Received: 20 February 2022 | Revised: 13 August 2022 | Accepted: 26 September 2022

DOI: 10.1111/ajr.12932

AJRH National Rural Health Alliance WILEY

COMMENTARY

Commentary: Improving access to cardiac rehabilitation (Heart: Road for health) for Aboriginal and Torres Strait Islander peoples in rural and remote areas of North Queensland

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Funding information
Tropical Australian Academic Health Centre

Abstract

Aims: To focus on the needs, challenges and opportunities to improve access to cardiac rehabilitation (CR) (Heart: Road to health [HRH]) for Aboriginal and Torres Strait Islander peoples in rural and remote (R&R) areas of North Queensland.

Context: It is known that there is insufficient access to HRH for Aboriginal and Torres Strait Islander peoples in R&R areas of NQ, who have the highest rates of heart disease and socioeconomic disadvantage mainly due to poor social determinants of health. However, at least in part due to the impact of colonialism and predominantly western medicalised approach to health care, few gains have been made.

Approach: This commentary draws on recent research and literature and reflects on cultural issues that impact on improving access to an HRH for Aboriginal and Torres Strait Islander peoples in R&R areas. The underutilisation of the skills of Aboriginal and Torres Strait Islander Health Workers (ATSIHW) and a lack of a defined process to ensure access to culturally responsive HRH are discussed. Finally, a way forward is proposed that includes the development of policies, pathways and guidelines to ensure that appropriate support is available in the client's home community.

Conclusion: It is proposed that culturally responsive, accessible and effective HRH is achievable through the reorientation of current health systems that include a continuous client-centred pathway from hospital to home. In this model, ATSIHW will take a lead or partnership role in which their clinical, cultural brokerage and health promotion skills are fully utilised.

Improving access to cardiac rehabilitation (Heart: Road to health) for Aboriginal and Torres Strait Islander peoples in rural and remote areas of North Queensland.

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KEYWORDS
Aboriginal Health, access issues, community based rehabilitation, communication, policy

1 | BACKGROUND

There is a need for effective health care for Aboriginal and Torres Strait Islander people, who have the highest heart disease (HD) rates in rural and remote (R&R) areas of Australia.[1] These rates of disease are compounded by socioeconomic disadvantage, due to poor social determinants of health (SDoH), which include low levels of education, income, inadequate housing, poor security and disempowerment due to the impact of colonialism.[2,3]

HD contributes to significant illness, disability, poor quality of life and high health care costs in Australia.[1] CR is an evidence-based model of secondary prevention that provides coordinated activities including education, medical care and physical, mental and social support for self-management to address risk factors for cardiovascular disease.[4] This process results in reduced mortality and morbidity, improved quality of life and optimal functioning, together with reduced client and health care costs.[4,5] Ideally, CR is provided through a holistic (health and well-being), multidisciplinary approach that is delivered in a variety of settings, which includes hospital inpatient Phase-1-CR and outpatient Phase-2-CR.[6] Despite known benefits, CR referrals and attendance are low (30.2%),[7] predominantly due to inadequate Phase-1-CR[8]; a scarcity of centre-based services in R&R areas; inadequate culturally responsive care for Aboriginal and Torres Strait Islander people; and poor acceptance of telephone support programs.[9,10]

Aboriginal and Torres Strait Islander peoples have more than 65 000 years of continuous culture,[11] disrupted by the effects of colonialism. Therefore, cultural aspects of health care are an essential component of health service planning and delivery.[12] Culturally responsive care is provided by Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHO) and Aboriginal and Torres Strait Islander Health Workers (ATSIHW), who offer a holistic approach, which is reported to reduce the effects of colonisation and structural racism.[12]

Changes are required to address deficits in the provision of health care and improve access to CR for Aboriginal and Torres Strait Islander peoples. Currently, on discharge from hospital, people with HD (clients) are usually advised to see their general practitioner (GP), or in areas serviced by Primary Health Care Centres (PHCC), to consult a clinic nurse. During this process, holistic multidisciplinary postdischarge care is compromised by a range of factors including:

(i) medical discharge summaries being delayed, predominantly clinical and rarely mentioning CR, holistic, multidisciplinary care or risk factor management[8];
(ii) poor understanding of CR by health staff and clients[8,9];
(iii) poor interhealth service communication[8] including non-sharing of medical records by different health care organisations[9];
(iv) use of predominantly western medical practices that are known to be ineffectual in treating Aboriginal and Torres Strait Islander people.[13]

