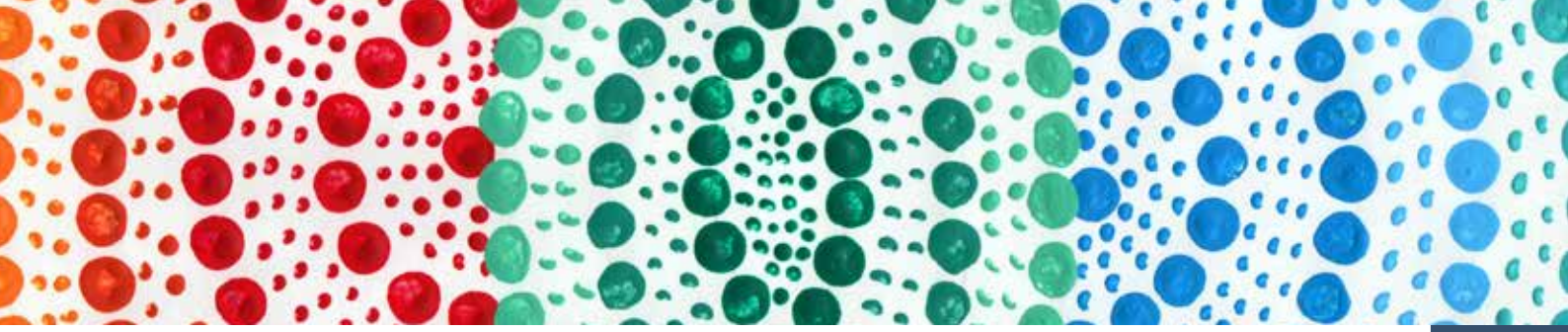

SETTING
Rural and Remote

PRINCIPLES
Cultural Safety
Integration and Continuity of Care

www.racp.edu.au/msaf

MSAF CASE STUDY

KATHERINE HOSPITAL, NORTHERN TERRITORY

Building an Outreach Program in Remote Indigenous Communities

Specialist Dr Simon Quilty started work in Katherine in 2012. In the past five years he has developed an outreach program to remote Indigenous communities in the Katherine area. In this interview with Dr Quilty, he discusses the importance of building remote outreach work on quality, ongoing relationships with patients and responsiveness to community needs identified by remote GPs, health services and clinic staff.

RACP
Specialists. Together

Artwork credit: Zachary Bennett-Brook is the artist and owner of Saltwater Dreamtime. A Torres Strait Islander artist born and raised in Wollongong (Dharawal Country), he has a love for the ocean and creating contemporary artworks which represent his culture and passions.
Bennett-Brook created an original artwork for the Royal Australasian College of Physicians to represent doctor-patient community engagement.

The red and orange concentric circles on the left symbolise the patient, their family and broader community contexts. The blue concentric circles on the right symbolise the doctor, the health service and the broader medical profession, college and university contexts. The green in the centre depicts the engagement space, where all these individual and contextual elements can connect to promote health and wellbeing.
www.saltwaterdreamtime.com

BACKGROUND Katherine

Katherine

Established in 1926, is the centre of a region which covers 346,000 km^2 and makes up about 25 per cent of the Northern Territory. It lies 320 km south-west of Darwin on the banks of the Katherine River. The town has a population of around 10,000.

People and Culture

Aboriginal people make up 52 per cent of the region's population. Larger Aboriginal communities include Ngukurr, Barunga, Bulman, Lajamanu and Kalkarindji. There are three main Aboriginal groups that intersect in the town of Katherine. These are the Dagoman, Jawoyn and Wardaman peoples. The region covers over 16 different tribal groups, the most prominent of which are Jaowyn, Wardaman, Dagaman, Nguliwuru, Walpiri, Gurindji, Waramungu and Myali. Many still live close to traditional ways. Over 30 languages are spoken. Kriol is the most widely used language in the Katherine region, with different variants spoken.

