

## Kelso Indigenous Chronic Disease Clinic—your one-stop health clinic

**Anne Vail, Jacqueline Gibbs**

Western NSW Medicare Local, NSW

### Introduction

Kelso is a suburb of Bathurst. It is situated on the eastern side of the Macquarie River and 3kms from Bathurst town centre. This is 200kms west of Sydney over the Blue Mountains. Census data (2011) concluded that 461 or close to 6% of the population of Kelso, within the 31,294 population of Bathurst were Aboriginal people. Kelso is also identified as a Suburb of High Level of Disadvantage.

### Background

Kelso Indigenous Chronic Disease Clinic commenced on 3<sup>rd</sup> November 2011. The then Central West Division of General Practice had identified a need to provide an access centre for Aboriginal people in Bathurst to receive care for their diabetes. Consultation with Orange Aboriginal Medical Service focused around a good model of planning and co-ordination. Area Health Service consultation addressed service gaps and provision for more individually tailored care along with a team approach to diabetes. The community meeting with the Kelso Aboriginal community, including Elders at Kelso gained support for both specialist and non specialist service provision.

At the clinic's inception, it initially opened for one day per fortnight and comprised of an Aboriginal Chronic Disease Liaison Officer each fortnight, with an Endocrinologist and Diabetic Educator once per month and a Dietitian and Psychologist on the alternate fortnights per month. Over time this clinic has expanded to include a Podiatrist, an Exercise Physiologist and recently a Respiratory Physician.

The Indigenous Chronic Disease Clinic now operates weekly every Thursday. Seven Allied Health providers and Specialists are involved at the Thursday clinic which runs from a local council community venue "Kelso Community Centre". On other days, activities include breakfast club; outreach program; child and family health clinic; playgroup; and activities and mentoring programs for primary, early high school and teenagers.

Different providers are available on different weeks to offer patients a holistic approach to chronic disease management through targeted health goals. Providers include Endocrinologist, Respiratory Physician, Diabetes Educator, Dietitian, Exercise Physiologist, Podiatrist and Clinical Psychologist.

Our lovely Aboriginal Chronic Disease Liaison Officer is the frontline face who runs the clinic ensuring that patients are able to access the clinic. This is through coordinating referrals, booking appointments, providing reminder calls and assistance with coordination of transport. Liaising with General Practice as well as Connecting Care Supplementary Services Western Medicare Local Caseworkers and Connecting Care Local Health District staff is an integral component of the role to assist in gathering accurate client referral information.

Another component of the Aboriginal Chronic Disease Liaison Officer role is to provide monthly clinic attendance letters to referring General Practitioners and Connecting Care staff within the Local Health District and Western NSW Medicare Local regarding any referred patients as part of our Team Care Arrangement collaboration. These monthly attendance letters are also supplied for clients who fail to attend an appointment. This then enable the General Practitioner to be informed of the client's ongoing follow up.

Our Indigenous Chronic Disease Team work at the Kelso Community Centre, within the same building. All clinicians utilise the same clinical software which allows for a shared clinical patient file. This allows for joint goal setting for the patient in line with best practice clinical management.

The team coordinates case conferences for clients and also assists with the facilitation of Telehealth visits when required. This has worked well for patients travelling >100kms to access the clinic as well as during pregnancy for our visiting Endocrinologist. There were three Telehealth clinics coordinated through the clinic in the second half of the year due to the impending birth of our Endocrinologist's 2<sup>nd</sup>

child. Each clinic was able to continue with minimal disruption through the support of the other clinicians at the clinic.

For the past two years, the Kelso Indigenous Chronic Disease clinic had occurred every Thursday excluding a short Christmas period closure with a combination of up to four Allied and Specialist providers at the clinic each week.

Communication is the vital link between providers and referrers into the clinic for improved cohesiveness within the patient journey.