2 | HOW TO IMPROVE ACCESS TO CARDIAC REHABILITATION FOR PEOPLE IN RURAL AND REMOTE AREAS

Several recent research studies contribute to, and provide recommendations, for improving access and attendance to CR for people who live in R&R areas.[8,9,14] These studies include an integrative literature review that demonstrates a lack of understanding of CR, inflexible services, low referrals and attendance,[8] all underpinned by a weak systematic policy-driven approach. To address these shortfalls, there is a need for policy-driven, flexible, culturally responsive holistic programs, delivered by a multidisciplinary health team, with management support.[8] An epidemiological study found that Aboriginal and Torres Strait Islander peoples in North Queensland (NQ) were more likely to be hospitalised for HD than non-Indigenous Australians, (relative risk 1.27–1.98), but rates were lower than expected given Indigenous rates of HD are twice that of non-Indigenous Australians.[15] Also, referral rates to home-based telephone support CR (Coaching on Achieving Cardiovascular Health [COACH]) were found to be low in NQ: 4%–20%.[16] To compound this, a community study on provision and access to CR in R&R areas of NQ demonstrated that Aboriginal and Torres Strait Islander peoples prefer face-to-face communication with someone they trust.[9] Also, the term CR was found to be confusing as it was linked to centre-based care including gym, learning to walk poststroke, or hip replacement, or drug and alcohol programs.[9] To improve clarity and

understanding of CR, it is recommended that the term Heart: Road to health (HRH) is used.[9]

It is considered essential that the proposed HRH includes a pathway that commences with Phase-1-CR that includes education, discharge planning and referral to outpatient, community-based Phase-2-CR, taking a flexible client-centred approach. In this paper, the term pathway describes the process, commencing with effective hospital discharge planning, through a coordinated progression to community-based HRH. Guidelines refer to specific activities that are required for an evidence-based HRH, which includes clinical care, assessment, risk factor management and psychosocial support.[17]

Based on recent research,[8,9,14] the following pathway to HRH has been developed. The aim being to improve communication, coordination and collaboration between health care providers, centre or home-based CR services, leading to improved client outcomes (Table 1).

This proposed pathway is based on the utilisation and reorientation of available health resources, with or without a specialist HRH coordinator. Currently, all clients are seen by local health services, and we contend that improved coordination of services will result in more efficient and effective service and lead to improved health outcomes. To achieve this, it is proposed that the local community-based HRH coordinator will be a community nurse and/or ATSIHW who will undertake the initial assessment, develop a care plan, refer to AHP for risk factor management and/or arrange telehealth support. These locally based health professionals, either solely or in combination, will coordinate local secondary prevention services as outlined in Table 1. In line with recommended flexible services (Figure 1), this assessment may be at the local health centre or in the client's home as negotiated with the client. In the majority of cases, it is possible for people who live in the immediate community served by the local health centre. However, in areas where the client may live very remotely the assessment will need to be negotiated either via phone or computer link, with face-to-face conducted when the client visits the local centre for farm supplies or groceries.[9] Collaborative and consultative interorganisational policies, procedures, education

TABLE 1 Pathway to heart: road to health

Step	Activity	Responsibility
1.	Inpatient Phase-1-CR to ensure that clients: (i) understand their disease, postdischarge plan, and the need for a continuous HRH (ii) are referred to a CR service and/or a local HRH case coordinator (community nurse/ATSIHW) (iii) consent for follow-up	Hospital management and clinical staff
2.	In the client's home community, on receipt of a postdischarge referral and consent for follow-up, the HRH case coordinator contacts the client and organises a face-to-face meeting. This meeting may be at the client's home, with their family, or health centre, depending on the client's preference	Community nurse and/or ATSIHW
3.	During the initial meeting, the HRH coordinator will attend to immediate health care needs such as medications, blood pressure check and wound care (as required) and complete an assessment as per National Heart Foundation criteria[18]	Community nurse and/or ATSIHW
4.	The HRH coordinator will consult with a designated CR specialist, who may be based at a nominated CR centre, or a designated cardiac educator[a] to develop a HRH plan	Community nurse and/or ATSIHW & CR specialist
5.	Depending on the findings of step 3 & 4 referrals that include medical, nursing, ATSIHW, and allied health professional (AHP) care will be organised for follow-up and provision of secondary prevention services	Community nurse and/or ATSIHW
6.	Progress will be monitored and coordinated by the HRH coordinator, through a multidisciplinary case conference that includes all health care providers involved in the client's care	Multidisciplinary team
7.	Outputs from multidisciplinary case conferences will be documented and arrangements made for sharing information, when care is provided by a range of organisations	Multidisciplinary team
8.	The HRH case coordinator will stay in contact with the client and continue to coordinate care until the client is deemed able to self-manage	Community nurse and/or ATSIHW

[a]Currently, cardiac educators are not available in R&R areas of NQ.