Katherine Hospital

The hospital was established in World War 2 to treat soldiers at nearby military bases. Today, 85 per cent of its patients are Indigenous. It includes an emergency department, a 14-bed maternity ward and antenatal clinic, a 28-bed general medical and surgical ward, an 18-chair private offsite dialysis centre supported by the hospital, a palliative care room, an 18-bed children's facility, and a pathology and radiology department. In addition, there is a full cohort of allied health and rehabilitation staff and facilities, and an on-site satellite oncology infusion lounge.

> “Many of the clinics in my patients’ communities were unable to support phone consultations due to high staff ‘burn out’ and turnover. Working in remote community clinics is a tough job.”

Dr Quilty’s specialist outreach from Katherine Hospital

When you work in places like the Katherine area you soon notice lots of specialist service gaps. After I started at Katherine Hospital in 2012, it became apparent that outreach was going to be integral to working effectively with Aboriginal people across the hospital’s huge service area. Many of the clinics in my patients’ communities were unable to support phone consultations due to high staff ‘burn out’ and turnover. Working in remote community clinics is a tough job.

Too often, there was no choice but to ask an Aboriginal patient to drive the ‘x’ number of kilometres to the hospital so I could talk to them directly. They were travelling enormous distances there and back. Then they’d be called in again to get their – often negative – results. It was often a dangerous drive on dirt roads – and there’s animals and flooded creeks at the wet time of year.

In 2014, after some research, I developed a **telehealth model** in conjunction with Dr Sam Goodwin who was then director of medical services at Tennant Creek. There were five telehealth enabled community clinics in the Katherine region at the time, so it wasn’t a truly regional service. But it was a start, and it was very popular.

There were a few teething problems: because of my outreach work the telehealth enabled clinics became, in effect, out-patient telehealth services – on top of everything else they were doing! As I mentioned, ‘burn out’ is a big issue in these clinics and so it was important not to overload the remote staff.

By the end of that first year, it was clear that visits to these communities were also required if telehealth itself was to be sustainable, and not creating problems of its own. But it was hard to know where to start. There were no clear guidelines. But I had learned that I had to respond to what remote GPs, community clinics and health services wanted and could manage: I couldn’t just ‘overlay’ outreach over a community clinic and expect it to work.

Over 2015, I began discussions with Katherine West Health Board (KWHB) – an Aboriginal Community Controlled Health Service (ACCHS) that services a huge area to the west of Katherine. They were proactive about getting me into communities and they arranged funding to purchase my time from Katherine Hospital over 2016.

When I started working for KWHB, it was important to foster good relationships with my colleagues and work as a team member. I trusted that they knew the needs of their communities better than I would. I was happy for KWHB to tell me where they wanted me to go and what they wanted me to do.

In January 2017, through the **Specialist Outreach Northern Territory program**, a second physician, Dr Richard Budd, joined me to establish a regional outreach service across the entire Katherine area.

For the region-wide model to work and be sustainable, I've had to embrace flying almost everywhere. In my first year with KWHB I drove to communities as the funding doesn't pay for very much flight time – it's $5,000 per charter! But in doing so, I was encountering the same problems my patients faced when I started work at Katherine Hospital: dangerous roads, long hours of driving, obstacles, tiredness. I would have to drive for up to five hours and then hold a clinic. It just wasn't conducive to meaningful work.

Through SONT support, I now fly just about everywhere. But it's not luxury travel! You go everywhere in little four-seater twin-engine planes; it's tough and it's not for everyone. But it makes the work sustainable from a personal perspective and its kinder on my family. Your family already make sacrifices when you work remotely, and my wife and children were not happy for me to disappear for four days a month on top of all the other challenges of living remotely. Now I fly out during the day and fly home by the evening.

