

Nutritionists where there is no nutrition

Richard Sager

Darwin Dietitians, NT

Abstract

The involvement of a dietitian as a part of the primary health care team is essential to the health outcomes within rural and remote settings. Previously, individual nutritional care was provided by the remote health clinics, using their own interpretation of public health promotions or the advocacy of local clinic staff that have limited to no training in Nutrition and Dietetics.

It has been our observation that minimalistic recommendations and counselling services are being provided in the remote setting from resources electronically distributed from a central non-government organisation (NGO) or a supportive government department. This approach has limitations. It is our belief that achieving appropriate and adequate nutrition services is by far the most significant barrier towards improving the nutritional health status of residents in a remote setting.

Clinical dietitians are trained to provide intensive individual dietary advice, however for remote health clinics this service has traditionally only been able to be provided on an irregular basis. The disease burden of the remote community setting are far greater. This model of service is impractical for a relatively small population spread out over a vast area. Therefore if remote residents are to receive equitable access to services that promote quality nutrition advice to improve and to permanently support lifestyle changes, it is important to develop a service delivery model that meets the clinical demand of the population.

In recent years a Federal Government initiative managed through the Northern Territory Medicare Local is managed through the Northern Territory Medicare Local (NTML) known as Medical Outreach Indigenous Chronic Disease Program (MOICD), has improved access to clinical dietetic services within remote clinics. The funding has increased access to the necessary individual dietary advice for sufferers of chronic disease. This paper describes the current model used to provide the increased clinical dietetic services necessary for remote Aboriginal communities. Each community that is serviced has uniquely different needs in attempting to improve the quality of nutrition knowledge and capacity for Indigenous Australians, therefore the model of service is adapted accordingly.

To date this clinical dietetic service has provided more than 800 patient encounters over the past twelve months. This paper will review this model of service delivery, discussing the strengths, including clinical benefits, and limitations of the model. It will also encapsulate the views and experiences of clinical dietitians currently working to provide this service, and their recommendations on how the service can be more cost effective and achieve improved clinical outcomes.

Introduction

Over the years there has been an increased focus on managing health inequalities between Indigenous and non-Indigenous Australians, especially in regards to accessing the appropriate health services and providers. With the majority of Indigenous Australians living in either rural or remote Australia, overcoming the barriers to good health is an ongoing challenge, as rural and remote areas of Australia have reduced and limited access to health services compared to urban Australia.

With this in mind there is a high prevalence of chronic diseases within the Aboriginal population, which are complex cases that require intensive nutritional education, follow up and monitoring on a regular basis (1).

Looking at the health of Northern Territory Indigenous Australians, there have been a number of approaches created to enable increased access to allied health professionals, the most recent being the Northern Territory Medical Local, Medical Outreach to Indigenous people with Chronic disease program. Barriers to Aboriginal health need to be constantly evaluated to ensure that the needs of the individuals and the community are being met and that the barriers are being approached in the most effective manner.

Dietitians play an important role in managing and improving chronic conditions in regards to preventative measures, public health, disease management and clinical dietetics. It is important that these measures are targeted to improve health and see positive changes within the individuals and communities. Health promotion and public health approaches are vital and beneficial for the community; however with chronic disease being so prevalent within the communities it is essential that there be clinical dietetic intervention approaches as well, focusing on disease management. It is important that individuals be given targeted, personalised education to give them the skills and knowledge to assist in managing their chronic conditions.

Background

Closing the Gap looks at the differences in health between Indigenous and non-Indigenous Australians [2]. This paper focuses specifically on chronic diseases, which even with the improvements in medicine, continue to significantly contribute to the burden of disease worldwide. In Australia this is of particular concern for Aboriginal and Torres Strait Islanders, who continue to have a higher prevalence of chronic conditions compared to that of non-Indigenous Australians. In 2004-2005 a study focusing particularly on selected chronic conditions; cardiovascular disease, diabetes and kidney disease, identified that approximately 74,000 (16%) of Indigenous Australians is it reported to have at least one of the chronic conditions mentioned above. Of these conditions cardiovascular disease had the highest prevalence (12%), then diabetes (6%) followed by kidney disease (2%). (3)