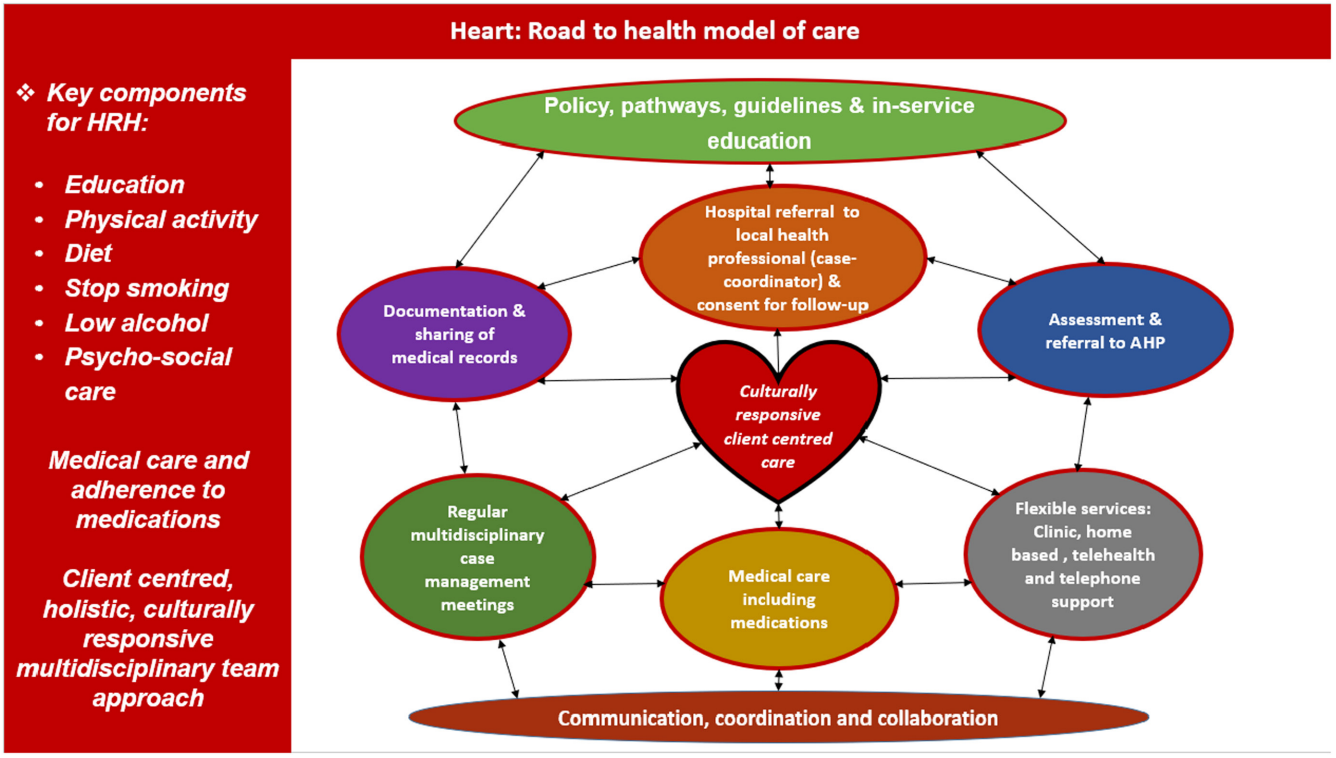

FIGURE 1 Heart: road to health model of care

and guidelines need to be developed to support all these processes.[9]

3 | CHALLENGES FOR HEART: ROAD TO HEALTH FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES IN RURAL AND REMOTE AREAS

Prior to improving access to CR for Aboriginal and Torres Strait Islander people, it is important to consider factors that impact on people's health, including culture, SDoH,[2] and the need for '...theory-based behaviour change intervention...'.[19] It is essential that clients and health staff have a better understanding of secondary prevention, cultural aspects of care and effective behaviour change strategies, in the context of the local culture, environment and SDoH.[9]