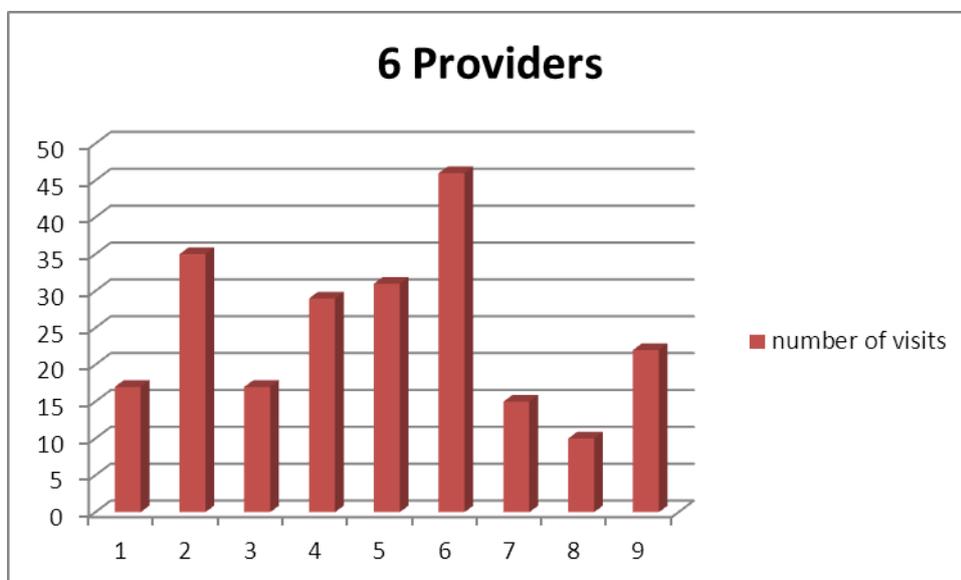
## Demographics

At the beginning of 2014 the clinic changed clinical software to enable software compatibility with secure email for sending and receiving of correspondence as well as investigations. At the time there were 100 clients transferred across into the new clinical software database.

82 active clients were booked appointment times with the providers at the ICD clinic in 2014 from a database of 100 clients.

The following graphs demonstrate the number of booked appointment visits made for each client over the 2014 calendar year. All appointments including non attendance are included. Client appointments that were rescheduled are included as the final appointment visit.

The following tables show the number of booked visits each client had in relation to the total number of Providers seen. Failures to attend appointments are also included.



Over half of the clients had definitive health improvements in a 12 month period.

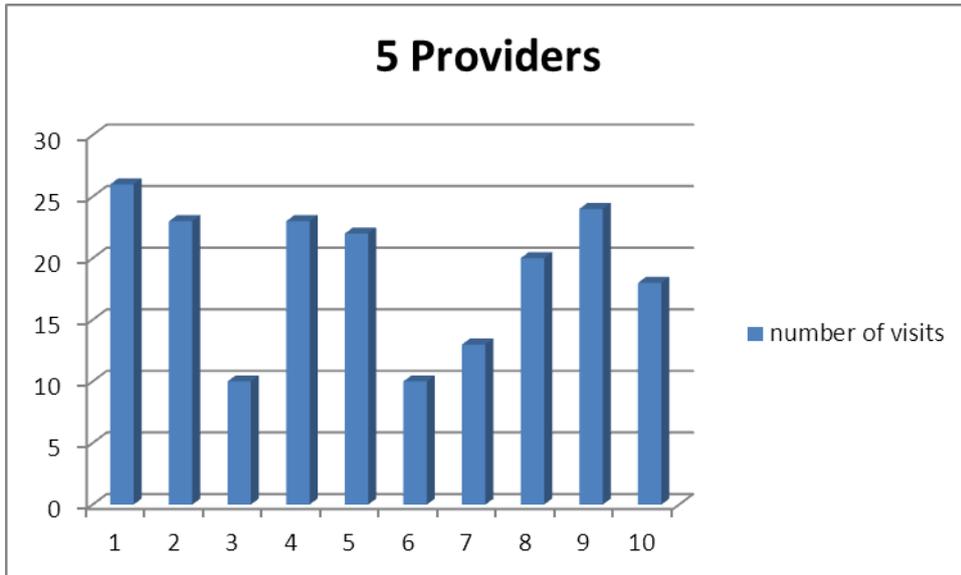
Client 2 had improved lipids

Client 3 had a 13.8% weight loss and an HbA1c reduction of 1.5%

Client 4 had an Hba1c reduction of 2.8%

Client 6 had a 5.3% weight loss

Client 9 had a 4.5% weight loss and an HbA1c reduction of 2%



Four of the clients had definitive health improvements in a 12 month period.

