity to engage in family-centred care, if desired [17, 42, 44, 45, 62]
- Developing a range of approaches which can accommodate people with varying complex needs [15, 26, 53, 54]
- Providing information to staff about external healthcare and non-healthcare services that are available to address people's needs [25, 49]
- Collaborating with non-healthcare services, including housing and other social services [14, 18, 26, 32, 35, 36, 44, 56]
- Advocating on behalf of clients to access non-healthcare services [14, 20, 28, 44]
- Establishing communication protocols and care pathways which ensure continuity of care when referring people to external services [16, 49]
- Identifying and endeavouring to link clients with Aboriginal and Torres Strait Islander staff when referring them to external services [13]
- Facilitating case conferences, potentially involving healthcare and non-healthcare service providers, clients and their families, and community Elders where appropriate [14, 20, 44]

Applications associated with Principle 3b: Life-course approach from pre-conception to post-mortality

A life-course approach may be applied by:

- Implementing disease prevention and health promotion activities, including maternal and child health, and youth programs [5, 16, 37, 44]
- Delivering age-appropriate health promotion activities in school settings in order to inform young people about the risks associated with developing chronic diseases [13, 42]
- Identifying risks of chronic disease and providing early interventions to address these risks [13]
- Enhancing health literacy throughout the lifespan [55]
- Organising respite excursions on Country as a strategy for dealing with stress [13]
- Facilitating support groups for various chronic diseases [13, 51]
- Providing acute care services in addition to chronic disease management [44]
- Supporting wellbeing within aged care services [13, 29]
- Facilitating appropriate palliative care, and end of life support [13, 16, 27, 44, 55]
- Providing services that support healing from grief and loss [13]

Applications associated with Principle 3c: Ensuring appropriate resources are available to meet local priorities and needs

Appropriate resources that meet local priorities and needs may be provided by:

- Compiling Directories of all local Aboriginal and Torres Strait Islander services including descriptions of the roles and responsibilities of various services [13, 55]
- Determining local priorities by utilising statistical data to identify trends and using qualitative evaluations to capture the stories that explain local trends [13]
- Identifying and evaluating the appropriateness of and, where necessary, adapting existing resources to ensure they are appropriate for use in local Aboriginal and Torres Strait Islander communities [13, 14, 16, 41, 42, 44]
- Ensuring information is user-friendly, for example, by using lay language [20, 50] or using visual aids to convey messages [16, 36, 56]
- Identifying and utilising a variety of methods for disseminating information that take account of the contexts and needs of clients and communities [13, 22, 27, 33, 56]
- Including local community members on resources such as flyers or posters [13]
- Providing information to communities about how to identify and interpret symptoms of chronic disease, such as early signs of a heart attack [13]
- Identifying and making use of healthcare standards, guidelines and programs that are appropriate for Aboriginal and Torres Strait Islander peoples [14, 16, 31, 63]

Applications associated with Principle 3d: Responding to family, community, cultural and spiritual responsibilities and obligations

Ensuring that primary healthcare services are aware of and respond appropriately to people's family, community, cultural and spiritual responsibilities and obligations may be achieved by:

- Actively seeking Aboriginal and Torres Strait Islander staff members' advice in order to give context to the circumstances of clients' families or their communities [17]
- Building relationships with community members who could further contribute to understanding of the cultural responsibilities, obligations and practices of individuals [16, 32]
- Developing procedures which ensure staff are aware of and respond appropriately to cultural sensitivities around gender and avoidance relationships [13]

Element 4: Wellbeing is supported by best practice care that addresses the particular needs of a community.

For Aboriginal and Torres Strait Islander communities, broadening the definition of best practice care to include not only evidence-based medicine, but also Aboriginal and Torres Strait Islander worldviews, will support wellbeing. Best practice care should also address the availability and accessibility of services and should empower communities to actively determine local healthcare priorities. Fostering a sense of empowerment is one strategy for supporting the wellbeing of entire communities. As there are complex interplays between physical, social, emotional, and spiritual aspects to health, it is important to develop multi-disciplinary teams that can adequately address the multiple dimensions of the health and wellbeing needs of people with chronic disease.

