Consultation Report

Mt Isa consultation

9 JUNE 2021

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Discussion Paper

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Consultation report: Mt Isa consultation

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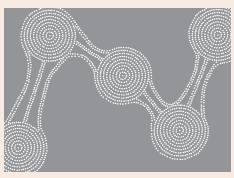
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

Acknowledgement of Country

Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body representing Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, acknowledge the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pay our respects to Elders past and present, and recognise the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

Making Tracks artwork produced by Gilimbaa for Queensland Health.



Sharing Knowledge artwork produced by Casey Coolwell for QAIHC.

Contents

Introduction

The Mt Isa consultation was undertaken on 9 June 2021 at Mt Isa Neighbourhood Centre. The consultation had 20 participants and was conducted over a five-hour period.

Workshop Purpose

The regional workshops were held statewide to:

- **increase the understanding of the Health Equity agenda**
- **explore how the Health Equity Regulation will change the health landscape in Queensland**
- **discuss what this means for Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in delivering health services**
- **explore the implications and associated challenges for HHSs in meeting their requirement to prepare their Health Equity Strategy (HES) within 12 months of the regulation being passed**
- **identify any tools that would assist HHSs to develop their HES**
- **socialise other potential health reforms (outlined in section 3 of the Discussion Paper) to identify the ones that have the greatest support and to identify any other important reform items.**

Workshop Structure

The workshop was broken into three parts to correspond to the three sections of the Discussion Paper. Each section was discussed and explored through key questions and subsequent discussion with the groups. Scribes from Queensland Aboriginal and Islander Health Council (QAIHC) and the Department of Health took notes to capture the essence of the discussions and the thoughts and opinions of the participants.

Section 1

Discussed the journey that Aboriginal and Torres Strait Islander peoples have taken to improve health outcomes in Australia and Queensland since 1971.

This included the services undertaken by the Aboriginal and Torres Strait Islander community-controlled sector and Queensland Health. While there have been some health gains, the current pace of reform and activities is not enough to meet the Close the Gap (CTG) targets by 2031.

Section 2

Discussed the health equity journey since 2017, including the current tranche of reforms being introduced in Queensland through the new Health Equity Strategy Regulation. There are going to be additional accountability requirements on HHSs to demonstrate co-design and working in partnership with ATSICCHOs.

Explored the current issues with the local health system and what will need to be done to build a health system that better meets the needs of community and where all providers are working collaboratively towards improved health outcomes.

Section 3

Discussed the 20 proposed ideas to drive further system reforms to supplement the new HESs.

These 'ideas' are not limited to 20 as others could be identified, but it is important to have an idea of what could be relevant to this region and its priority. Details of the ideas are provided in Appendix 3.

Report structure

During the consultative process across the state, there was overall agreement that the health equity design principles (page 23 of the Discussion Paper) should include cultural capability and social determinants of health. Accordingly, the health equity design principles used for this report are:

- First Nations leadership
- local and regional decision making
- reorienting local health systems
- cultural capability (this could be changed to cultural safety)
- social determinants of health.

Further, five key themes have emerged from the workshops. These are:

- systems
- care
- funding
- workforce
- culture.

This report drills down further to map the principles to the key themes. There is often overlap in the learnings and how they have been attributed to the principles, so you may see some comments in multiple places as they are applicable to a variety of areas.

Executive summary

The Mount Isa workshop generated robust discussions about the need for local health system change and reform. Participants welcomed the opportunity presented by the new HES to reset the local health system but were realistic about the challenges because previous attempts over the years had not resulted in sustained or substantive improvements.

Mt Isa HHS does not currently have a board of directors in place, but an administrator was appointed recently. Historically, there have not been strong partnerships between the HHS and the local Aboriginal and Torres Strait Islander health services.