In the 2012-2013 Australian Aboriginal and Torres Strait Islander Health Survey it was found that in regards to chronic diseases, focusing particularly on diabetes and cardiovascular disease, 1 in 8 Indigenous Australians had heart disease and 1 in 12 Indigenous Australians had diabetes or high sugar levels in either blood or urine. The rates of these chronic conditions compared to non-Indigenous Australians were significantly higher for all age groups, especially with diabetes where the rate for Indigenous Australians was 3 to 5 times higher than non-Indigenous Australians.(4) The survey also showed that the levels of overweight and obesity within the Indigenous Australians was significantly higher with just under one third (30.4%) of children aged 2-14years, and two thirds of the ATSI people aged 15years and older being classified as overweight or obese (28.6% and 37.0% respectively for adults).(4) For chronic kidney disease, in the period from 2008-2013, the prevalence of end stage kidney disease was 7 times higher within the Indigenous population compared to the non-Indigenous population, with Northern Territory having the highest prevalence (16 times higher than non-Aboriginal Australians). (5)

As these chronic conditions are so prevalent among Indigenous Australians, improving access to health information and health professionals is important in 'closing the gap'. Nutrition is one of the main aspects involved in preventing and managing chronic diseases within the entire population.(5) In urban settings it is easier for individuals to access health information and health professionals, while in the remote setting, focusing on remote Northern Territory, this is restricted by access and funding.

Looking into the use of health services and clinics by Indigenous Australians, focusing on consultations with health professionals, in the period of 2012-2013 just over 1 in 5 (21.9%) people had seen a GP/specialist in the past two weeks prior to the survey and 1 in 5 (18.5%) people had seen a health professional other than a doctor. Since 2001 the utilisation of health professionals other than GP/specialists has significantly increased from 16.3% to 18.5%. (4) This is seen as a result of increased access to health professionals in remote communities as well as increasing awareness of the benefit of these services for communities and health in general.

Regarding nutrition, access has been improved in recent years with public health nutritionists and clinical dietitians servicing the remote communities. The focus of the Northern Territory Government for remote areas is to promote a healthy lifestyle within the communities and work to manage the health of people with nutrition related conditions. However in more urban settings there is the added service of individual and group consultations. (6) The main function for dietitians is to contribute to the promotion of good health, prevention of poor health and the use of medical nutrition therapy for chronic and acute conditions. (7) Public health nutritionists and clinical dietitians have two different roles when working within a community and both are essential to improve the health outcomes of the communities as a whole.

Public health nutritionists work to promote and maintain nutritional health of the population through organised efforts within the community and improving awareness and knowledge so that society can make informed choices when it comes to their overall health. (3) They focus specifically on group settings whether that be at a small group level or community or population level, working with health promotion and disease prevention. This differs from clinical dietitians who focus on the individual, providing intensive, personalised nutritional education and care that is tailored to the client's needs. This approach focuses on the specific needs of the individuals in the community to educate, assist and empower them in the management of chronic diseases.

As mentioned above the prevalence of chronic diseases is significantly higher in Indigenous Australians. In 2013 the Aboriginal population was estimated to be 698,583, of this total 71,111 (10%) lived within the Northern Territory making up 30% of the Northern Territory population (8). It is estimated that 32% of the Indigenous Australians live within major cities, 43% living in regional areas and 25% living in remote areas (9). This means there is approximately 17,000 Indigenous Australians were living remote NT with high prevalence of chronic diseases and limited access to allied health professionals.

Clinical dietetics in the remote setting

In the past there was no structured approach to providing clinical dietetics to remote communities as the focus was predominately on health promotion and public health nutrition. Individual nutritional care was provided by the remote health clinics, using their own interpretation of public health promotions or the advocacy of local clinic staff that have limited training in nutrition and dietetics. For some remote clinics clinical dietitians were visiting on an irregular basis, making it hard for clinics and communities to work efficiently. Mostly clinic managers and staff are forced to draw from generalised resources and public health publications to provide individual dietary advice.

