Can you hear me? Raising hearing loss awareness through rural Medicare Locals

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Introduction
This paper describes a campaign by the National Relay Service (NRS) to develop relationships with Medicare Locals (MLs) in order to increase the awareness of primary health professionals about hearing impairment and the NRS. It provides some background on hearing impairment and the NRS and also summarises feedback from a number of rural MLs about the NRS’s approach. This is then placed in a broader context, drawing some broader lessons about effectively working with these new entities.

Hearing impairment
Estimates of the number of Australians with some degree of hearing impairment/loss vary from one in six to one in ten. One in sixteen report hearing loss at a level where they report it as an ongoing health condition or disability.

Over half the population aged between 60 and 70 have a hearing loss. This increases to more than 70% of those over the age of 70 years and 80% of those over the age of 80. Men have a higher incidence of hearing loss than women, particularly older men, mainly due to noise exposure in the workplace (including farming) and during war service. There are also 37,000 veterans registered with the Department of Veterans Affairs to receive hearing loss care. There are also strong associations between hearing impairment/loss and other co-morbidities such as depression.

The National Relay Service
The NRS is an Australia-wide phone relay service that can help people with hearing or speech impairments have good phone conversations with less misunderstanding and repetition. They can get things done such as make appointments and business calls, and keep in touch with friends and family. Older people who become deaf(er) in particular do not seem to know about the NRS, when it has proved to be a valuable tool for such people to remain connected with their community. The NRS is an enabler for people to continue their normal use of the telephone and all that implies.

The NRS uses specially trained relay officers who act as a bridge between callers. For people with hearing loss, the relay officer types the other person’s responses, which can then be read on the screen of an adapted phone called a TTY, or, in the case of an internet relay call, on a computer screen. All calls via the National Relay Service are confidential and cost about the same as a local call, anywhere in Australia. Training is free.

Promoting use of the NRS
As noted above, older people comprise the majority of those with hearing impairment, which they typically acquire over time. However typically many such older people do not see themselves as having a disability, tend to hide their impairment, and are not linked into disability networks where they would hear of the NRS. They tend to be the group that has the most to gain from using the NRS to keep in touch with their family, friends, business and health professionals.

The NRS is working to increase awareness of its service among those with hearing impairment and this older age group especially via a number of avenues:

- running an ongoing campaign to assist older people and their families and service networks to know about the NRS, eg via Men’s Sheds or with people with degenerative diseases like MS, MND or neuropathies
- working directly with practice manager and nurse associations
• working with audiologists and hearing specialists
• working with business and government, particularly where they have large call centres that receive customer calls through the NRS
• working with Indigenous communities/organisations.

Primary health care professionals are obvious avenues through which to increase older people’s awareness of the NRS. In preliminary research in June 2011 the NRS discovered a very low awareness of the NRS among GPs and other practice staff, but also that a fairly low awareness of hearing loss itself.

Medicare Locals

As you undoubtedly know, 61 Medicare Locals have been established by the Federal Government to achieve a range of aims, especially to coordinate primary health care delivery and tackle local health care needs and service gaps.5 They have been described as the ‘primary health care flagship of the national health reforms’. 6 They are really regional organisations (not local at all) that now appear to be playing three main roles, namely to:

• plan and coordinate improvements in primary health care for a designated population, that is be change agents, “to go in search of disruptive innovation”7, to create more of a system and make it easier for patients to negotiate the maze of services
• support front line primary health-care services and providers—especially general practitioners and private allied health providers
• provide some services in some circumstances, but only where context dictates, eg as a transitional move or where no obvious providers exist (eg for Mental Health Nurses shared across the catchment).

The MLs are being funded to tackle particular problems: after hours primary medical care, primary mental health care, and to build links with hospitals and with other community based services like Aboriginal health, local councils, self-help groups and other social care organisations, to improve community health.