Client 1 had an HbA1c reduction of 0.8%

Client 6 had improvements in cholesterol and ACR

Client 8 had an HBA1c reduction of 0.3%



50% of the clients had definitive health improvements in a 12 month period.

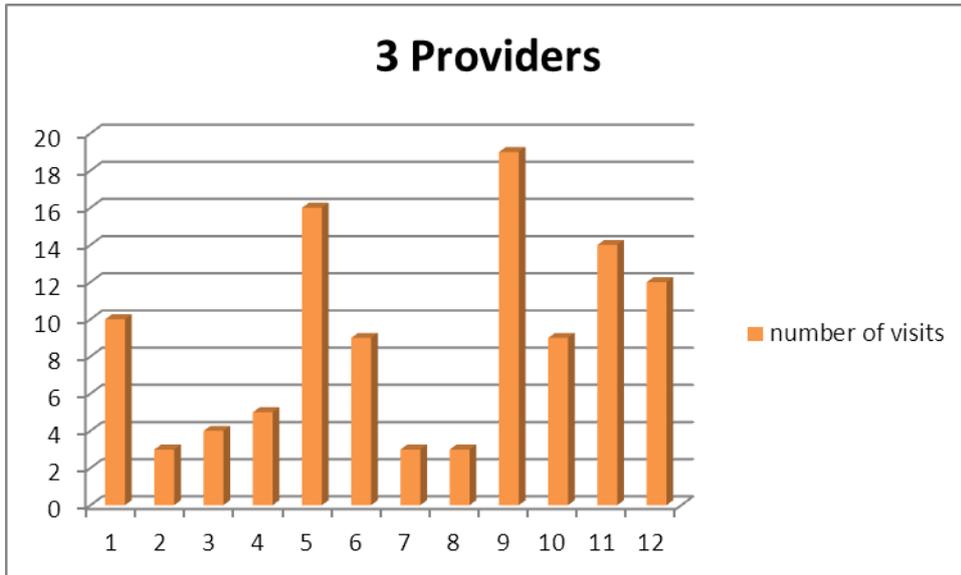
Client 1 had an HbA1c reduction of 0.8%

Client 3 had a 24.38% reduction in body weight

Client 7 had an HBA1c reduction of 2.0%

Client 8 had a weight loss of 1.56%, an HbA1c reduction of 0.3% and improved lipids and ACR

Client 10 had an HbA1c reduction of .7%



Four of the clients had definitive health improvements in the 12 month period.