PRINCIPLES

Principle 4a: Utilising cultural and scientific evidence to provide best practice healthcare

Best practice care is based on the use of evidence from well-designed and conducted research in healthcare decision-making [references still to be inserted]. This includes ensuring continuous quality improvement through ongoing monitoring and regular evaluation [13, 14, 16, 43]. To adequately support wellbeing, it is important to expand current clinical understandings of 'best practice' to incorporate Aboriginal and Torres Strait Islander worldviews [13] and to include different types of evidence and knowledge where appropriate [5, 13].

Principle 4b: Ensuring that primary healthcare services are available, accessible and acceptable

By exploring with communities the factors that impede peoples' engagement with healthcare services, including financial barriers [16, 20, 33], primary healthcare services can implement strategies to increase the availability, accessibility and acceptability of services in order to adequately meet local needs [13, 44, 45]. This may include facilitating access to specialist services [20], as well as ensuring adequate follow-up care in some cases [13].

Principle 4c: Empowering communities to be involved in determining local healthcare priorities

Encouraging open and continuous dialogue between communities and primary healthcare providers, and ensuring that communities are able to make informed decisions, will assist in ensuring that healthcare priorities are contextually relevant [5].

Principle 4d: Developing multi-disciplinary teams that support holistic care

In Aboriginal and Torres Strait Islander communities, it is important to recognise a broad range of conditions that could be considered chronic, including social, emotional, mental and spiritual health issues [6, 13]. Maintaining integrated teams of healthcare staff who can provide a range of services, including those that support social and emotional health as well as chronic disease management, will better meet the needs of people living with chronic conditions [13, 14, 16, 20, 44, 46].

APPLICATIONS

Applications associated with Principle 4a: Utilising cultural and scientific evidence to provide best practice healthcare

Evidence-based best practice healthcare may be applied by:

- Including traditional healers, traditional bush medicines, and complementary healthcare within chronic disease care [6, 13, 49]
- Ensuring staff are trained in evidence-based practice [13]
- Identifying and implementing evidence-based best practice guidelines [43, 56, 64]
- Identifying or developing, and then implementing minimum service standards [16, 25]
- Responding to locally based clinical contexts [5, 13, 14, 28, 33, 49, 59]
- Ensuring that information management systems support systematic, organised and coordinated evidence-based care [16, 33, 44]
- Integrating existing information management systems to ensure that timely and accurate information is available to support the care that is provided to individuals [16, 49]
- Capturing population-based data to identify the healthcare priorities of local setting [16, 44]
- Ensuring that Aboriginal and Torres Strait Islander ethnicity is identified, where appropriate [16]
- Developing the capacity of primary healthcare services for in-house research, monitoring and evaluation to reduce reliance on external research capacity [13]

Applications associated with Principle 4b: Ensuring that primary healthcare services are available, accessible and acceptable

Enhancing the availability, accessibility and acceptability of primary healthcare may be achieved by:

- Establishing accessible primary healthcare services, including after-hours services and telephone support [13, 16, 33, 45]
- Using technology (e.g. texting people reminders of appointments) and social media to encourage access to services [13]
- Providing transport to primary healthcare facilities including vehicles that can accommodate people with limited mobility [13, 20, 31, 42, 44, 45, 47, 65]
- Keeping waiting times to a minimum [13, 20, 45, 47]
- Providing specialist outreach services where they are not readily accessible [13, 20, 33, 44, 45]
- Encouraging the use of E-Health especially for transient clients [13]
- Evaluating the acceptability of care provided to individuals and communities [31, 37, 43, 59]

Applications associated with Principle 4c: Empowering communities to be involved in determining local healthcare priorities

Ensuring that healthcare priorities are determined by empowered communities and primary healthcare services together may be achieved by:

- Building and maintaining strong relationships between communities and primary healthcare services [6, 14, 16, 18, 20, 32, 36, 44, 66, 67]
- Facilitating regular dialogue and continuous consultation between primary healthcare providers and communities [6, 14, 16, 44]
- Providing information regarding consumer rights and formal processes for addressing consumer rights issues [55]

