**Evidence-Based Decision-Making Matrix on Health System Enablers and Barriers to Continuity of Care for First Nations Peoples Living with Chronic Disease**

**Introduction:** This decision-making matrix is designed to assist decision-makers and implementors in co-designing healthcare services with First Nations Peoples. It is tailored to meet the specific needs and preferences of First Nations Peoples within the healthcare system, offering insights into prioritising and designing care solutions based on a comprehensive review of the healthcare challenges faced by First Nations Peoples in Australia, Canada, and Aotearoa (New Zealand).

**Methods:** The matrix is informed by a rapid qualitative review co-designed with key stakeholders, including the Wardliparingga Aboriginal Health Equity Theme at the South Australian Health and Medical Research Institute (SAHMRI) and the SA Aboriginal Chronic Disease Consortium. The review included studies published in English from January 2010 to July 2022, focusing on chronic conditions such as cancer, cardiovascular disease, chronic kidney disease, and diabetes, involving First Nations Peoples from the mentioned regions. Of the 1654 articles initially identified, 153 studies were included in the review. The quality of these studies was assessed using various appraisal tools. Health system barriers and enablers were qualitatively extracted following WHO's IPCHS principles.1, 2

**Matrix Overview:** The matrix is divided into two sections: person-focused care and population-based care. Each section identifies enablers ranked in order of importance based on the frequency of themes identified within the qualitative review process by 4 independent reviewers and a multidisciplinary and multicultural team of nine co-authors. These enablers were identified as essential for ensuring continuity of care and improving health outcomes for First Nations Peoples.

**Person-Focused Care:**

1. **Interpersonal continuity (Rank 1):** Tailoring care to align with patients' behavioural, personal, and cultural beliefs and family influence.
2. **Informational continuity (Rank 4):** Fostering positive communication between patients and healthcare providers to ensure transparency and shared decision-making.
3. **Longitudinal continuity (Rank 5):** Facilitating proactive, ongoing monitoring of long-term health conditions supported by care navigators or community connectors.
4. **Management continuity (Rank 6):** Enabling proactive case-finding and early detection of high-risk individuals, with effective case management spanning different healthcare sectors.

**Population-Based Care:**

5. **Case-finding and detection (Rank 7):** Proactively identifying and detecting high-risk individuals to enable timely interventions.

1. **Links and referral strategies (Rank 8):** Establishing robust links and referral pathways for healthcare professionals to ensure seamless transitions between different levels of care.
2. **Care and follow-up by a professional or team (Rank 9):** Providing care and follow-up by a professional or a team across all care settings and levels for continuity.
3. **Support by informal carer or social network (Rank 10):** Recognising the role of informal caregivers and social networks in providing support and community connections in healthcare.
4. **Case management across sectors (Rank 11):** Facilitating effective case management across different care sectors to promote collaboration and coordination.
5. **Care planning with multiple providers' perspectives (Rank 12):** Engaging multiple providers in care planning and considering their diverse perspectives for holistic and patient-centered care.
6. **Discharge planning from admission (Rank 13):** Ensuring effective discharge planning right from admission to provide a clear and structured transition out of healthcare facilities.
7. **Information shared among providers and settings (Rank 14):** Emphasising the importance of sharing critical information among healthcare providers and settings to promote continuity of care.
8. **Shared collaborative care by an interdisciplinary team (Rank 15):** Encouraging shared collaborative care provided by an interdisciplinary team to leverage diverse expertise in healthcare delivery.
9. **Shared, synchronised care records (Rank 16):** Ensuring shared and synchronised care records across various care settings to enhance information flow and coordination.
10. **Standardised clinical protocols (Rank 17):** Implementing standardised clinical protocols in all care settings to promote consistency and evidence-based practices.
11. **Care provided by the same central providers (Rank 18):** Offering care provided by the same central providers for all care needs to ensure continuity and familiarity in healthcare delivery.