Client 3 had an HbA1c reduction of 1%

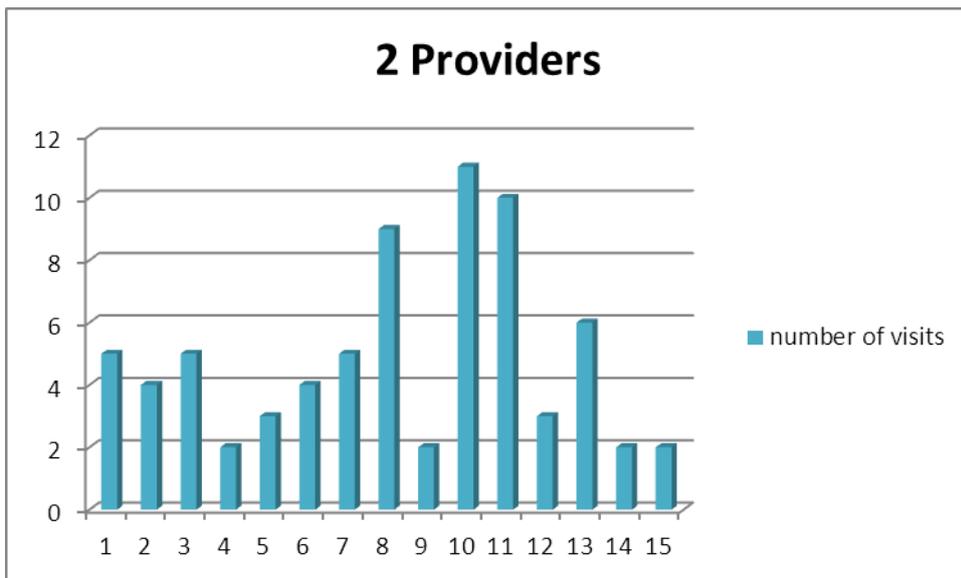
Client 4 had a 2.4% weight reduction

Client 5 had a weight reduction of 1.7 % and an HbA1c reduction of .6%

Client 6 had a 10.5% weight reduction

Client 9 had an 8.3% weight reduction

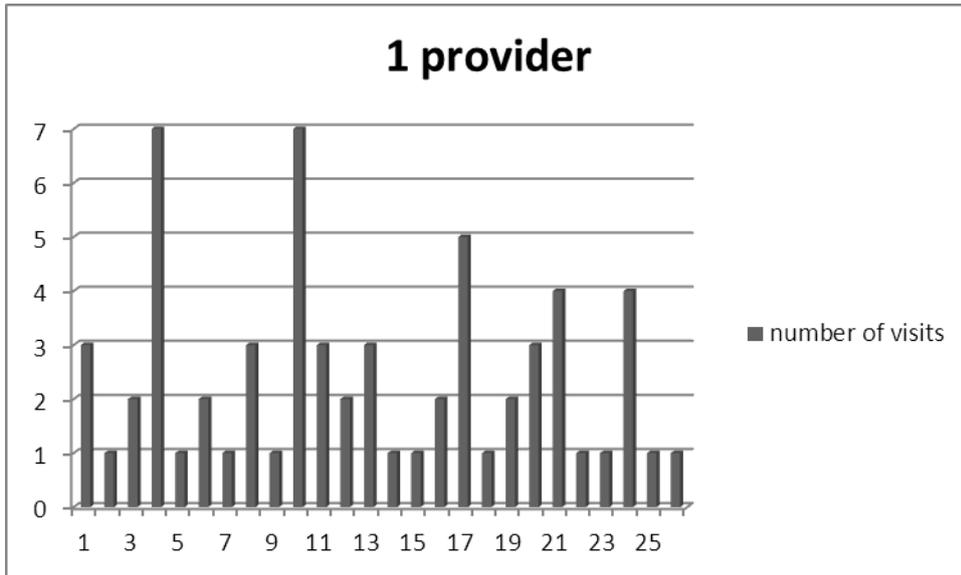
Client 12 had a 10.3% weight reduction



Two clients had definitive health improvements within the time period.

Client 2 had a .1% HbA1c reduction

Client 10 had a 16.1% reduction in weight



Two clients had definitive health improvements within the time period.

Client 1 had a 5.8% weight reduction

Client 18 had a 4.3% weight reduction

The results appear to imply that there is a higher correlation of health improvements relating to both the number of types of providers seen by a client as well as the number of interactions with a provider.

Interactions involving numbers of visits greater than 10 appear to have more of an impact on health outcomes.

### Achievements

Patient survey and feedback is regularly sought for ongoing improvement of the clinic. At intake to the clinic new clients are provided with an “intake pack” including culturally appropriate pamphlets about the services, a confidentiality form and a client survey. The ACDLO assists clients to complete the survey if needed.

The Client Survey was collated this year with completed surveys received from twenty clients.