Key themes discussed included:

- The North West Hospital and Health Service (NWHHS) catchment includes many clients shared with Gidgee Health and Injilinji Aged Care. The current mechanisms for co-design in health care and a collaborative approach to shared clients varies greatly between NWHHS and the Aboriginal health services. A robust partnership agreement is needed, engaging all parts of the health system and local community.
- Models of care and issues caused by the remote location need to be addressed. The current model of care and the issues of distance continue to be barriers to good health outcomes for First Nations peoples. The journey through the health system is complex and needs to be simplified, with consideration given to at-home and e-health options.
- The need for a better coordinated approach to client care, along with more culturally appropriate secondary and tertiary care, is vital to improve health in this area.
- As with most rural and remote areas, it is difficult to attract and retain a skilled workforce, particularly for this area, which seeks to attract and retain skilled First Nations health professionals. This shortfall exacerbates the health issues faced by the local Aboriginal community, which needs a pipeline with a longer-term ability to grow its own workforce and to have training available locally.
- There needs to be accountability for each client along the whole 'patient journey', with a better and more streamlined system that ensures culturally safe ongoing care at each stage, from home and back to home. Models of care need to be developed that will let clients receive treatment locally, rather than having to go away to major cities.
- Technology and e-health can play major roles in place-based care, thus ensuring streamlined care and minimising the need for further interventions.
- Racism needs to be tackled; audits need to occur, and their findings dealt with. More training and support must be available to hospital staff. Complaint mechanisms must be streamlined to allow Aboriginal and Torres Strait Islander peoples to feel comfortable using the system.
- Social determinants such as education and housing are not integrated into the health and wellbeing of Mt Isa's First Nations peoples.

Top five health reforms

considered a priority for this region by the participants

2 Increase Queensland Health's First Nations employment target

8 Establish regional coordinated care hubs

16 Factor equity into existing QH funding models

11 Embed cultural capability into clinical services capability framework

20 Drive an anti-racism strategy across the health system

Key discussion points

The discussion from the Mt Isa consultation will be incorporated into the overall state consultation report, which will be used to develop the guide and toolkit that HHS will use to develop their health equity strategies over the next 11 months.

The ideas discussed during the workshop have been mapped against the health equity design principles and can be used to have further conversations about what actions need to be undertaken to redesign the local health system to better meet the needs of people in the Mt Isa region.

Principle 1: First Nations leadership	
Need to support HHS and work with administrator to begin HES	
Systems	• Partnerships need to be developed to ensure seamless patient journey. • Need to ensure accuracy of data when sharing patient information. • Need to have better data-sharing capability and ensure accuracy and timeliness. • Community and staff education on what the different components of the health system are responsible for. • Need to ensure all players are at the table moving forward—not just historical ways of doing things. • Need work as one to ensure greater effectiveness. • Use existing partnerships to begin HE. • Need to get data accessible across all areas of the health system to see true picture. • Partnerships need to be developed to ensure seamless patient journey. • Need assistance with communications materials to ensure cultural accuracy for local mob. • Need to get Commonwealth to the table—can NACCHO assist? • Community education regarding health and health services is needed.
Care	• Need to ensure that health education is provided to mob. • Health promotion and targeted health education need to occur. • SDoH need to be factored into patient outcomes.
Funding	• Resources need to go where they are needed. • Need to ensure that resources are being best utilised and that there is no duplication or gaps in service.
Workforce	• Need a workforce strategy with training pathways. • Need to consider regional education.

Principle 2: Local and regional decision making	
Systems	• Partnerships need to be developed to ensure seamless patient journey. • Good communication and partnerships are needed to break down an 'us and them' mentality. • SDoH need to be factored into patient outcomes. • Need to consider housing availability in workforce strategy. • Need to ensure all players are at the table moving forward—not just historical ways of doing things. • Need work as one to ensure greater effectiveness. • Need to work out what structure is best to ensure best outcomes. • Need to identify how to move forward. • Need to have a structured and accountable partnership with all parts of the health system involved. • Need to ensure that all parts of the health system are working together consistently. • Need to have a structured and accountable partnership with all parts of the health system involved. • Need to ensure that true partnership and co-design occur.
Care	• Need to have 'one' health service with multiple points of entry and exit. • Health promotion and targeted health education need to occur. • Consideration needs to be given to discharge plans of patient in remote areas.
Funding	• Resources need to go where they are needed. • Need to ensure funding is being utilised effectively and there is no duplication or gaps in service.
Culture	• Need to ensure language used in communication is appropriate for mob. • Need to ensure that local community is involved in all aspect of design and delivery.

