A Tale of two rural communities in north Queensland: How centralised policy implementation impacts disproportionately on the regions

CHA conference Canberra 2015

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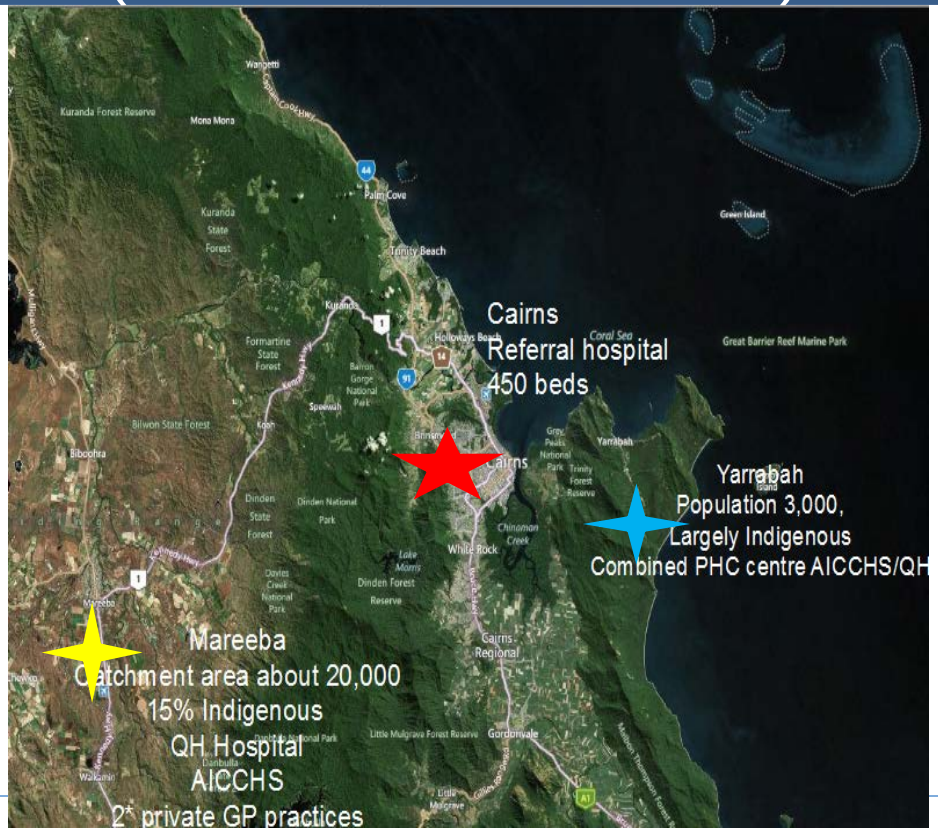
Aim: Develop a demonstration model of health workforce planning using a geographically bounded area including a regional centre (Cairns) and two small rural communities (Mareeba and Yarrabah)



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Method: Action research methodology of 4 cyclical stages with key partners and stakeholders[1,2, 13]

Develop "basket of services" for each planning area -start with rapid appraisal of local needs

Remodel appropriate and responsive health services to respond to current and future needs

Assess skill-sets required and configure desired workforce

Develop a workforce and training plan to deliver this workforce

Essential basket-of-services

- Provision of whole person, continuing, comprehensive primary health care... “ Health-care home”
- Access to particular services: acute inpatient, maternity, surgical, medical, paediatrics, mental health, cancer/palliative care; community and allied health services
- Access to After Hours emergency care (including emergency transfers, pathology, radiology and pharmacy services)
- Access to specialist advice and services in a timely fashion (including hospital admission and procedures as necessary)
  - Directly
  - Telemedicine
  - Skilled up generalists with specialist support

Service delivery requirements and principles

- Services should be accessible, culturally appropriate, high quality and affordable
- Services need to be responsive to changing community needs.
- Cradle to grave service provision, as close to home as possible
- Focus on generalism and workforce flexibility to optimise use of available workforce
- Multidisciplinary teams involved in service provision, with flexible allocation of roles
- Integration of services to streamline the patient journey and optimise safety
- Teaching and learning health systems. Linked up clinical supervision (undergraduate and postgraduate) for sustainability of workforce