The western biomedical approach to health care is known to be a barrier to effective health care for Aboriginal and Torres Strait Islander peoples. To minimise this, ACCHO use a holistic wellness-based model.[13] Queensland Health (QH) continues to predominantly use the western biomedical approach to provide services for all people either solely,[9] or in collaboration with ACCHO or Royal Flying Doctor Service (RFDS).[9] However, the working relationship between QH and ACCHO, at times, lacks the collaboration necessary for holistic multidisciplinary care, and locally based ACCHO are not available in all R&R areas. The National Health and Medical Research Council guidelines provide information on culturally responsive programs for Aboriginal and Torres Strait Islander peoples.[20] These guidelines are supported by the recommendation of Taylor et al.[21] as pathways to culturally responsive, flexible CR in which ATSIHW play a key role.[21]

There are examples of successful CR programs for Aboriginal and Torres Strait Islander people in Western Australia (WA)[13] and Tasmania,[22] but no evidence of their systematic implementation,[10,13,21,23,24] in other areas of Australia.[25] Overall, there is a history of neglect for improving access to CR, especially for Aboriginal and Torres Strait Islander people in R&R areas, that is exacerbated by inadequate health information systems and communication, resulting in inadequate pathways for CR from hospital to home.[24]

Before access to CR for Aboriginal and Torres Strait Islander people can be improved, a whole of systems approach is required to ensure that there is adequate post-discharge information about secondary prevention and clinical management that is received in a timely manner by local health staff.[8,9] Staff education and support to provide client-centred culturally responsive care is essential as depicted in the HRH: Model of care (Figure 1).[9]

This model integrates the NHMRC guidelines[20] and the findings of previous research[8–10,13,16,21–24] depicting a

model for implementation in a range of environments for a range of diseases. It is argued that should this model be fully implemented, supported by necessary policies, pathways, guidelines and in-service education, with ongoing monitoring and evaluation, effective health provision should be realised. This process needs to be tested, but based on the known effectiveness of CR, it is expected that improved access to CR will result in improved health outcomes for people with heart and potentially other chronic diseases, with subsequent cost savings.[5]

4 | ROLE OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS IN PROVIDING HRH

The range of health services available in R&R areas of NQ provides opportunities for a culturally responsive HRH. An essential component of these services is ATSIHW, whose skills include health promotion, cultural brokerage and clinical care.[26] Their involvement is essential in achieving improvements in HRH. Despite ATSIHW promoting home visits that were valued by clients, these were seldom supported by health systems or managers, resulting in, at times, ATSIHW being used as transport or administration officers.[9] Whilst there are weaknesses that need to be addressed, there are also examples of effective collaboration between QH and ACCHO, which can be built upon.[9]

The primary role of ATSIHW and variations in service delivery of available health services are key factors that need to be addressed in the delivery of appropriate and effective culturally responsive health services.[12]

5 | HEALTH SERVICE PROVISION AND OPPORTUNITIES FOR PROVIDING HRH IN RURAL AND REMOTE AREAS

Health services in R&R areas of NQ are provided by QH, ACCHO, RFDS and a range of contracting organisations. Services are provided either autonomously or through collaborative service provision,[9] by a range of community-based or visiting health professionals, including nurses, ATSIHW, doctors and AHP, augmented by telehealth services.[9] As discussed, it is proposed that community-based HRH could be provided by utilising these services. To achieve this, there is a need for improved working relationships between current health service providers, with ATSIHW taking a lead, or partnership role,[9,13,23,25,27] thus strengthening service provision and reducing health care costs through the reduction in hospital readmissions.[5] Before sustainable gains can be made, there is a need to ensure that:

1. communication, coordination and collaboration between QH, ACCHO, RFDS and health service contractors are improved;
2. client-centred, holistic, multidisciplinary health care is provided[9];
3. health staff are provided in-service education and support to ensure that they are equipped to provide HRH;
4. ATSIHW are supported in a lead role.