Principle 3: Reorienting local health systems	
Systems	• Need to have better data-sharing capability and ensure accuracy and timeliness. • Need to ensure all players are at the table moving forward—not just historical ways of doing things. • Need to get data accessible across all areas of the health system to see true picture. • Need to ensure accuracy of data when sharing patient information. • Need to ensure that all parts of the health system are working together consistently.
Care	• Models of care need to be explored to ensure a wrap-around service for patients. • Need to look at models of care to ensure they meet patient needs. • Need to ensure that patient discharge is coordinated. • Need to ensure that there is consistency in the patient journey and continuity of care. • Funding for SEWB needs to available for all patients regardless of who hold the funds.
Culture	• Health promotion and targeted health education need to occur. • Consideration needs to be given to discharge plans of patient in remote areas.

Principle 4: Cultural capability	
Systems	• Need to have a structured and accountable partnership with all parts of the health system involved. • Need to ensure that true partnership and co-design occurs.
Workforce	• Need a workforce strategy with training pathways. • Need to consider regional education. • Need to start health training within the school system.
Culture	• Need to ensure language used in communication is appropriate for mob. • Need to ensure that health education is provided to mob. • Need to ensure that cultural safety is built into all areas of the health system.

Principle 5: Social determinants	
Systems	• Need to have areas responsible for SDoH at the table and work together.

Appendix 1—Section 1: The journey so far...

**Have aligned comments to the health equity principles as a guide to move from concept/ideas/comments to action.*

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
General discussion		
Let's not be having this conversation in ten years' time. Want real change. Legislation hasn't happened before; that's the change.		
The Key Principles of EQUITY: • First Nations leadership • local and regional decision making – regional CEO forums with all stakeholders • reorienting local health systems.		
NWHHS, THHS, Gidgee and TAIHS need to work together, given the patient travel that occurs between the regions. Transport is an issue where TAIHS and Gidgee need to be funded for this.	• Partnerships need to be developed to ensure seamless patient journeys. • Resources need to go where they are needed.	P1: First Nations leadership P2: Local and regional decision making
Principle 3: concern about the patient journey in the region between Gidgee and HHS, that is, staff running down the other service, etc. Need to have strong, courageous conversations about this.	• Good communication and partnerships needed to break down an 'us and them' mentality. • Need 'one' health service with multiple points of entry and exit.	P2: Local and regional decision making
Confusion at Mornington Island. People don't really understand what PHC is.	• Need to ensure health education is provided to mob.	P1: First Nations leadership
Community needs health literacy. Mob need to understand community and our world-view, social determinants, etc.	• Health promotion and targeted health education needs to occur. • SDoH need to be factored into patient outcomes.	P1: First Nations leadership P2: Local and regional decision making
Workforce, particularly Aboriginal and Islander Health Worker workforce, which is shallow, and the system doesn't value its roles. No training for AHWs/AHPs; have to go away for training.	• Need a workforce strategy with training pathways. • Need to consider regional education.	P1: First Nations leadership P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Have to start the AHW/AHP pipeline in schools.	• Need a workforce strategy with training pathways.	P1: First Nations leadership
?? Doesn't believe staff know the difference between primary and secondary health care.	• Community and staff education on responsibilities of the different components of the health system.	P1: First Nations leadership
Accommodation directly affects work-force availability, particularly on Mornington and Doomadgee.	• Consider housing availability in workforce strategy.	P2: Local and regional decision making
Watch our language and be careful not to reinforce a negative narrative about community.	• Ensure language used in communication is appropriate for mob.	P2: Local and regional decision making P4: Cultural capability
Fast Facts sheet—the top five would be different for this region.		
Gidgee to 'in-reach' to the HHS to enhance the chances of step-down succeeding.	• Explore models of care to ensure a wrap-around service for patients.	P3: Reorientating local health systems
Information and sharing are key for patient safety. Different medical software, patient consent and confidentiality, etc.	• Ensure accuracy of data when sharing patient information.	P1: First Nations leadership

Appendix 2—Section 2: Embedding health equity into local health...