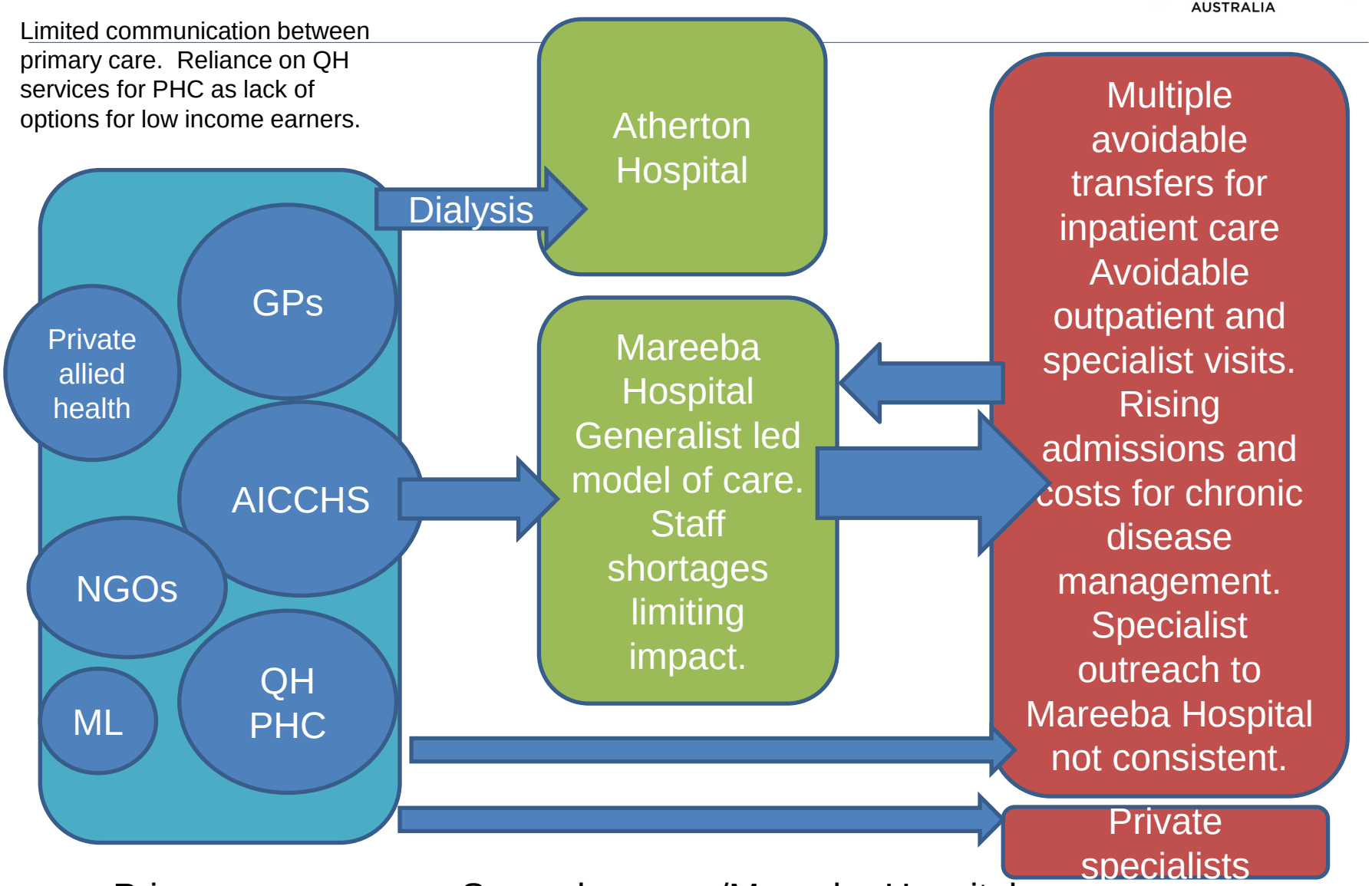

MAREEBA

Mareeba – Community and Health service profile

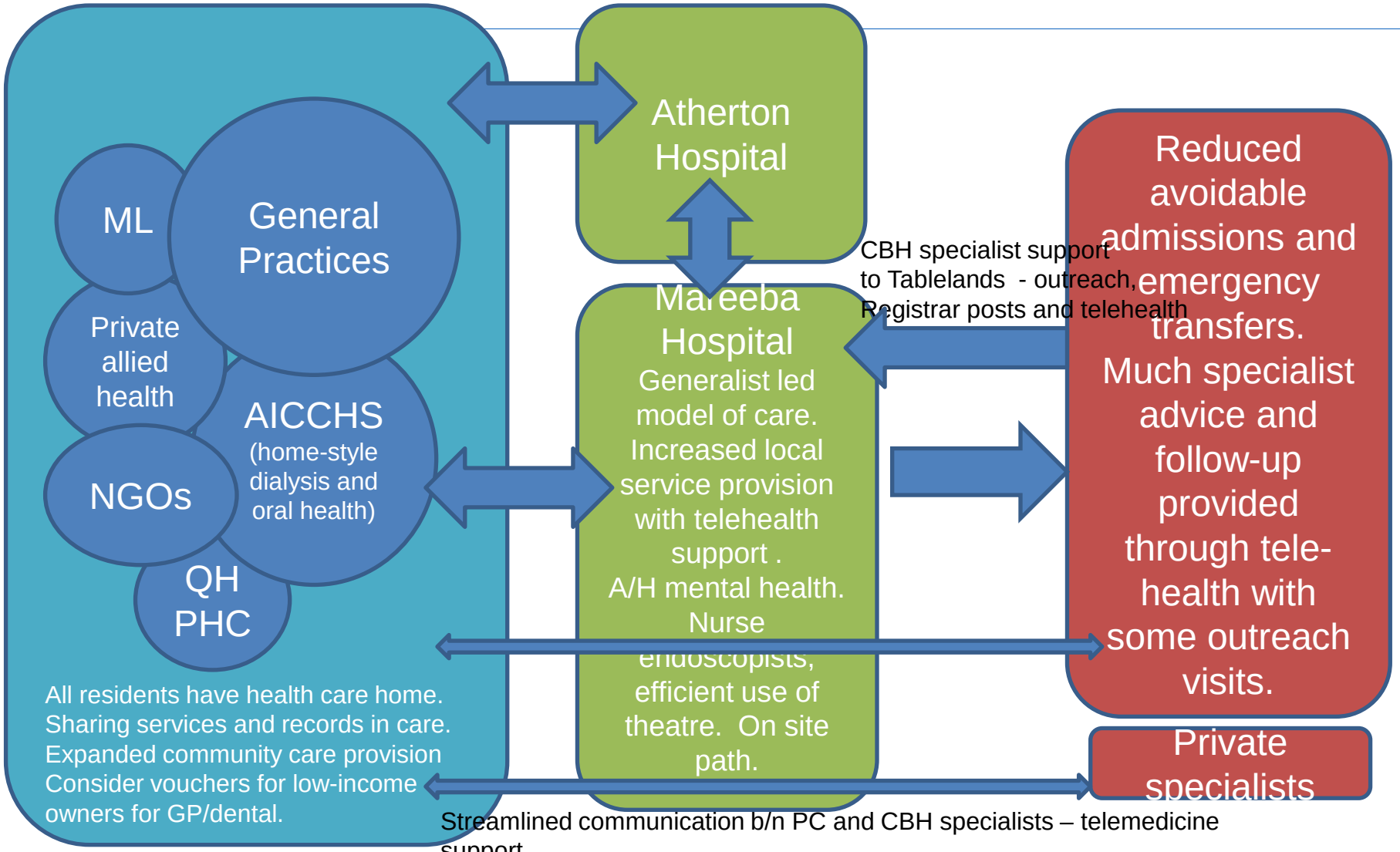
- Catchment area is around 22 000 people (7 000 in town itself)
- 15% identify as ATSI
- Main service providers:
  - 45 bed hospital (QH)
  - 2 private general practices
  - Mulungu (AICCHS)
- COAG Section 19.2 exemption

Mareeba model of service delivery: current

Limited communication between primary care. Reliance on QH services for PHC as lack of options for low income earners.