Commitment is important. Richard and I are on call 365 days a year. The GPs, nurses and staff in any of the community clinics we work in know they can call us at any time for advice. I probably get between 5 and 10 phone calls every week from remote clinics. I'm happy to answer the phone because these people are my colleagues and my friends. I know how challenging their jobs are – they're extraordinarily challenging in ways that are very hard to understand unless you've spent time in a remote community.

And the outreach program continues to expand. We now have a rapid access telehealth service; this service allows remote clinicians to have same-day specialist general medical review of unwell patients in the community. So, we have an elderly man who has cancer and he might be reaching the very end of his life. Community clinic staff who are not comfortable with providing palliative care can videoconference us on the day, and we can help them navigate the right decision as to whether he should pass at home, or whether his needs are too complex for the clinic and the community to manage.

Aother thing that we've just started is monthly case conferencing. I work with the GPs at KWHB – there's four or five of them. Richard works with GPs at Sunrise (Katherine East area's ACCHS). The basic idea is that we support the GPs to handle as much as is clinically possible – particularly with patients that GPs have established relationships of trust with, and where the 'on hand' expertise of a specialist is not critical. So, it's very much about building relationships with GPs and clinic and service staff and providing clinical back-up. And through this, we're hoping to see less 'burn out' of remote GPs and clinic staff: a serious issue, as I've highlighted already.

Looking back, to get the program to where it is now has been an iterative and collaborative process. It started slowly with telehealth, then with my outreach at KWHB, and now has expanded to cover an entire region thanks to Richard's commitment and enthusiasm. But some things haven't changed. What we do now is still entirely dependent on remote GPs, community clinics and ACCHSs telling us what they want us to do. It's they who are in the driver's seat.

I think we are starting to make a difference. When I arrived in Katherine, many Aboriginal people didn't trust hospitals. And some were dying – often far too young – just because of that fear. Further, many remote living Aboriginal people didn't want to travel to Darwin or Katherine because they don't feel culturally safe there, away from their community and country. But now with Richard and I visiting them in their communities, on their country, they feel culturally safe because of where they are.

I like to think that we take some of that sense of safety with us if a remote living person we've seen in community is then airvac'd to Katherine Hospital – for a severe pneumonia, for example. Richard or I can meet them on ward and they're much more comfortable seeing a familiar face. So, the outreach program is also about building relationships with patients as much as with clinic staff or remote GPs.

In closing, I've learned that a relationship is probably among the most important things that remote Aboriginal people want from health practitioners. They want to know who you are. It's hard for somebody from Sydney to understand what it's like, but Aboriginal people who grow up and live in remote communities know everybody in their community. There's nobody that they don't know. When they go to a hospital, even Katherine Hospital which is small, they're quite overwhelmed by the numbers of new people that they meet. It's a very unusual experience for them. Building relationships over the long term is the only way to gain people's trust and in that way to be able to make sure that an Aboriginal patient gets what they need out of the health system.

The impact of a multidisciplinary model

Dr Rodney Whyte, Duty Remote Medical Practitioner, provides phone-based support for acute and remote care in the Katherine region, guiding whether care can be provided in communities or if a medical evacuation is needed.

- "A specialist will get on the phone with the remote nurse and work out what needs to happen… if the patient does need to go to Katherine Hospital, it results in much better care because of the continuity of care."
- "Patient trust is given to a person not a position; this is the power of the model. Having Simon there helps counter the issue of high staff turnover in remote areas."
- "This model spreads the load across people like myself, the duty nurse and the specialist – the few times we have called Simon has been an absolute life saver."
- "The continuity of care bears fruit – less crazy evacuations and more palliative care on country."
- "With palliative care patients, clinics often feel they can't cope. New clinic staff won't want someone to die in their care, but often after speaking with a specialist, staff feel supported by having a specialist who knows the patient well acknowledge that that it is acceptable for the patient to die in the next few days. This has a much better outcome for patients who are able to die in community."
- "Personal and individual trust is a high value game changer for patients. Often specialists are providing practical problem solving and trust – remote care staff feel they have support and can manage."