Placing First Nations peoples and voices at the centre of healthcare service delivery

**Have aligned comments to the health equity principles as a guide to move from concept/ideas/comments to action.*

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
General discussion		
Local-level data across all services—ATSICCHOs and HHSs.	• Need better data-sharing capability, accuracy and timeliness.	P1: First Nations leadership P3: Reorientating local health systems
Workforce future projections, that is, benchmarking • desktop analysis of what's already been done.	• Need a workforce strategy with training pathways.	P1: First Nations leadership
Understanding who's in the space as well. Service-mapping exercise, that is, JCU aren't involved in the tripartite but would like to be, in future.	• Need to ensure all players are at the table moving forward—not just historical ways of doing things.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
Help local providers establish the initial conversation.		P1: First Nations leadership
'Tripartite agreement'.		P1: First Nations leadership
More people now travel to Brisbane to receive services.	• Need to look at models of care to ensure they meet patient needs.	P3: Reorientating local health systems
Equity takes all sectors to be involved—'all ships have to rise.' Deal with the causes.	• Need to ensure services are appropriate for all ages.	P3: Reorientating local health systems
Language is huge barrier for Aboriginal and Torres Strait Islander peoples—English is not always the first language.	• Need to have areas responsible for SDoH present and working together.	NEW: Social determinants
Include Housing in the toolkit.		NEW: Social determinants
Marmot needs the cultural elements added to it.	• Need to ensure all strategies are culturally appropriate.	P4: Cultural capability
'Collective Impact Approach'.	• Use existing partnerships to begin HE.	P1: First Nations leadership