- Demonstrating how primary healthcare services are addressing the priorities suggested by communities [16, 44]
- Sharing information between healthcare providers and communities to empower community members to make informed decisions, both about their own healthcare and regarding community priorities for local healthcare services [6, 14, 16, 18, 36, 44]

Applications associated with Principle 4d: Developing multi-disciplinary teams that support holistic care

Holistic, multi-disciplinary chronic disease care may be developed by:

- Setting goals for chronic disease care [17, 26, 31, 51]
- Recruiting skilled healthcare staff into chronic disease roles [25, 59]
- Ensuring that roles and responsibilities for chronic disease staff are transparent [14, 26, 33]
- Establishing specific chronic disease training which can be easily transferred into practice settings [33]
- Ensuring that chronic disease staff have the dedicated time required to build relationships and work together with clients [13, 30]
- Developing teams that may include traditional healers, complementary health practitioners, pharmacists, psychologists, social workers, drug and alcohol workers, allied health staff, and non-clinical support workers [13, 55]
- Maintaining strong leadership within chronic disease teams to ensure they function to best meet people's needs [13]
- Co-locating staff who treat and manage people with chronic disease [13]
- Utilising people living with chronic diseases as members of chronic care teams, as mentors, or as community educators for health promotion [13]
- Using care plans as required [13, 26, 54]
- Ensuring continuity of care, especially when transitioning between healthcare and non-healthcare services [13, 16, 31]
- Co-ordinating follow-up healthcare [13, 16, 31, 42, 44]
- Facilitating peer support groups [13]
- Assisting to coordinate care for people with multiple care providers [17, 26]
- Brokering tertiary healthcare and non-healthcare services which are not available within the primary healthcare service [14, 46]
- Establishing formal pathways for referral and interagency follow-up [55]

Acknowledgements

This study was supported by a grant from the **Australian Primary Health Care Research Institute**. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Australian National University.

The following people – including the thirteen Aboriginal and Torres Strait Islander Research Fellows from seven Aboriginal Medical Services who participated in Stage Three of the study – were part of the **Wellbeing Study Team**: Timena Ahmat, Gary Brahim, Alex Brown, Carol Davy, Anna Dowling, Tania Kelly, Shaun Jacobson, Kaylene Kemp, Elaine Kite, Fiona Mitchell, Tina Newman, Margaret O'Brien, Jason Pitt, Bernadette Rickards, Kesha Roesch, Christine Saddler, Leda Sivak, Maida Stewart and Tiana Thomas.

We would also like to acknowledge the significant contribution that the following **Aboriginal Medical Services** made to this study: Danila Dilba Medical Service, Maari Ma Health Aboriginal Corporation, Nunkuwarrin Yunti Inc, Tharawal Aboriginal Corporation, Winnunga Nimmityjah Aboriginal Health Service, Wirraka Maya Health Service Aboriginal Corporation and Wuchopperen Health Service.

In addition, we would like to offer special thanks to the following **National Reference Group** members for their generous input into this project: Associate Professor Deb Askew, Dr Peter Bennett, Professor Ngiare Brown,Mrs Mary Buckskin, Dr Hugh Burke, Mr Justin Canuto, Ms Kerry Copley, Dr Malcolm Darling, Mr Garth Dodd, Ms Anne-Marie Eades, Ms Sonya Egert, Dr Beverly Essue, Ms Kristine Garrett, Mr Rob Gerrie, Dr Odette Gibson, Ms Karen Glenn, Ms Karen Glover, Dr Sally Goold, Ms Raylene Gordon, Ms Vicki Gordon, Mr Kiel Hennessey, Ms Deborah Hobbs, Ms Jenny Hunt, Mr Shaun Jacobson, Professor Stephen Jan, Dr David Johnson, Ms Liz Kasteel, Ms Wendy Keech, Ms Cath Kennedy, Ms Alison Killen, Ms Rosie King, Dr Chris Lawrence, Ms April Lawrie-Smith, Ms Noblelene Mackenzie-Stewart, Ms Dallas McKeown, Ms Sandra Miller, Ms Liz Moore, Uncle Lewis O'Brien (OAM), Ms Kim O'Donnell, Ms Regina Osten, Ms Karen Page, Ms Shereen Rankine, Ms Janice Rigney, Dr Nadeem Siddiqui, Dr Jim Stephen, Dr Julie Tongs, Ms Vicki Taylor, Dr Vicki Wade, Ms Lesley Woolf and Mr Darryl Wright.