The main limitations of this approach include:

- Lack of intensive nutritional education provided through consultation with a clinical dietitian.
- Clinics advocating nutrition using their own interpretation of public health promotions, (Although they may mean well they might be relaying incorrect or out of date information to the individuals).
- Health professionals with limited to no training in Nutrition and Dietetics giving nutrition advice. Lack of education regarding nutrition, diet-disease relationships, barriers to adequate nutrition, nutritional requirements at all stages of life and conditions, equals limited education information given to the individual.
- Education is not personalised to target specific issues or barriers that the individual is experiencing. Providing 'blanket' education or nutrition advice may cover some basics but does not allow for delving further into reasons behind lifestyle choices nor readiness to change.
- Limited and irregular clinical dietetic visits. This can result in chronic disease conditions not being followed up as required, clinics struggling to organise efficient systems for referrals and utilisation of clinics. Servicing dietitians also have difficulty getting to know and building rapport with the communities.

The limitations of this approach affect the communities and the individuals significantly as with chronic disease management, the continuity of care, individualisation and follow up is crucial. The service and provision of clinical dietitians has improved with the increasing realisation of the significant role that they play in managing chronic disease conditions.

The new model of service

To address the gap in services, the Federal Government has created an initiative aimed at increasing access to a range of health services including multidisciplinary care and expanded primary health care for Aboriginal and Torres Strait Islander people. The primary focus is on chronic conditions including diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and cancer. The initiative, known as the Medical Outreach Indigenous Chronic Disease Program

(MOICD), is managed through the Northern Territory Medicare Local (NTML), the only Medicare Local in Australia to receive this funding. Funding is for the period of 1 July 2013 to 30 June 2016¹.

The MOICD program has allowed remote health clinics in the Northern Territory to further develop their allied health services, including clinical dietetics. Remote Top End Northern Territory communities serviced by a clinical Dietitian through this funding are Wadeye, Lajamanu, Ampilatj Nguiu, Maningrida, Elcho Island and Yirrkala to name just a few. Presently, these communities receive more frequent, and therefore regular, clinical Dietetic services than they did prior to the introduction of MOICD. When in community, the clinical Dietitian provides one on one consultation at the clinic or in client's homes, assessing and providing therapeutic dietary management for adults with a chronic disease, on an individual basis. Public health nutrition programs are coordinated and most paediatric clients are seen by the Public Health Nutritionists.

As NTML is a partnership between Aboriginal Medical Services Alliance Northern Territory (AMSANT), the Northern Territory Department of Health (NT DoH) and the Associate Membership Committee, there are slight differences in the funding for each of the communities. For example, Lajamanu and Elcho Island are funded by AMSANT and therefore privately funded. They were able to choose which area of allied health the funding would be used for, and chose clinical Dietetics. The other communities, Wadeye, Nguiu, Maningrida and Yirrkala, received funding through the NT DoH which was designated to clinical Dietetics. As each community is unique in their needs and challenges, the model of service is adapted to best provide for the specific community. This can include which chronic diseases are targeted and prioritisation depending on the profile of each community, the consultation space available and method of referral.

Strengths and limitations

One particularly strong benefit of the increased frequency of remote visits is the rapport that the clinical Dietitians are able to build with both clinic staff and local community members. Strengthened relationships with clinic staff allows for more effective multidisciplinary health care. Through the increased communication and understanding of roles there is an increased dietetic referral and increased service delivery to those in need. Building rapport with local community members is very important as it develops trust which is a crucial element in achieving effective nutritional therapy and health outcomes.

It is highly pertinent that the Dietitian establish a sound working cultural knowledge for the region. It is not to be expected that the Dietitian become fluent in the language but have cultural capacity within their field of expertise. It is the Job of the Dietitian to understand some of the intricacies of each location so as not to present naive to the community and local health providers. This in turn can lead to clinical benefits such as better controlled diabetes, improved renal biochemistry and sustained weight loss. Increased regularity of trips allows the remote clinics to plan referral lists and particularly clients required to be seen by the clinical Dietitian. It also increases the capacity of the clinical Dietitian to see clients who may be out of community for periods of time and previously would have been very difficult to see.

There are also limitations to the new model. Although there is an increase in the number of trips compared with previously, the frequency is still inadequate for all newly referred clients and reviews to be seen within appropriate recommended time frames. The nature of the fly in fly out service across multiple communities limits opportunities to learn the local language and characteristics of each individual community, which would assist in not only engaging with community members but also providing assessment and education.

The reality: from a personal perspective

Having now worked with the MOICD program for the past 2-9 months respectively, the authors will now discuss the reality of working as a clinical Dietitian in these remote communities.