## 2015 Health Outreach Clinic Patient Questionnaire

(Total Surveys Returned: 20)

	1 = strongly agree	2 = agree	3 = neither agree or disagree	4 = disagree	5 = strongly disagree
1. I am satisfied with the treatment I have received under the WML's Kelso ICD Clinic	20	0	0	0	0
2. I have reached my goal/s identified in treatment under the WML's Kelso ICD Clinic <i>1 survey unanswered.</i>	14	3	2	0	0
3. I have discussed with my nominated GP the treatment I have received under the WML's Kelso ICD Clinic <i>3 surveys unanswered.</i>	Yes 17	No 0	0	0	0
4. I am satisfied with the health professional who provided me with treatment  <i>But please have an Endocrinologist which is here in person. Would prefer face to face with Endocrinology.</i>	19	1	0	0	0
5. I am satisfied with the health professional, please comment why:  If you were dissatisfied with the venue, please comment : <i>Need better access for cars. Need a proper chair to raise feet in podiatry.</i>	18	1	0	0	1
6. I am satisfied with the length of time that it took for me to receive an appointment  ATSI Identified	19 Yes 18	1 No 0	0 Not answered 2	0	0
Comments: <i>The Foot Dr was lovely.</i>					

Our Aboriginal Outreach Worker received a call from a client's partner in October 2014 and shared it with the clinic providers. "I had a call from one of our pts wives today..... She just wanted us to know how much of a difference we have made to not only XXXX life but hers as well and the impact that has on his 2 daughters. Stating "I couldn't wish for anything better", "that we always show openness of friendliness, compassion and concern to XXXXX and without any judgements or trouble". The partner stated that they "have tried everything in means of support and have found our clinic to be the best they have encountered".

In our provider survey from May 2014, five of our six contractors responded that they would be continuing at the same rate or more frequently in the future.

All 6 providers have indicated they are willing to offer Telehealth visits as part of the service.

All the allied health contractors expressed an interest in a permanent position if available in the area.

One contractor wrote "I am thoroughly enjoying working with the patients and other Allied Health professionals within the Kelso clinic. I think it is great having a variety of health professionals available under the one roof, collectively working together with the patients to promote health, help/assist/guide them to improve management of their chronic health conditions."

## Service Provider Feedback Survey 2014-2015

	Sent Surveys	Returned Surveys	Return Rate
	6	5	80%
1. In what capacity do you think you will provide outreach services 2014-2015 FY?	Continue Same 4	Less Visits	More Visits 1
2. What is your current waiting list	Less than 1 month 4	1-4 months 1	More than 4 months
3. Would you be interested in providing outreach services to other areas?	Yes 5	No	
4. Would you be interested in providing Telehealth services in addition to your current face to face visits?	Yes 5	No	
5. If a Staff Specialist position became available within the region would you be interested	Yes 4	No 1	
6 How long do you intend to provide outreach services within our region	Less than 1 year	1-3 years 1	More than 3 years 4
Do you have any further comments			

### Service provision

The Kelso Indigenous Chronic Disease clinic's aim is to improve chronic disease outcomes for Aboriginal patients within the community and enhance access to support services.

In 2014 there were 34 active clients with a Diagnosis of Diabetes seen at the Kelso Clinic. The Kelso ICD Clinic recognises that General Practice is the primary care lead in delivering Chronic Disease Management, and supports General Practice to meet their targets such as completion of Diabetic Cycles of Care by providing timely feedback of all Podiatry Care to comply with 6 monthly foot checks. The Endocrinologist, Diabetic Educator, and Dietitian also support the client to meet HbA1c targets including follow through with completion of pathology.

Having the multidisciplinary team together allows for enhanced referral between the team and each clinician can actively support the client with follow up to another clinician if appropriate. Whilst there has been traditional referral to the clinic for Diabetes related service provision the clinical roles of psychology and exercise physiology have traditionally been referred on a much smaller basis.

Due to funding capabilities of the Kelso ICD Clinic through the Rural Doctors Network with the support of the Department of Health there is not a necessity to receive Allied Health referral forms for Medical Benefits Scheme funds. This has enabled a different approach to engaging clients into the service.