Planning and coordination may not sound such radical activities in 2013 but in reality little of this has ever been undertaken before in primary health. Apart from some planning by the States of their own primary health care services and some basic work by Primary Care Partnerships in Victoria, the ‘system’ has grown by itself, shaped predominantly by market forces rather than population health need, and it has created a sharp maldistribution of services within and across areas.

MLs were established in a staggered way with three tranches starting six months apart. However early months were a difficult and challenging period for many MLs. They were predominantly formed from previous Divisions of General Practice but there were many fewer MLs than Divisions. So for all but a small number of MLs, this merging of different Divisions both took some time but was also a somewhat tortuous process in some cases. The new legal entities had to be formed, new Boards established, staff had to be re-employed and new staff engaged, new advisory structures developed, new strategic and other plans developed including community consultations undertaken, and many new relationships negotiated. New cultures and norms have had to be developed, with some MLs’ “hanging on to old ways” in a new environment. This took up to 6-9 months in a few cases. At the same time, the government’s expectations and requirements were very high (some say excessive).

Working with MLs

The NRS commenced discussing this issue with MLs from early 2012 with the Tranche 1 Medicare Locals and is still contacting the last Tranche 3 MLs. All MLs had therefore been in operation for more
than six months but this was still relatively early days for them and the NRS tried to be low-key and respectful in its requests, given the above context.

By mid March 2013, NRS had contacted well over 40 MLs and had had teleconferences with 38 of them. Of these the majority were non-metropolitan MLs.

MLs were initially approached by phone to the CEO or a senior manager, sent some basic information by email and then a teleconference arranged to talk through possible collaboration in more detail.

MLs were typically open to discussions on this issue and a diverse range of strategies was jointly developed to raise awareness within the sector. In rural Australia, these varied from distributing regular brief communication items (via e-newsletters or hard copy health provider or consumer magazines, etc), to educational sessions for practice nurses, to running booths at agricultural shows. The NRS also developed an innovative online learning module on hearing impairment and the NRS (which is CPD points-eligible for some professionals) was launched early March 2013 and information about this is now being distributed to MLs.

The NRS attended the National Primary Health Care Conference in Adelaide [this conference effectively being the first national conference for Medicare Locals] in November 2012 and made contact with a range of ML staff.

Data

Importantly the NRS also commissioned data from the Australian Bureau of Statistics (ABS) on hearing and speech impairments by ML catchment to feed into each ML’s population health planning. This was sent initially by email so that it was available as soon as possible for their population health planning, but later followed up with a coloured two page brochure (in pdf format) containing both these statistics and basic easy-to-read information about the NRS.

Specific projects with individual Medicare Locals

The NRS also initiated (and co-funded) specific projects with two individual MLs, ie Murrumbidgee and New England. The NRS and Murrumbidgee Medicare Local [MML] have developed a joint plan for the region to promote NRS awareness through information and training sessions, conferences, expos, professional publications and radio promotion. MML will become ‘Relay Service Friendly’ ensuring it is accessible to people who are deaf or have a hearing or speech impairment. As an ‘NRS Champion’ MML will promote the NRS locally and with other Medicare Locals.

As examples of subsequent activity, over 1,000 items were ordered from the Helpdesk by various MML staff between August and the end of December 2012. Further the MML promoted and organised the NRS presence at the Henty Field Days 18-20 September, and NRS awareness during the Tumut Health Expo on 6 September. NRS also provided an article for Zest, a quarterly publication distributed to General Practices targeting community health awareness.

Working with Aboriginal workers

The NRS is working with the New England Medicare Local (NEML) as a pilot project to upskill the Aboriginal Health team to be able to talk more confidently about the NRS and promote access to training across the region. This will be extended gradually to involve the Murrumbidgee Medicare Local where the broader pilot is already under way (see above) and their Aboriginal communities. It is also exploring a similar project with Northern Territory Medicare Local. A high profile Indigenous business leader has been appointed to advocate on NRS behalf, networking nationally to promote engagement with the NRS.