Mareeba model of service delivery: proposed



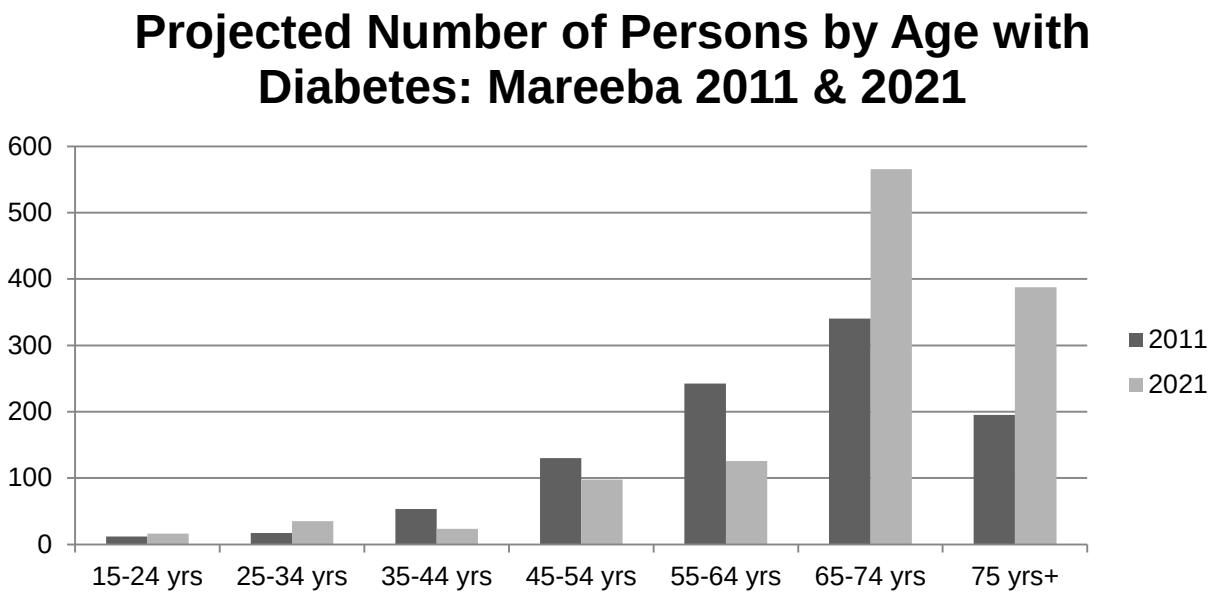
Expanded, integrated PHC

Secondary care/Mareeba Hospital Tertiary care/CBH

Main issues for Mareeba

- Lack of access to bulk-billing primary health care services leads to a high % of primary care patients seeking care through the hospital ED
- Rising rates of chronic disease
- Persistent difficulties in recruiting and retaining nursing and allied health staff to Mareeba
- High volume of (unnecessary) transfers to Cairns
- Services to provide subsidized care to low income earners

Projected prevalence of diabetes



- Prevalence of DM: 5.7% of the population in 2011 (n=991) to 6.4% in 2021 (n=1251) (based on NHS 2007 and 2011 data)
- Adjusting for Aboriginal and TSI population prevalence 7% (n=1221) in 2011 and 7.7% (n=1510) for 2021

Better care needed for chronic disease

- Significant shortages in some competencies
  - Foot care
  - Nutritionists
  - Diabetes educators
- Training up AHWs and community nurses
- Better use of diabetes care plans and utilisation of practice nurses to assess and perform extended MBS requirements