The nature of remote communities in itself is a barrier to achieving optimum health care. *Community mob* can be quite transient between communities, often away visiting family or attending ceremony. There can be funerals or 'sorry business' occurring within the community or elsewhere that can last for weeks, often taking priority over health care. There are periods of 'Men's Business' and 'Women's

Business' which are private ceremonies, and again can last for a week or more at a time. So merely being able to find clients to coordinate consults can be difficult. Additionally, some clients are then scared of clinic, too shy to come in, are busy or just not willing to engage. Visiting clients at home, in the Arts Centre or at the Aged Care Centre can assist with engagement with health care. However home visits are not always practically or culturally safe to do, or may require Aboriginal Health Workers or drivers who are not always available. There are also practical barriers to working effectively. A significant one is the limited space in clinics to do consults, which often end up occurring in walkways or outside offering limited privacy. Access to Communicare and PCIS (Primary Care Information System), programs used for referrals and reporting, regularly involves technical difficulties with login and system function as they are not used routinely.

Some of the limitations experienced have been due to clinical issues rather than design. Issues predominately focused around organisation, for example health clinics not being fully organised or ready for clinical dietitian visits, can be due to many different changes within the clinic and communities as mentioned above but ultimately reduce the effectiveness of the visit. When the clinics aren't organised or prepared for the dietitian visits the clients do not know that the service is available and may not show up for consults, meaning that many appointments are opportunistic rather than targeted. The assistance of either a driver or Aboriginal health worker in organising and collecting clients is an asset to the visit as it allows the clinical dietitian to focus on the individual consults and meeting client needs rather than spending that time driving around communities.

Overall remote community members and clinic managers are very appreciative that this service is available to the communities and that the chronic disease management is being targeted. As not all things go to plan when working with remote communities and health clinics, there are times where there are minimal clients to see. This time is optimised by providing up-skilling activities for the health clinic staff, especially Aboriginal health workers. These up-skilling activities are determined by the clinic and staff needs and can range anywhere from giving supermarket tours and label reading to training staff on how to take accurate waist measurements and, using guidelines, interpret these for individuals. Many of the Aboriginal health workers are keen to further their knowledge, learning how to look after themselves and then being able to pass that message onto others within the community. It is important for this to be promoted as the Aboriginal health workers are looked to as role models within their communities and need to demonstrate healthy practices themselves, backed up with the knowledge of 'why', so that it can be explained.

The model doesn't work as efficiently as it was designed to yet but it is a new approach which has the potential to impact remote communities significantly in a positive way.

Looking into the future

To further improve the service of clinical Dietitians to remote communities, here are a number of recommendations.

1. Each community has a driver or Aboriginal health worker that can assist the clinical dietitian in collecting the clients; this enables the clinical dietitian to focus on providing individual nutrition consults and maximising the number of chronic disease clients that can potentially be seen for the duration of the visit. As the length of trips is short (the average trip being three days) there is a need to ensure that they are efficiently organised so that the remote health clinics and, more importantly, the clients' needs are met. This includes;
 - a. Access to an appropriate consultation space that allows for client confidentiality.
 - b. Easy access to referral lists.
2. Improved referral system between clinics and visiting dietitians. The health clinics need to set up a referral system that ensures that clients with chronic diseases are being followed up.

Conclusion

Chronic disease is prevalent within Indigenous populations within remote Northern Territory. Health services, including clinical dietetics, are essential in the management of these chronic diseases; historically access to these services has been limited for remote populations. Improved funding has allowed new models of service targeting this area of need within the communities to be created. MOICD, the most recent model put forward by NTML, provides increased access to clinical dietitians on a regular basis which allows the management of chronic diseases to be more effective on an individual level. As highlighted through the personal experiences of dietitians working in this model, there are areas that still need improvement to make it more efficient however communities are already seeing a difference and welcome having regular access to the services of clinical dietitians.

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Presenter

Richard Sager originally a Chef, he completed his Dietetics degree at Newcastle University. He completed a Masters of Science degree investigating health promotion options within General Practice. Richard is completing his Doctorate and has been working in Private Practice with Darwin Dietitians for the past 10 years. He has a mix of particular interest towards workforce in remote, food Intolerances and promoting capacity around nutrition.