The NRS is also training its own staff who have completed a professional development unit “Work Effectively with Aboriginal and/or Torres Strait Islander People”.

12th National Rural Health Conference 3
Collecting feedback
In addition to the 38 teleconferences, NRS sought feedback by ringing the ten rural MLs with which it had had most collaboration several months after the initial contact. The NRS consultant held a phone interview with the key contact officer/manager within the ML. At the time of writing, seven MLs had generously provided feedback and the NRS is grateful to them for their contribution. The data was broadly thematically analysed.

Given the relatively small number of interviews, the findings should be considered as indicative only. However there was very significant consensus about the key issues. (The Conference presentation will include fuller feedback from a larger number).

Results
The results presented here focus on the key themes from the interview feedback about working successfully with MLs, augmented by some reflections by the NRS on its own practice.

Understanding of Medicare Locals’ roles and clarity of purpose of collaboration
MLs have been, and continue to be, approached by a multitude of external organisations. Apart from local providers and other key local stakeholders, MLs reported being regularly approached by a range of broader organisations with statewide or national remits and often very specific foci. Many did not understand MLs’ roles (“we are not a bottomless pit”), their stage of development or the “turbulent times, now and ahead” in which MLs operate.

Many MLs appreciated that the NRS had taken time to understand this context.

Unrealistic expectations
Many organisations have certainly approached the MLs: “everyone wants to be our best friend”. They have often come with high expectations about both funding possibilities, and the ML’s capacity to respond to their issues or needs quickly. This reflected insufficient understanding of the stage of development of the organisations, its variability across MLs, and the constraints on MS’s budget. They do have some resources but these are predominantly focused on the MLs’ key roles, especially in an environment where they are being required to produce regular deliverables for the Commonwealth (eg population health plans, needs analyses, strategic plans etc) with an implied agenda of recording ‘early wins’. Some external organisations have been ‘over-demanding’ according to some MLs, and this has constrained the development of their relationship.

Initial approach
Most MLs preferred that the initial approach be to the CEO (especially in their early days of establishment or for smaller MLs) or at least a senior manager in larger MLs. This ensured that there was clear management support for engagement with the NRS and enabled the relevant staff members who were delegated the liaison roles to understand its (relative) priority on the ML’s agenda. This was particularly important for an issue such as hearing impairment, which was not really on the radar of almost any of the 38 MLs contacted so far.

Most MLs stated that approaching them via a phone call worked well for them, and appreciated the prompt follow up with written information via email. This gave them the opportunity then to do some research and assess whether they would engage, and who would lead this work internally.

The subsequent teleconference enabled a more detailed conversation to occur and for the NRS and the ML to gauge how their mutual needs meshed and could be met efficiently. This was a key step in developing the relationship, and allowed the NRS to be sensitive to the stage of development of the ML. For most MLs the scope of potential stakeholders and partners has expanded very significantly with their new roles. As one respondent noted,
“we are still feeling our way, finding out who we are as an ML from being a Division—there’s a much broader range of people to work with ... and so it is better for us to be sure of who we are going to work with”.

Overall, all MLs assessed the manner in which the NRS approached and developed a relationship with them as very appropriate or appropriate. Helpful to the MLs was the clarity of purpose of the approach (and its relevance to MLs’ roles) and the fact the NRS “brought something to the table”, ie a range of ‘products’ of use to MLs.

Providing ML-specific data
MLs highly valued that the ABS data that the NRS had specifically commissioned as highly valuable. One of the key roles of the MLs is to undertake population health planning. They have often found some data much harder to access than anticipated, in particular data by ML catchment. The ABS data offered them data they did not have. This was often reported as timely and ensured that the issue of hearing impairment was considered in developing their strategic and other plans. It also created a point of difference for the NRS, given most organisations had not offered such data on their own issues.

Tailored information
The MLs appreciated the range of types of info that the NRS had available and the NRS’s willingness to tailor them to the ML’s communications needs and the different audiences.