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Why isn't there an Office of Health Equity, since there is an Office of Rural and Remote Health? How does QH reflect health equity within their structures and frameworks?		
Discussion around regional structures, for example, RAICCHO.		
Community engagement, that is, the prescribed stakeholder list.	• Need to ensure local community's involvement in all aspects of design and delivery.	P2: Local and regional decision making
People are living longer but are sicker. It's about quality of life.		
Males: there's 16-year gaps in the Mt Isa region.		
HHS data: what is the real gap?	• Need for data accessibility across all areas of the health system to see true picture.	P1: First Nations leadership P3: Reorientating local health systems
North-West Primary Health Network (PHN) dataset is more specific.	• Need for data accessibility across all areas of the health system to see true picture.	P1: First Nations leadership P3: Reorientating local health systems
Health literacy: ensure patients are well informed and understand the health systems, if they need to ask questions.	• Need to ensure health education is provided to mob.	P4: Cultural capability
Patient journey between Mt Isa and Townsville.	• Develop partnerships to ensure seamless patient journey. • Resources to go where they are needed.	P1: First Nations leadership P2: Local and regional decision making
Improved communication.	• Need to ensure all players are at the table moving forward—not just historical ways of doing things.	P1: First Nations leadership P2: Local and regional decision making
Patient discharge information needs to be coordinated particularly in the Gulf communities.	• Need to ensure that patient discharge is coordinated.	P3: Reorientating local health systems
Gidgee would support patients' movements and coordinate with Mt Isa and Townsville HHSs.	• Partnerships need to be developed to ensure seamless patient journey. • Resources need to go where they are needed.	P1: First Nations leadership P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Patients' information needs to match.	• Need to ensure accuracy of data when sharing patient information.	P1: First Nations leadership P3: Reorientating local health systems
Note: the Mt Isa HHS currently has an administrator (that is, no board). Further follow-up with QH.		
How will Mt Isa HHS achieve health equity without a board?	• Need to support HHS and work with administrator to begin HES.	P1: First Nations leadership
Health and Wellbeing Queensland: —what is their role? And, what support can they provide us?	• Consider using local language in signs, documents etc	P1: First Nations leadership
Any partnership/committee should be regional; that includes Mt Isa, Gulf and Mornington Island—or should there be a specific local partnership/committee set-up that links directly into the regional structure?	• Need to work out what structure will ensure best outcomes.	P2: Local and regional decision making
Who will take the leadership role in establishing these partnership/steering committees? Resources?	• Need to identify how to move forward.	P2: Local and regional decision making
No influence over the $ or where funds are spent.		P1: First Nations leadership
Need to refocus on health promotion and education, as well as community engagement.	• Health promotion and targeted health education need to occur.	P3: Reorientating local health systems
Education needs to target expectant mothers/fathers/families/children to get health gains.	• Health promotion and targeted health education need to occur.	P3: Reorientating local health systems
Three-year workforce planning for the region.	• Need a workforce strategy, with training pathways.	P1: First Nations leadership
Local workforce support, that is, 'growing our own'.	• Need to start health training within the school system.	P4: Cultural capability
Investment from all to ensure our services/workforce are culturally safe.	• Need to ensure resources are being best used, with no duplication.	P1: First Nations leadership P2: Local and regional decision making
Cultural discussion across all service needs to happen (a consistent approach).	• Need to ensure cultural safety is built into all areas of the health system.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
There needs to be one system that everyone can use; one system, and one resource, being the database that is being used. The system is forcing us to use a different way of working in our community.	• Need to ensure that all parts of the health system work together consistently. • Discharge plans for patients in remote areas need to be considered.	P2: Local and regional decision making P3: Reorientating local health systems
Too many different communications from the HHS to the community, always to different groups. Too many different discharge plans.	• Need to ensure consistency in the patient journey and continuity of care.	P3: Reorientating local health systems
We all need to sit around the table; there is no current yarning with AMS and HHS. We need to work together; we've got to find a way to work together. We can't be here saying this again in the next 5 years	• Need a structured and accountable partnership with all parts of the health system involved.	P2: Local and regional decision making P4: Cultural capability
Money is always caught up with the Commonwealth. What does NACCHO do to help the AMS? Does the Commonwealth support the efforts of this health-equity consultation?	• Need to get Commonwealth to the table—can NACCHO assist?	P1: First Nations leadership
Royal Flying Doctor Service don't do any more SEWB—how does Gidgee Healing get funding for SEWB? Everyone else gets it, but not Gidgee. Mission Australia gets money. Check up on who gets money.	• Funding for SEWB must be available for all patients, regardless of who hold the funds.	P3: Reorientating local health systems
How do we get joint control of the funds? It is confusing if we are not aligned. How do we get the money?	• Need to ensure funding is being used effectively, with no duplication or gaps in service.	P2: Local and regional decision making
Local-level data, across the HHS and Gidgee.	• Need to set up systems to ensure data is being shared and is available to providers.	P3: Reorientating local health systems
Better tools for community, what's realistic and true.	• Need community education about health and health services.	P1: First Nations leadership
If it's going to be co-designed, why isn't Gidgee involved? Why is it just the HHS?	• Need to ensure true partnership and co-design.	P2: Local and regional decision making P4: Cultural capability
There's no help with marketing and comms here in Mount Isa. QAIHC needs to adapt the marketing tools so everyone can share and use them consistently.	• Need assistance with communications materials to ensure cultural accuracy for local mob.	P1: First Nations leadership