Reducing unnecessary demand on tertiary services

- Mental Health after-hours:
  - Hinterland hub service for MH being developed
  - Increased use of telehealth
  - MH nurse from ML to sit in ED
- Basic physician trainee post at Mareeba (dependant on adequate supervision and college approval)
- Fracture clinic (already underway)
- Agreement with CHHHS hospital surgeons to perform less acute surgical procedures (rural generalists) in Mareeba
- Expand telehealth for routine hospital visits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YARRABAH
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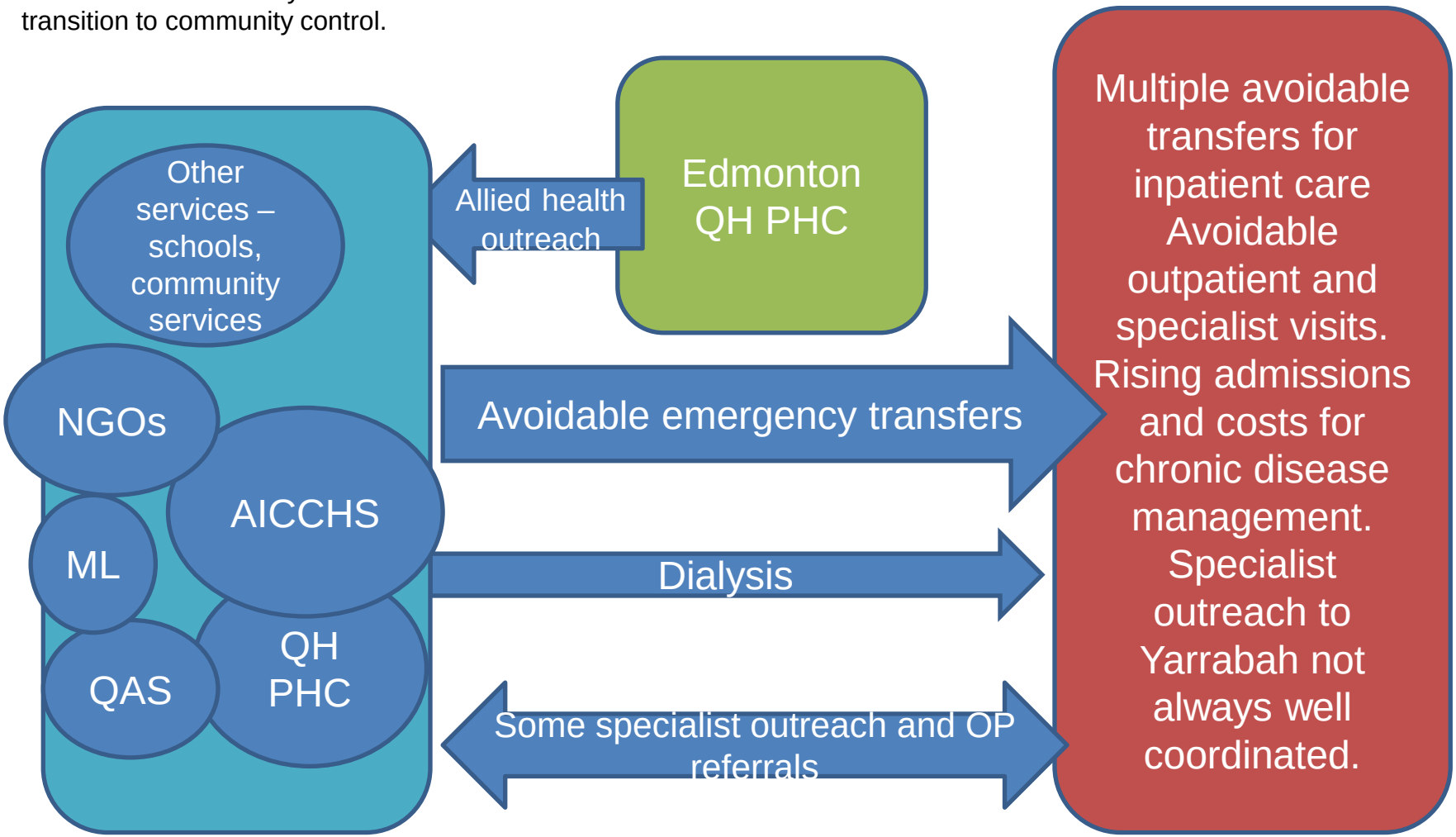
Yarrabah – Community and health service profile