The involvement of ACCHO and ATSIHW is essential to facilitate holistic culturally responsive services that are congruent with the HRH. This approach would strengthen HRH from a cultural perspective and diminish systemic racism that has been identified in government health services.[12]

6 | THE WAY FORWARD

To enable the provision of an appropriate HRH for Aboriginal and Torres Strait Islander peoples, culturally, holistic, multidisciplinary, client-centred services, delivered by ACCHO and ATSIHW in conjunction with the other health care organisations such as QH, RFDS and health service contractors, are necessary. To achieve this, strong relationships between these organisations and individual service providers are essential. The first step in this process is the development of a pathway from hospital to the client's home community, supported by guidelines, and in-service education, with frequent updates, due to high staff turnover.[14]

In summary: A systems-based approach is required to ensure a culturally responsive effective HRH. To achieve this, all health care providers need to work collaboratively, supported by policies, procedures, a pathway and guidelines which ensure:

- improved support for ATSIHW to enable them to include health promotion, cultural brokerage and clinical care in their role;
- in-service education is provided for all health staff at regular intervals;
- improved coordination and utilisation of local/visiting staff (especially AHP), in conjunction with telehealth and home-based telephone support programs;

- improved communication from discharging hospitals to locally based and visiting health care providers that comprises:

  - referrals to local health care providers, for example, community nurses and/or ATSIHW,
  - medical discharge summaries that are timely and provide guidance and support for CR, secondary prevention and risk factor management,
  - sharing of medical records between health care organisations and individual health care providers.
- resources to revise and develop health care systems to support the implementation of the HRH;
- coordination and accountability at a regional level;
- continuous quality improvement cycle that includes development, monitoring and evaluation of health systems and delivery of HRH.

To assist with this process, there are examples of pathways and guidelines for a holistic multidisciplinary CR/HRH. These include Western Australian[28] and National Heart Foundation pathways.[18]

Whilst the development of health care systems is considered essential for improving access to culturally responsive HRH in R&R areas, it is unlikely that the desired impact will be achieved unless there is an overall, cooperative trusting relationship between health care providers and the communities for whom they care.[12] Clearly, utilisation of ATSIHW would strengthen relationships and facilitate the provision of health care in Indigenous communities. This, combined with previous research, strengthens the proposition that ATSIHW and ACCHO have a primary role in the provision of health care for Aboriginal and Torres Strait Islander peoples.[10,13]

There are further examples of successful patient-centred, culturally responsive, holistic, multidisciplinary models in which ATSIHW are key team members. These could provide a way forward for the development of HRH and include the Cape York Kidney Care program,[29] and diabetes client-centred model of education and self-management.[30] Both programs include routine home visits, and a coordinated plan of care, developed in conjunction with clients and their family. These models are built on a multidisciplinary team approach that includes medical care (GP and specialist), diabetic educators/renal nurse practitioners, ATSIHW and AHP, all of whom work collaboratively to provide patient-centred care.[9,29] Telehealth and telephone support programs are services available to augment HRH, but further investigation is required into their suitability given a lack of information on effectiveness with culturally and linguistically diverse populations, especially in R&R areas.

7 | CONCLUSION

It has been demonstrated that implementation of a culturally responsive, accessible and effective HRH is feasible in R&R areas of NQ and could be implemented through reorientation of current health systems, which includes a continuous client-centred pathway from hospital to home. To achieve this, revision of current health systems to include improved communication, coordination and collaboration between health care providers, with ATSIHW taking the lead role, or at least working in partnership with community-based health professionals is necessary. Further development of these ideas and pilot studies on the implementation of revised models are essential next steps for an effective Heart: Road to health or chronic diseases for Aboriginal and Torres Strait Islander peoples in R&R areas of NQ.

AUTHOR CONTRIBUTIONS

PEF: conceptualization; funding acquisition; project administration; resources; validation; visualization; writing – review and editing. RCF: conceptualization; funding acquisition; project administration; resources; supervision; validation; visualization; writing – review and editing. RB: conceptualization; supervision; validation; visualization; writing – review and editing. IR: conceptualization; supervision; validation; visualization; writing – review and editing. PAL: conceptualization; supervision; validation; visualization; writing – review and editing. KC: conceptualization; supervision; validation; visualization; writing – review and editing.

ACKNOWLEDGEMENTS

Acknowledgement of Townsville Hospital and Health Service, and Torres and Cape Hospital and Health Service for their support and assistance throughout this project.

FUNDING INFORMATION

Funding support from Tropical Australia Academic Health Centre (TAAHC), James Cook University, Townsville, Qld.

CONFLICT OF INTEREST

There are no conflicts of interest to declare.

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How to cite this article: Field P, Franklin RC, Barker R, Ring I, Leggat P, Canuto K. Commentary: Improving access to cardiac rehabilitation (Heart: Road for health) for Aboriginal and Torres Strait Islander peoples in rural and remote areas of North Queensland. Aust J Rural Health. 2022;00:1–7. doi:10.1111/ajr.12932