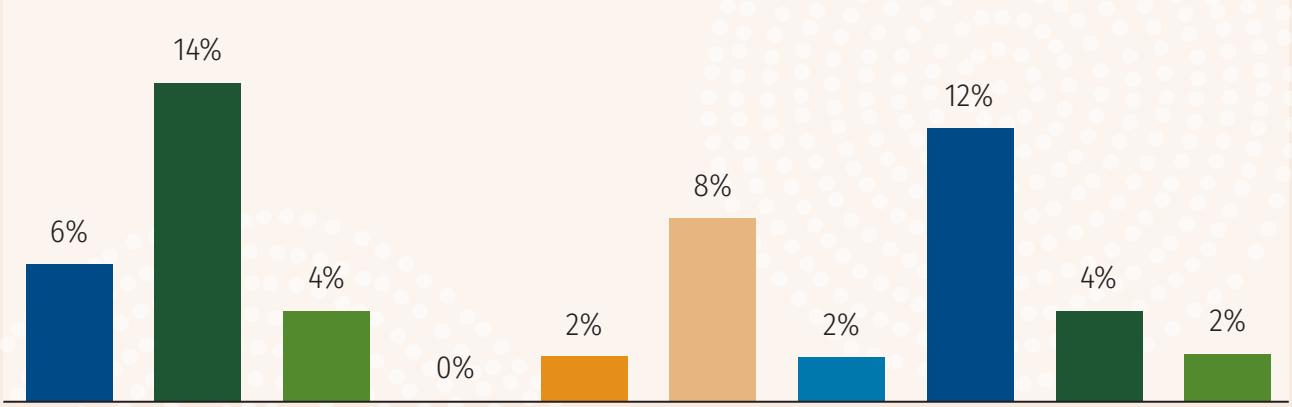
Attendee's comments/views/input
Other comments—Ideas
• Toolkit will be shown to the Aboriginal and Torres Strait Islanders' Executive Directors in HHSs and ATSICCHO CEOs. Show it to the prescribed stakeholders. • Develop a checklist template for them to use. • Make the toolkit something that is ready to use, that is, develop a generic toolkit template, Regulation and Key Priority Areas in the regulation that HHSs have to include in their strategies. • Cultural capability isn't about dealing with racism; it's about building the minimum standards of cultural knowledge required for staff. • Cultural capability vs cultural safety. • How does this reform fit in with other policy agendas? • First tranche of reforms being introduced in Queensland through the new HES Regulation – must focus on what can be achieved in three years—relationships, governance and partnerships; service integration; workforce. • Among all of this is our relationship with the Commonwealth Government, that is, what they invest in and who they are funding. • 'We cannibalise each other's workforce.' • Engagement with PHNs at the Commonwealth level, particularly around workforce and mental health funding. Check up as well. • Need to cut out the 'middleman' in funds holding rolls, that is, Checkup, Health and Well Being Queensland, QH, QAIHC. • JOINT CONTROL OVER ALLOCATION OF FUNDING. • State level—NIAA, PHNs and other funders to agree to fund identified regional priorities.

Appendix 3—Section 3: Driving health equity across the health system and addressing the social and cultural determinants of health...

Future ideas for discussion

Mt Isa Health Equity Consultation Workshop

Voting on the 20 health reform ideas in Section 3 of the Health Equity Discussion Paper



Reform Idea 1 Establish a First Nations Health Board

Reform Idea 2 Increase QH First Nations employment target

Reform Idea 3 Legislate the responsibilities of the Chief ATSI Health Officer

Reform Idea 4 Release a biennial First Nations health equity report

Reform Idea 5 Appoint a Deputy Chief ATSI Health Officer

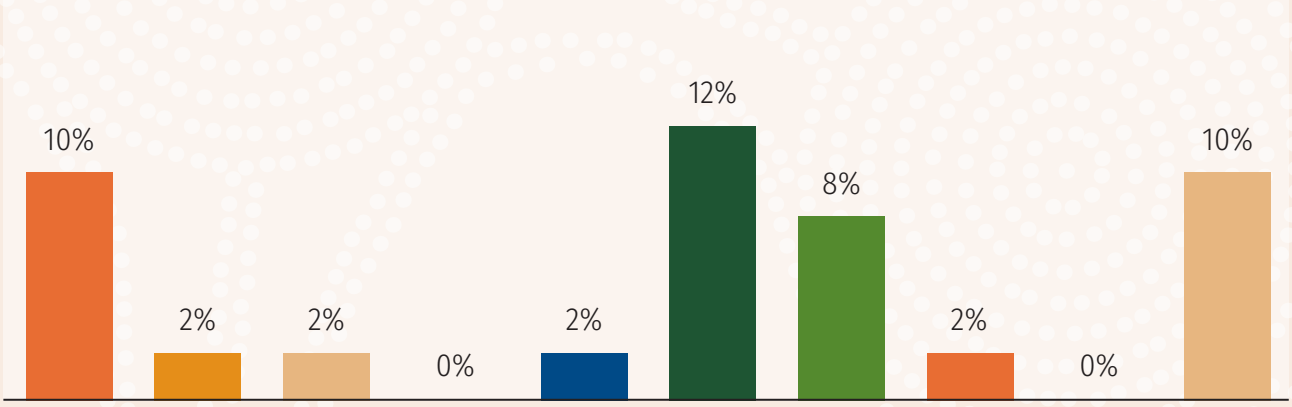
Reform Idea 6 Introduce First Nations employment measures