References

1. World Health Organisation, *Declaration of Alma-Ata*. 1978, World Health Organisation: USSR.
2. United Nations, *United Nations Declaration on the Rights of Indigenous Peoples*. 2008, United Nations: Brussels.
3. World Health Organisation, *The Ottawa Charter for Health Promotion*. 1986, World Health Organisation: Ottawa.
4. National Aboriginal Community Controlled Health Organisation, *Towards a National Primary Health Care Strategy: Fulfilling Aboriginal peoples' aspirations to close the gap*. 2009, National Aboriginal Community Controlled Health Organisation: Canberra.
5. Griew, R., E. Tilton, and N. Cox, *The link between primary healthcare and health outcomes for Aboriginal and Torres Strait Islander Australians*. 2008, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing: Canberra.
6. Huffman, M.D. and J.M. Galloway, *Cardiovascular health in Indigenous communities: successful programs.* Heart, Lung and Circulation, 2010. **19**(5): p. 351-360.
7. Vicary, D.A. and B.J. Bishop, *western psychotherapeutic practice: engaging Aboriginal people in culturally appropraite and respectful ways*. 2005, Curtin University of Technology: Perth, Western Australia.
8. Grieves, V., *Aboriginal spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing*. 2009, Cooperative Research Centre for Aboriginal Health: Casuarina, NT.
9. Brown, A., *Kurunpa [Spirit]: Exploring the psychosocial determinants of coronary heart disease among Indigenous men in Central Australia*, in *School of Population Health*. 2009, The University of Queensland: Brisbane.
10. Coffin, J., *Rising to the Challenge in Aboriginal Health by Creating Cultural Security.* Aboriginal and Islander Health Worker Journal, 2007. **31**: p. 22-24.
11. Nash, R., B. Meiklejohn, and S. Sacre, *The Yapunyah project: Embedding Aboriginal and Torres Strait Islander perspectives in the nursing curriculum.* Contemporary Nurse, 2006. **22**: p. 296-316.
12. Nursing Council of New Zealand, *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing and midwifery education and practice*. 2002, Nursing Council of New Zealand: Wellington.
13. Aboriginal Research Fellow Workshop Two, *Wellbeing Model Study*. 2014, Kanyini Vascular Collaboration: Adelaide.
14. Gordon, R., et al., *Chronic Care for Aboriginal People Model of Care*. 2010, NSW Department of Health: North Sydney.
15. Aboriginal Research Fellow Workshop One, *Wellbeing Model Study*. 2014, Kanyini Vascular Collaboration: Adelaide.
16. Gordon, R., et al., *The Walgan Tilly Project: Chronic Care for Aboriginal People*. 2008, PriceWaterhouseCoopers.
17. Battersby, M.W., et al., *Research implementing the Flinders Model of Self-management Support with Aboriginal people who have diabetes: findings from a pilot study.* Australian journal of primary health, 2008. **14**(1): p. 66-74.
18. Hayman, N.E., N.E. White, and G.K. Spurling, *Improving Indigenous patients' access to mainstream health services: the Inala experience.* Medical Journal of Australia, 2009. **190**(10): p. 604-6.
19. Kanyini Vascular Collaboration, *Monograph: Welcoming Spaces*. 2014, Kanyini Vascular Collaboration: Adelaide.
20. Tchan, M., et al., *The outback vascular health service evaluation report*. 2012, The George Institute for Global Health: Sydney, NSW.
21. Kanyini Vascular Collaboration, *Monograph: Remaining engaged with care*. 2014, Kanyini Vascular Collaboration: Adelaide.
22. Kanyini Vascular Collaboration, *Monograph: Care and Caring*. 2014, Kanyini Vascular Collaboration: Adelaide.