- Discrete aboriginal community
- 2 500 inhabitants (more like 3 500)
- Median age is 21 (compared to Cairns is 34)
- 100% of residents classified high socio-economic disadvantage
- 2 main providers:
  - Gurriny Yelalamucka
  - QH PHC centre – no inpatient care
- Full community control achieved in 2014

Yarrabah model of service delivery: current

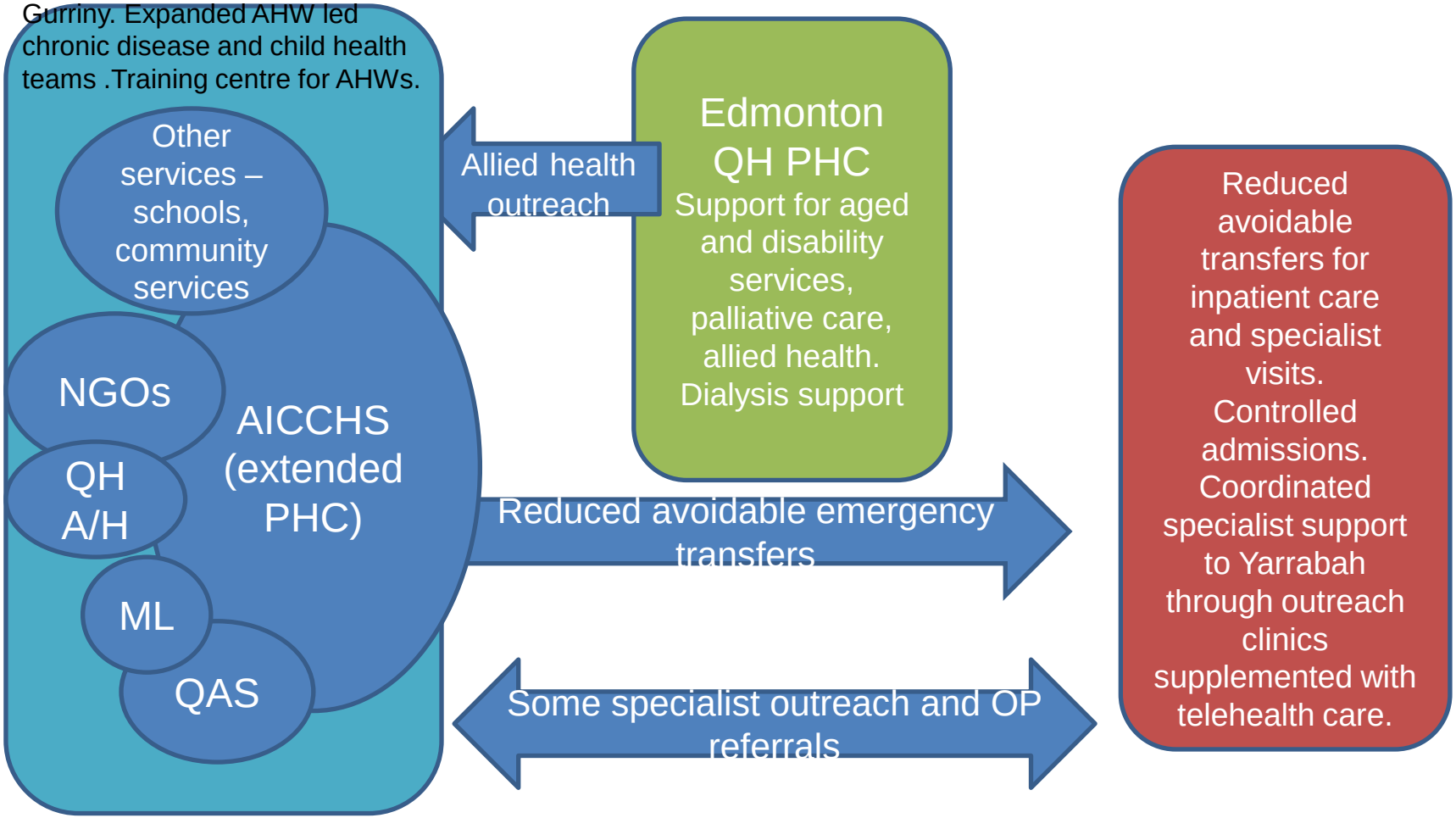
Primary care elements could communicate more fully. Partial transition to community control.



