Strengthening Cardiac Care for Aboriginal and Torres Strait Islander Patients with Acute Coronary Syndrome.

Cardiovascular disease (CVD) is the major cause of deaths in Australia with death rates falling over the past three decades [1]. However, significant disparities exist in terms of survival from CVD in relation to socioeconomic status, geography, and ethnicity [2, 3]. These disparities are most particularly evident in the 17-year life expectancy gap between Aboriginal and non-Aboriginal Australians, with CVD being a significant contributor [2]. In 2006, the Australian Institute of Health and Welfare (AIHW) reported that Aboriginal patients have more than twice coronary artery disease death rate in hospitals; a 40% lower rate of being investigated by angiography; a 40% lower rate of percutaneous coronary intervention (PCI) including coronary angioplasty or stent procedures and a 20% lower rate of coronary artery bypass surgery (CABG) [4].

In 2011, a committee was established at St Vincent’s Hospital (STV) in Melbourne to evaluate the care of Aboriginal patients with acute coronary syndrome (ACS) and a quality improvement project was planned. A grant application to the Department of Health to fund the project was successful in June 2011. A steering committee was established comprising key stakeholders from the Victorian Aboriginal Health Service (VAHS) in Fitzroy, the Heart Foundation, the Aboriginal Health Branch and the Victorian Cardiac Clinical Network of the Department of Health, STV Aboriginal Health program and Cardiology, and the St Vincent’s/Australian Catholic University (ACU) Centre for Nursing Research (SVCNR), assisted with the overall direction of the project. The Director of Mission, who is responsible for the Aboriginal Health program at STV, was also on the steering committee. A working group comprising of the research staff and key individuals from the STV Mission Department provided advice for implementation of the research.

An Aboriginal Hospital Liaison Officer (AHLO) and a cardiac nurse developed and implemented a working together model of care to specifically address the recommendations of the National Heart Foundation published in Better Hospital Care for Aboriginal and Torres Strait Islander People Experiencing Heart Attack [5] for improved care co-ordination, cultural safety and better data collection among the Aboriginal patients admitted to STV with ACS. This model of care has been reported as improving care co-ordination, especially in socially disadvantaged people [6]. The AHLO provided cultural safety and the nurse provided clinical expertise.

An essential element of the model of care is the provision of cultural safety. Cultural safety is a subjective experience which can only be defined by the recipient of care [7]. When applied to the area of Aboriginal health, the concept implies a recognition of the social and health impacts of colonisation in Australia as well as the significant impact of loss and grief on health [8, 9]. The more recent history of Aboriginal Australia has had profound effects on health and well-being and it should be recognised that for many Aboriginal people, hospitals are symbols of the very institutions that had a role in their marginalisation in Australian society. Hospitals are also places where Aboriginal people continue to experience poor attitudes, racism or poor cultural understanding [8]. Structural factors such as access and co-ordination also impact on the health of Aboriginal Australians as do socioeconomic disparities [8].
The AHLO screened admission lists of patients daily and any Aboriginal patient admitted with chest pain was reviewed by the AHLO and the cardiac nurse and included in the project if the subsequent diagnosis was ACS. Those patients were then approached by the AHLO and asked if they were willing to be seen and followed up by the cardiac nurse and the AHLO. The project was given Human Research Ethics Committee approval as a Quality Assurance project so formal consent was not sought as the project comprised enhanced normal care.

Fifteen patients were followed up between November 2011 and the end of June 2012. The mean age of the participants was 57 (±10) years and 60% of them were male. The majority of the patients were from the inner and northern Melbourne metropolitan region (46%) with other patients coming from rural regions. These 15 patients had a total of 22 admissions: five patients had CABG and eight patients had PCI with insertion of drug eluting stents. All patients agreed to care co-ordination and follow up by the AHLO and the cardiac nurse. This included meeting patients and family in the hospital, reviewing medications, liaison with other clinicians, explaining procedures and ensuring that the patient received a referral to cardiac rehabilitation. Sixty percent of the patients attended cardiac rehabilitation after discharge.

The AHLO and a cardiac nurse using the working together model implemented at STV, improved care co-ordination, resulting in increased clinical engagement with Aboriginal health on a number of levels including medical, nursing, allied health, clerical staff and providers of cardiac rehabilitation. The most significant achievement of the project is improved referral to and attendance at cardiac rehabilitation and follow-up with patients and their primary care providers. More than half of the patients seen by the AHLO and the nurse attended cardiac rehabilitation, a rate which is higher than reported rates of attendance for the wider community in published reports. This has significant potential clinical outcomes for the patient. When a culturally safe space is provided, as in this project using the working together model, improvements in care are possible.

5. National Heart Foundation of Australian and Australian Healthcare and Hospitals Association, Better Hospital Care for Aboriginal and Torres Strait Islander people experiencing heart attack. 2010.