Reform Idea 7 Create a capability pipeline for HHS Board members

Reform Idea 8 Establish regional coordinated care hubs

Reform Idea 9 Establish regional ATSICCHO backbone organisations

Reform Idea 10 Implement QH funding initiatives to drive equity



Reform Idea 11 Embed capability into *Clinical Services Capability Framework*

Reform Idea 12 Refresh *QHATSI Cultural Capability Frameworks 2010–2033*

Reform Idea 13 Undertake annual independent institutional racism audits

Reform Idea 14 Amend birth notification to acknowledge birth parents cultural connection to Country

Reform Idea 15 Strengthen functions of other health statutory authorities to drive health equity

Reform Idea 16 Factor equity into existing QH funding models

Reform Idea 17 Utilise the Health Equity Strategies as future health investment plans

Reform Idea 18 Establish pilot Marmot city regions across Queensland

Reform Idea 19 Set statewide and regional QH procurement targets to purchase from ATSI-owned businesses

Reform Idea 20 Drive an anti-racism strategy across the health system

Appendix 4—Attendee list

Name	Organisation
Renee Blackman	Gidgee Healing
Jennifer Cameron	Gidgee Healing
Roxanne Parker	Gidgee Healing
Pattie Lees	Injilinji Aged Care
James Cripps	ITEC Health
Linda Ford	James Cook University (JCU)
Catrina Felton-Busch	James Cook University (JCU)
Stephanie King	JCU Murtupuni Centre for Rural and Remote Health
Sabina Knight	JCU Murtupuni Centre for Rural and Remote Health
Shaun Solomon	MICRRH/Gidgee Board
Susan Sewter	Mornington Island Health Council
Dianne Phillips	North West Hospital and Health Service
Christine Mann	North West Hospital and Health Service
Xiu-Ching Hong	North West Hospital and Health Service
Shannon Ah Sam	North West Hospital and Health Service
Melissa Harcourt	North West Hospital and Health Service
Synara Rankine Johnson	North West Hospital and Health Service
Bevan Ah Kee	QAIHC
Cleveland Fagan	QAIHC
Jason Fagan	QAIHC
Tiana Lea	QAIHC

Appendix 5— Agenda

Proposed times	Agenda item
10:00–10:30am	Welcome to Country, housekeeping, introductions
10:30–11:00am	The Health Equity Project— • Who is on the Project Team? • What will the project do? • How will it bring better health for me and my family in the future?
11:00am–12:00pm	Discuss Section 1: The journey so far... (page 6–23)
12:00–12:30pm	LUNCH
12:30–1:30pm	Discuss Section 2: Embedding health equity in local health systems... (page 24–31)
12:30–1:30pm	Discuss Section 3: Driving health equity across the health system and addressing the social and cultural detirminants of health... (page 32–43)
2:30–3:00pm	Wrap up and close the meeting

Appendix 6—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal and Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Department of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HES	Health Equity Strategy
HHS	Hospital and Health Service
HR	Human Resources
IUIH	Institute for Urban Indigenous Health
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
OH&S	Occupation Health and Safety
PHC	Primary health care
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Well Being (also ESWB)
WHO	World Health Organization

Notes

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government