MSAF CASE STUDY

NSW RURAL DOCTORS NETWORK

SETTING
Rural and Remote

Reaching Out to Prevent, Detect and Manage Chronic Disease in Rural and Remote NSW Indigenous Communities

In this case study, the NSW Rural Doctors Network discuss their work to facilitate chronic disease specialist outreach services in rural and remote NSW Indigenous communities through the Medical Outreach Indigenous Chronic Disease Program. In 2016, about half of the 220,000-strong NSW Indigenous population lived in regional and remote areas where, as across Australia, there is significant unmet need for specialists. This is particularly so in Indigenous communities where cardiovascular disease, cancer, diabetes and kidney disease are a major health challenges.

RACP
Specialists. Together

SNAPSHOT NSW Rural Doctors Network (RDN)

Background

The NSW Rural Doctors Network (RDN) is a not-for-profit NGO with over 1,500 members including over 1000 registered medical practitioners. It aims to ensure people in rural and remote NSW have access to a highly skilled health workforce. The Australian Government has designated the RDN as the Rural Workforce Agency in NSW. As such, it works to attract, recruit and support the health professionals needed in NSW rural and remote communities. RDN is also the NSW fund holder for the Australian Government Medical Outreach Indigenous Chronic Disease Program.

The Medical Outreach Indigenous Chronic Disease Program (MOICDP) aims to prevent, detect and manage chronic disease in Indigenous communities through providing multidisciplinary outreach services. MOICDP is one of several outreach programs implemented by RDN and includes addressing a range of financial disincentives experienced by health professionals when providing outreach services for people in rural, remote and some urban areas of Australia; and providing cultural awareness and safety training to participating health professionals and workers.

The MOICDP is the largest of seven of Federally-funded outreach programs administered by RDN. About a third of the almost 1000 clinicians involved are medical specialists. Royal Australasian College of Physician's members including cardiologists, endocrinologists and nephrologists already participate, working with GPs, nurses, Aboriginal Health Workers, allied health workers, psychiatrists and psychologists in multidisciplinary teams, and in both primary and secondary care settings.

Specialists in private practice are usually engaged through RDN's devolved administration model that provides funding to Aboriginal Community Controlled Health Services (ACCHSs), Local Health Districts (LHDs) and other regionally-based NGOs that form direct relationships and contracts with outreach health practitioners. In addition, many staff specialists are supported to provide outreach through their hospital employment arrangements. RDN funds through its contracts with LHDs to 'back-fill' a set number of hospital or other days so staff specialists are freed up to help provide the outreach clinics. Typically, these clinics will be delivered once a month, or once a fortnight, at an Aboriginal Community Controlled Health Service or other facility that is accessible for communities.

As stated above, MOICDP is a multidisciplinary program and specialists work in teams. The RDN aims to invest in the capacity and sustainability of the local health workforce by utilise available local or regional practitioners to build these teams and will only 'import' workers, including specialists, if the required health practitioners are not available or at capacity. The outreach specialist providers then might be in the same town, or in a neighbouring one. Recruiting multidisciplinary teams as close to communities as possible has a number of benefits; patients who require care outside of the outreach clinic will have better access to the same outreach practitioner who may

practice in a large regional centre. When available, local and regional recruitment generally lessens travel distances which is more sustainable for health practitioners and more cost effective. Specialists are also likely to work with local GPs, nurses and so on. This has the additional advantage of building local professional relationships and multidisciplinary health service capacity, and building knowledge in the local health workforce: in particular, knowledge of local Indigenous communities, how they work and the challenges they face.

Most MOICDP specialists are on annual contracts. But the retention rate from year to year is high. Indeed, some clinicians have stayed with the program for more than ten years and annual survey feedback indicates four out of five intend to continue outreach for three years or more. Whilst the program offers some financial incentives to support outreach, health practitioners are primarily motivated by the opportunity to provide healthcare to disadvantaged people, offer complex care in challenging situations and support colleagues in rural areas. There are many rewards: meeting new colleagues, working in teams, working with Indigenous communities, the satisfaction of working with people who really need and benefit from specialist knowledge and skills, and the change in work patterns all significantly enhance MOICDP-specialists' overall job satisfaction.