So the NRS provided both short e-newsletter items (30–80 words with a web link to more information) and longer articles about the NRS or human interest-type stories for hard copy magazines aimed at professionals or consumers.

The NRS also has a set of short brochures tailored to specific population groups, eg older people, younger people, school leavers, job-seekers. MLs have been very willing to distribute these via their practice support or community liaison staff who have in many cases taken them out on their regular visits to practices or community events.

The NRS also has a couple of videos—a short sharp (3 mins) one giving a snapshot of how NRS calls work, as well as longer (10 min) story about a relationship between two young people, one deaf.

Some MLs have found the NRS information specifically useful in providing to GP practices for accreditation purposes, enabling them to meet accessibility standards (particularly Criterion 1.1.2 Telephone and electronic communication).

Presentations
Quite a few MLs have invited the state-based NRS Liaison Officer to a network meeting or educational session. This generally had a strong impact as it “enabled staff to realise its importance and implications”.

Effective project management
Where the NRS ran a pilot project with one ML, they reported the value of having clarified responsibilities, working from same joint plan specifying deliverables, support and communication, who was responsible for what, who was to solve problems, using common documents (using Dropbox), establishing personal relationships, and having clear commitment from both CEOs.

Impact on primary health care sector
It is too early to assess whether the range of activities implemented have indeed made an impact of professionals’ awareness or behaviour. MLs interviewed could not discern such an outcome yet. However the relationship and activities had clearly in most cases raised hearing impairment as an issue on their agendas or at least radars so that a range of staff within many of the MLs were now aware of the issue and the NRS’s value as an enabler. Although the issue is just one of a wide range of issues the MLs
are addressing (or starting to address) and has a lower incidence or significance than various others (eg cancer, or access), one ML respondent stated that it was at least on their map as 

“Pluto ….. in their universe now—small but connected”.

Other positive factors
Apart from those described above, MLs reported they have generally appreciated and found useful approaches by external organisations where they wanted to achieve system outcomes. They also appreciated where organisations were treading carefully with the new partnerships, recognising there might be different pathways to achieve this with different MLs.

What hasn’t worked?
MLs reported that not all approaches by external organisations were easy to manage. Characteristics of less successful approaches included:

- Not starting with the CEO (or senior manger in large MLs), so that any project takes longer to get going and to go through internal processes
- Not coming with a partnership approach and not recognising MLs’ stage of development
- Having high expectations (just their own agenda), having unrealistic expectations about ML funding, and no ongoing engagement
- Not taking responsibility for project management, eg lack of joint plan, critical deliverables not ready on time, resources not delivered, poor management or governance
- Not sufficiently maintaining relationships once established, eg in rural context taking time to ensure periodic face-to-face contact
- Having an “in your face approach, being too pushy, giving me deadlines!” or sending meeting requests before making initial phone calls or emails.
- Over-promising
- Not taking MLs’ advice about how to engage with GPs, their practice staff, allied health etc
- Trying to communicate too much information too quickly to health professionals (eg “GPs talk in dot point form” and need straightforward concise practical information).

Conclusion
Medicare Locals have clearly been very open to engaging productively with a range of external stakeholders, and the NRS’s experience confirmed this. Indeed, given the limited set of drivers and levers available to them, the quality of their relationships with the health sector and beyond can be seen as their chief asset. However MLs are under significant pressure and organisations should not expect the MLs to do the heavy lifting in the relationship but be proactive and take significant responsibility for its development. There are clearly a number of key lessons for organisations to learn, teased out above, in order to work together with and make it easier for MLs.

Recommendations
- That the broader health and community sector recognise MLs as a valuable ally in improving primary health care services and seek ways to work effectively with them.
- That governments continue to provide increasing levers for the MLs to improve primary health care, and its equity in being accessible to all population groups.
Notes
(If you would like to know more about hearing impairment and the National Relay Service, the NRS Team has a booth at the Rural Health Conference. You might even win a prize by filling in a short five-question survey. More information is also available at www.relayservice.com.au)

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References