Primary care | Secondary care - QH/Edmonton | Tertiary care/CBH

Yarrabah model of service delivery: proposed

Primary care elements integrated. Full transition to community control. On-site dialysis at Gurriny. Expanded AHW led chronic disease and child health teams .Training centre for AHWs.



Primary care | Secondary care - QH/Edmonton | Tertiary care/CBH/QH

Main issues for Yarrabah

- Transition to community control
- Progress with locating a dialysis unit in Yarrabah
- Training for Aboriginal Health Workers in Yarrabah
- Telehealth – using it to full advantage to optimise the benefits
- Maximising Medicare billing
- Expanding chronic disease and child/youth health teams
- Support for secondary services from Edmonton
- Local pharmacy services
- Increasing ambulance services

Progress toward solutions

- Transition to community control signed off for June 2014
- Recruitment of an NP to manage chronic disease care plans underway
- Strategy for maximising telehealth utilisation under development
- Funding received to provide AHW training in north Queensland and will lead to development of a centre for AHW training (expanded skills) in Yarrabah
- Renal dialysis unit in Yarrabah – funding application using Kimberley model of care

Initial outcomes:
Development of a primary health teaching facility focusing on chronic disease care in Mareeba –

Creation of a multi-disciplinary primary care teaching centre (based upon Kardinia Health model, Victoria).