**Conclusion:** This decision-making matrix provides a structured approach for decision-makers and implementors to co-design evidence-based care solutions with First Nations Peoples. By prioritising these enablers, healthcare systems can enhance continuity of care and improve health outcomes while addressing each community's specific needs and preferences. The matrix reflects vital insights from a comprehensive review of healthcare challenges and highlights the importance of tailored, culturally sensitive care for First Nations Peoples living with chronic diseases.

**Decision-making matrix to co-design evidence-based care solutions with First Nations Peoples**

| **The Health System** | **Person-focused care** | | | | **Population-based care** | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Interpersonal continuity** | | **Informational continuity** | | **Longitudinal continuity** | | **Management continuity** | |
| ***1*** | Care adapted to patients’ behavioural, personal, cultural beliefs, and family influence | **4** | Positive patient-provider communication: Patients are informed of what and why their care is changing | **5** | Care navigator or community connector | **6** | Proactive, regular monitoring of long-term conditions |
| ***2*** | Continued relationships and trust among providers, patients, and caregivers | **14** | Information shared among providers and settings to ensure “collective memory.” | **8** | Links and referral strategies for care professionals | **7** | Case-finding and detection of high-risk individuals |
| ***3*** | Flexible, consistent, adaptable care along the continuum | **16** | Shared, synchronised care records | **9** | Care and follow-up by a professional or team in all settings or care levels | **11** | Case management across sectors |
| ***18*** | Care by the same central providers for all care needs | **17** | Standardised, common clinical protocols in all care settings | **10** | Support by informal carer or social network | **12** | Care planning with the perspectives and recommendations of multiple providers |
|  |  |  |  | **13** | Discharge planning from admission | **15** | Shared collaborative care by an interdisciplinary team |
| **Micro and Meso levels** | | | | **Meso and Macro levels** | | | |

This table underscores the importance of tailoring care to individuals' unique needs as they transition within the healthcare system. It emphasises the significance of considering their behaviours, personal attributes, cultural beliefs, and family dynamics. Additionally, it gives importance to fostering trust and rapport among healthcare providers, patients, and caregivers, which is crucial in enabling such personalised care. Such a patient-centric process demands the delivery of care characterised by flexibility, consistency, and adaptability across the entire continuum of care; these things must be embedded as a mechanism for continuous and consistent communication facilitated through an adaptable care plan. This care plan is pivotal in establishing and maintaining a relationship grounded in precise information and transparent instructions regarding the agreed-upon care strategy.

Within an enabled care process, individuals and their families are better equipped to comprehend potential modifications in their care, possibly with the support of a care navigator or community connector, who assumes a central role in proactively and consistently monitoring long-term conditions. These connectors are strategically positioned within the community. They may even be peers or members of the same family or group, ensuring a solid connection with the local population and a deep understanding of the community's geographical and other dynamics. Consequently, these connectors facilitate the seamless integration of services, including establishing links and referral strategies to other healthcare professionals. They also foster a shared understanding among informal caregivers and social care networks, enhancing care management across the healthcare system's micro, meso, and macro levels.

For a more comprehensive analysis, please refer to our review, which delves into the complexities of achieving continuity of care for First Nations Peoples living with chronic diseases in Australia, Canada, and Aotearoa. It underscores the vital importance of culturally adapted care, trust-building, and flexible healthcare services, especially in communities with a history of negative experiences. Furthermore, the study emphasises the need for a collaborative co-design and partnership approach with communities across different system levels and life stages. This approach involves adapting care to meet cultural needs, systematically addressing identified barriers such as the lack of culturally appropriate community initiatives and inadequate health and social care networks in remote areas and addressing the deficiency of coaching and peer support services. Collectively, these efforts hold the potential to significantly enhance healthcare outcomes for First Nations Peoples, ultimately resulting in reduced health disparities and improved well-being.

**Key references**

1. WHO. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. 2018.

2. Pinero de Plaza MA, Brown S, Wu C-J, et al. System enablers and barriers to continuity of care for First Nations people living with chronic conditions: A rapid qualitative review protocol, <https://figshare.com/articles/online_resource/System_enablers_and_barriers_to_continuity_of_care_for_First_Nations_people_living_with_chronic_conditions_A_rapid_qualitative_review_protocol/20310117> (2022).