23. Dudgeon, P., et al., *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people*. 2014, Australian Institute of Health and Welfare: Canberra.
24. Hoy, W.E., S.N. Kondalsamy-Chennakesavan, and J.L. Nicol, *Clinical outcomes associated with changes in a chronic disease treatment program in an Australian Aboriginal community.* Medical Journal of Australia, 2005. **183**(6): p. 305.
25. Si, D., et al., *Assessing health centre systems for guiding improvement in diabetes care.* BMC Health Services Research, 2005. **5**(1): p. 56.
26. Bailie, R., et al., *Improving organisational systems for diabetes care in Australian Indigenous communities.* BMC Health Services Research, 2007. **7**(1): p. 67.
27. Tilton, E. and D. Thomas, *Core Functions of primary health care: a framework for the Northern Territory*. 2011, Northern Territory Government: Darwin, Northern Territory.
28. Kanyini Vascular Collaboration, *HOME Study Interview*. 2014, Kanyini Vascular Collaboration: Adelaide.
29. Reference Group Two (May 2014), *Wellbeing Model Study*. 2014, Kanyini Vascular Collaboration: Adelaide.
30. Hoy, W.E., et al., *A chronic disease outreach program for Aboriginal communities.* Kidney International, 2005. **68**: p. S76-S82.
31. Mills, D., et al., *Eyre Peninsula chronic disease self management project for Aboriginal communities in Ceduna/Koonibba and Port Lincoln*. 2003, Port Lincoln Aboriginal Health Services, Ceduna Koonibba Aboriginal Health Service, Eyre Peninsula Division of General Practice: Bedford Park.
32. Wade, V., D. Jackson, and J. Daly, *Coronary heart disease in Aboriginal communities: towards a model for self-management.* Contemporary Nurse, 2003. **15**(3): p. 300-309.
33. Menzies School of Health Research, *Sentinel Sites Evaluation Final Report*. 2013, Menzies School of Health Research: Darwin, NT.
34. Gordon, R., et al., *The Walgan Tilly Project: Chronic Care for Aboriginal People*. 2008, NSW Health.
35. Statewide Cardiology Clinical Network, *Cardiac rehabilitation: a model of care for South Australia - stage two*. 2011, SA Health: Adelaide, South Australia.
36. Gracey, M., et al., *An Aboriginal-driven program to prevent, control and manage nutrition-related "lifestyle" diseases including diabetes.* Asia Pacific Journal of Clinical Nutrition, 2006. **15**(2).
37. Weeramanthri, T., et al., *The Northern Territory Preventable Chronic Disease Strategy-promoting an integrated and life course approach to chronic disease in Australia.* Australian Health Review, 2003. **26**(3): p. 31-42.
38. Hoy, W.E., et al., *Chronic disease profiles in remote Aboriginal settings and implications for health services planning.* Australian and New Zealand Journal of Public Health, 2010. **34**(1): p. 11-18.
39. Harkins, J., *Shame and shyness in the Aboriginal classroom: A case for "practical semantics".* Australian Journal of Linguistics, 1990. **10**(2): p. 293-306.
40. Eades, D., *They don't speak an Aboriginal language, or do they?* , in *Aboriginal ways of using English*. 2013, Aboriginal Studies Press: Canberra, ACT. p. 56-75.
41. Aboriginal Health Council of South Australia Inc., *Annual Report 2011-2012*. 2012, AHCSA: Unley.
42. The Pilbara Aboriginal Health Planning Forum, *Pilbara Aboriginal Health Plan 2012 - 2015*. 2012, The Pilbara Aboriginal Health Planning Forum: Pilbara, WA.
43. Wise, M., et al., *National Appraisal of Continuous Quality Improvement Initiatives in Aboriginal and Torres Strait Islander Primary Health Care*. 2013, Lowitja Institute: Carlton South, Victoria.
44. Cerasa, D., *Australian health care: closing the service gap.* Nursing management (Harrow, London, England : 1994), 2011. **18**(8): p. 16-9.