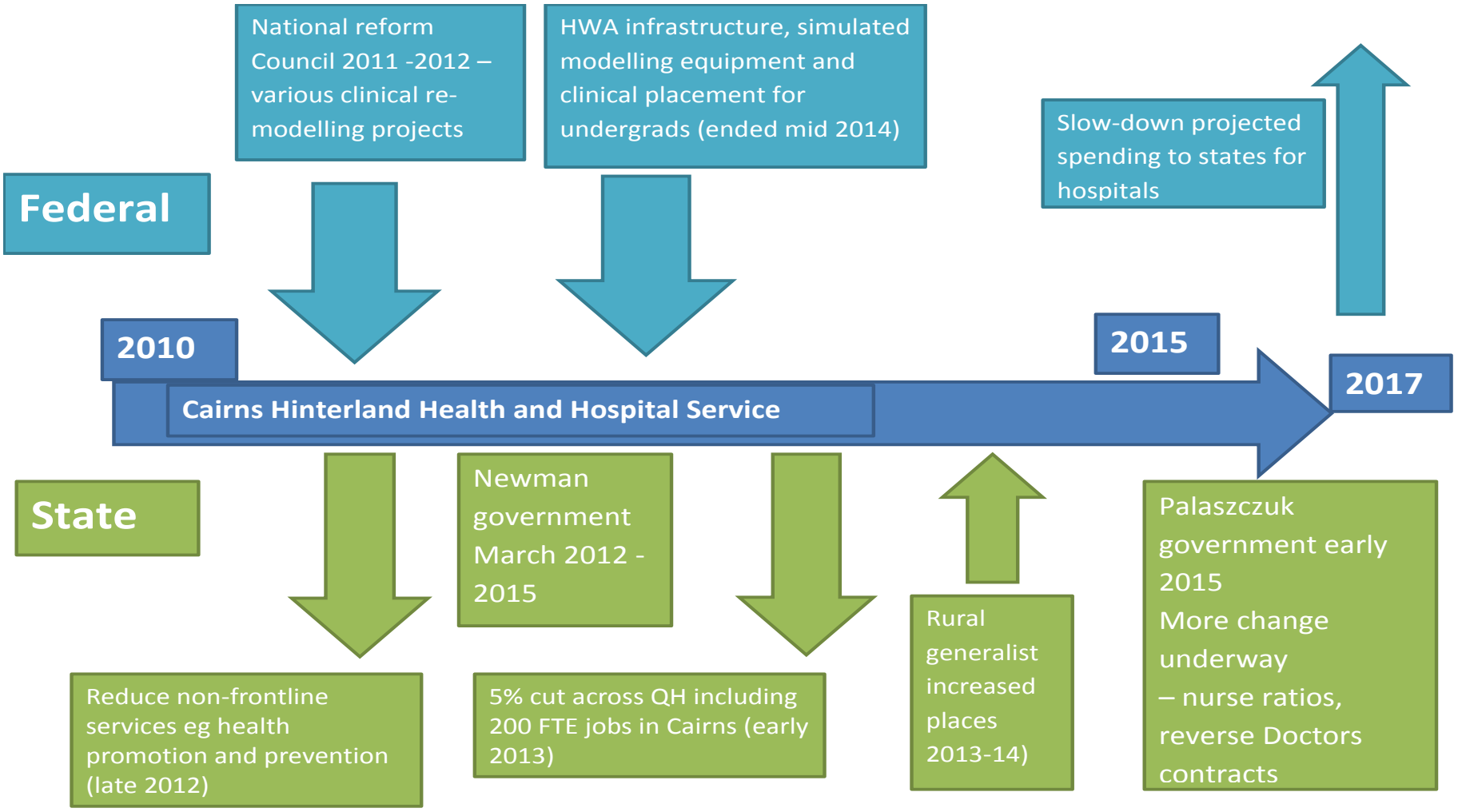
- Collaborative approach between CHHS, Mulungu, Private GPs, JCU and ML
- Transfer Primary health care resources from Mareeba Hospital to clinic (0.6 GP, 1.2 CN)
- Private GPs to share resources
- JCU provide lecturer to run teaching clinics
- ML provide associated AH services
- Assistance to register for Patient Controlled Electronic Health Record (PCEHR)
- After hours Nurse Practitioner for less acute presentations

Initial outcomes (cont): Locating a renal dialysis unit in Yarrabah – Kimberley model

Initial proposal submitted to locate 2 dialysis chairs in Yarrabah

- Clinic-based Haemodialysis (HD) capability at Gurriny
- Currently infrastructure (water tanks and ports) to support the location of 2 chairs
- This will provide treatment locally for 8 patients (will cut down demand on transport by over 50%)
- A renal trained nurse is already working in the Yarrabah health facility for the CHHHS and another is keen to commence training
- Indigenous Health Workers (IHWs) keen to be trained in supporting the nurses to deliver dialysis*http://capter.kamsc.org.au/aboriginal-health-worker-training.html*
- FMC is the largest private provider of dialysis care in Australia and can provide the machines and chairs with maintenance for a competitive rate: ($90 per treatment approx)

Policy initiatives from state and federal governments (2010-15)



Conclusion

- Policy initiatives make it difficult to implement change on the ground
- Staff often demoralised, uncertainty
- State and federal policy blame-game
- Workforce (particularly certain skills) shortages further exacerbates
- Community loses out!
- Discharge summaries - technology

Acknowledgements:

-Clinical reference group members at Mareeba and Yarrabah

-QAIHC (Mr Selwyn Button, Mr Bevan Ah Kee, Dr Aaron Hollins, Ms Amy Dellit)

-Far North Queensland Medicare Local

-Tablelands Regional Council and Yarrabah Council

-Prof. Leonie Segal - UniSA

Funded by Health Workforce Australia

Ethics approval QH – CBH HREC and SSA, and JCU HREC.

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