CASE STUDY: A nephrologist works with the Kempsey Aboriginal community

The MOICDP supports a multidisciplinary team to provide chronic kidney disease (CKD) services, including telehealth nephrology clinics, for the Aboriginal community through the Durri Aboriginal medical service in Kempsey. Prior to the clinic's establishment, over 1000 Indigenous people were identified as living with diabetes in the area. Services had reported that a significant proportion of this Cohort were at risk of, or already had developed, kidney disease but it was mostly undetected and going untreated.

The clinic was established by a nurse practitioner who worked with the local Aboriginal Medical Service staff and patient records to identify patients at risk of kidney disease, stage their category of CKD (i.e. stages 1-5) and refer them to the primary health team and nephrologist as appropriate. The CKD team, including a nephrologist, nurse practitioner, GPs and Aboriginal health workers then developed and implemented customised kidney health care plans for patients. Patients with CKD stages 1-3 were generally managed by the primary health team and those in stages 4-5 also received assessment and review by the nephrologist.

A number of beneficial systematic changes were also made to enhance management of CKD including a consistent approach to maintaining chronic disease information in the practice's software. In addition to generally increased staff awareness, GPs and others at the practice utilise CKD codes that automatically flag patients at risk of CKD. In addition, telehealth systems and protocols were established so patients can access nephrology

consultations when needed. The CKD team also undertook health promotion including profiling CKD at Chronic Disease Day events and providing resources that explain CKD in language that is culturally accessible.

Feedback from local GPs indicates the CKD service has presented opportunities for disease prevention and some patients have improved, not only their renal furcation, but also addressed common risk factors for a wider range of chronic diseases.

In human terms, the preventing of the progression of kidney disease to the point where dialysis or even transplants are needed cannot be understated. It is also a much more efficient use of limited health service resources. Kidney disease is mostly asymptomatic until it gets serious. Treatment at early stages can not only prevent further progression but even reverse its progress.

In its work, RDN has learnt that every Indigenous community situation is individual. What might work for community 'A', might not work for community 'B'. RDN uses a 'ground up' approach to make sure the MOICDP is responsive to a local service and workforce needs as well as an Indigenous community's needs and unique circumstances.

In doing this, RDN primarily works with local health services and agencies, including ACCHSs, LHDs, Primary Heath Networks (PHNs) and other NGOs that have knowledge of priority service gaps in the local Aboriginal population. In this process of need-identification, the RDN also considers available objective population and health data and might ask for practice data showing the number of Aboriginal patients that have been referred for specialised chronic disease care or who have been identified or diagnosed with a chronic disease from within a given area.

Through the MOICDP, RDN will also explore breaking down barriers for Aboriginal people accessing existing specialists and local services. These might include:

- **Physical barriers**: services might be hundreds of miles from communities, or closer, but in areas no public transport between communities and services.
- **Out of pocket costs**, particularly for Aboriginal people who are among the most disadvantaged population groups in Australia. For these, a practitioner who does not bulk bill may be financially out of reach.
- **Cultural and related barriers**. Sometimes a service is, or is perceived to be, unwelcoming or not culturally safe for Indigenous people.

The RDN will try to work through these barriers at first instance and in ways that work for all parties. Using bulk-billing as an example, the RDN and its local partner agencies have worked to negotiate a predictable level specialist referrals for local Aboriginal community members that are bulk billed on a per annum basis. This helps makes the specialist financially accessible to the community while also enabling practices forward plan financially with confidence.

If despite these efforts the need for an outreach service is identified and quantified, for example, 'a cardiologist is required on site in community 'A' one day per month' RDN then seek to meet that need in the broader context of a State-wide planning process. This involves the NSW Aboriginal Health and Medical Research Council, the State's peak body for Aboriginal Community Controlled

Health Services, the Ministry of Health and other relevant agencies.

The RDN requires and compensates MOICDP-specialists and other health workers to undertake face-to-face cultural training and to complete an online training module before providing a clinic. They are also required to complete a local Indigenous community orientation training usually designed by local Aboriginal Community Controlled Health Services. This might involve learning about the community's history, meeting Elders, and visiting significant sites to get a 'feel' for the community they are going to be working in. Otherwise, by Aboriginal Community Controlled Health Services hosting the clinics when this is available, culturally safety for patients is certainly supported.

To find out more about the Medical Outreach Indigenous Chronic Disease Program and your State or Territory Rural Workforce Agency contact **www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-medical-outreach-icdp**