45. Govil, D., et al., *Identifying culturally appropriate strategies for coronary heart disease secondary prevention in a regional Aboriginal Medical Service.* Australian journal of primary health, 2013.
46. Queensland Aboriginal and Islander Health Council, *A blueprint for Aboriginal and Islander health reform in Queensland*. 2011, QAIHC: South Brisbane.
47. Menzies School of Health Research, *Sentinel Sites Evaluation Interim Report*. 2012, Menzies School of Health Research: Darwin NT.
48. Battersby, M., et al., *An analysis of training and information options to support chronic disease prevention and self-management in primary health care*. 2008, Commonwealth Department of Health and Ageing: Canberra.
49. Gibson, O., et al., *Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: A systematic review*. 2014, Kanyini Vascular Collaboration: Adelaide.
50. Cass, A., et al., *Renal transplantation for Indigenous Australians: identifying the barriers to equitable access.* Ethnicity and Health, 2003. **8**(2): p. 111-119.
51. Kit, J.A., et al., *Chronic disease self-management in Aboriginal communities: Towards a sustainable program of care in rural communities.* Australian journal of primary health, 2003. **9**.
52. Lawn, S., J. McMillan, and M. Pulvirenti, *Chronic condition self-management: expectations of responsibility.* Patient Education and Counseling, 2011. **84**(2): p. e5-e8.
53. South Australia. Dept. of Health. Statewide Service Strategy Division, *Cardiac Rehabilitation: a Model of Care for South Australians - Stage One*, S.S.S.D. Department of Health, Editor. 2011: Adelaide.
54. Battersby, M.W., *Health reform through coordinated care: SA HealthPlus.* British Medical Journal, 2005. **330**(7492): p. 662.
55. Reference Group Consensus Workshop (Nov 2014), *Wellbeing Model Study*. 2014, Kanyini Vascular Collaboration: Adelaide.
56. Hoy, W., et al., *The Aboriginal Chronic Disease Outreach Program*. 2004.
57. Murray, R.B., et al., *Sustaining remote-area programs: retinal camera use by Aboriginal health workers and nurses in a Kimberley partnership.* Med J Aust, 2005. **182**(10): p. 520-523.
58. Kanyini Vascular Collaboration, *Inverview - CAHPS*. 2014, Kanyini Vascular Collaboration: Adelaide.
59. Gardner, K.L., et al., *Understanding uptake of continuous quality improvement in Indigenous primary health care: lessons from a multi-site case study of the Audit and Best Practice for Chronic Disease project.* Implementation science : IS, 2010. **5**: p. 21.
60. Gardner, K.L., et al., *Reorienting primary health care for addressing chronic conditions in remote Australia and the South Pacific: Review of evidence and lessons from an innovative quality improvement process.* Australian Journal Rural Health, 2011. **19**: p. 111-117.
61. Harvey, P.W., et al., *Self-management support and training for patients with chronic and complex conditions improves health-related behaviour and health outcomes.* Australian Health Review, 2008. **32**(2): p. 330-338.
62. Queensland Aboriginal and Islander Health Council, *Annual Report 2011 - 2012*. 2012, QAIHC: South Brisbane.
63. Brown, A., et al., *Essential service standards for equitable national cardiovascular care for Aboriginal and Torres Strait Islander people.* Heart, Lung and Circulation, 2014. Article in press(http://dx.doi.org/10.1016/j.hlc.2014.09.021).
64. Weeramanthri, T., et al., *Chronic disease guidelines and the Indigenous Coordinated Care Trials.* Australian Health Review, 2002. **25**(2): p. 1-6.
65. Menzies School of Health Research, *Sentinel Sites Evaluation Interim Report - Appendices*. 2012, Menzies School of Health Research: Darwin, NT.
66. Liaw, S.T., et al., *Successful chronic disease care for Aboriginal Australians requires cultural competence.* Australian and New Zealand Journal of Public Health, 2011. **35**(3): p. 238-248.

67. Hoy, W.E., et al., *Reduction in natural death and renal failure from a systematic screening and treatment program in an Australian Aboriginal community.* Kidney International, 2003. **63**: p. S66-S73.