Initially our Psychologist had limited referrals and client's response when informed there was a Psychologist available was that they "did not need to see a Psychologist". Past negative experiences with aspects of mental health care have created barriers to clients actively accessing Psychology services.

Since our ACDLO began referring to our Psychologist as "the other member of the team who sees people about stress", there have been a much greater appointment allocation and attendance levels for appointments.

These appointments have traditionally been more conversational at commencement, with a focus on engagement rather than clinical outcomes. Further review is being undertaken to examine culturally appropriate mental health assessment tools. As some clients become more readily accepting of the psychologist role there may be capacity for some of these clients to engage in group sessions.

The role of the Exercise Physiologist is another developing area within the Kelso ICD clinic team. It was quite common for clients when asked if they would like to see the Exercise Physiologist to respond that they don't exercise. Bringing the clinician into the waiting room to have conversations

with clients regarding going for walks has led to the regular weekly river walking groups and swimming groups led by our Exercise Physiologist.

The length of the walking group has expanded over the year as the participants have been able to complete longer walks and increased confidence in their ability to complete simple exercises. These groups are also encouraging clients to invite their family members to participate in exercise groups and also introduce family members to the Kelso ICD Clinic and its services.

In 2015 the Kelso ICD Clinic has 107 active clients as we expand to offer more services to a broader range of Chronic Diseases including Respiratory Disease.

We aim to be able to provide all aspects of chronic disease management from the clinic over time as we continue to expand the service. Oral health care and Eye care are two aspects not currently offered at the clinic but there is provision for these services within the Bathurst area and further exploration of the needs of the Kelso community for these services will be undertaken.

## Challenges

The most significant challenges for the Kelso ICD Clinic in 2014 were the change of clinical software to enable downloading of investigations and access to letters to be sent and received via secure email. All clinicians at the clinic have readily embraced the change. Clinical outcomes data is slowly being incorporated into client records which will lead to further review of clinical outcomes in the future.

The Kelso ICD Clinic has recently commenced analysing data on PENCAT. Further work is to be done to ensure clean data continues to be entered into client files for extraction.

One notable exclusion to the data collected has been recording of Blood Pressures, so future planning will involve increasing capacity of providers to conduct blood pressures with further scope of equipment.

A review of the scales is also in order as many clients with reduced mobility and those over 120Kg cannot be accurately weighed at the clinic

There may be opportunity to engage an Aboriginal Health Worker to complete baseline observations for clients on entry to the clinic.

## Recommendations

The role of the Aboriginal Chronic Disease Liaison Officer in running the clinic is under recognised. Most clients don't see the clinic without the "face of Jack". Clients do not quietly sit in the waiting room for their appointment but generally spend time engaged in conversation with our ACDLO sharing stories of family and their own health.

One client recently explained the use of some bush medicines to complement treatments for cancer whilst waiting for an appointment. This social interaction is an untapped component of the clinic which assists to reduce the social isolation that many clients experience.

Further understanding of the ACDLO role would benefit the establishment of future clinic models.

Ongoing improvements in data entry will allow for increased data analysis of clinical outcomes. Ongoing upskilling of clinicians regarding data entry within the clinical software will enable future clinical outcome reviews.

Finally it is beneficial that the Kelso Indigenous Chronic Disease Clinic is not reliant on funding from MBS billing via Referrals for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex needs or the referral for follow-up allied health services under Medicare for People of Aboriginal or Torres Strait Islander descent.

These referrals often require the client to discuss issues that they may not be comfortable to discuss with their General Practitioner and are then reliant of the General Practitioner initiating the referral.

Due to the Kelso clinics funding there is capacity to receive General Practice focused referrals as well as client initiated referral.

There is also no limit other than appointment availability and clinician professional availability for a client to access the service where under the MBS referral processes there are recognised limitations for numbers of services.

In conclusion The Kelso ICD Clinic recommend that referral forms for access to Allied Health Services under Medicare should not be limited per calendar year to enable all people with Chronic Disease access to services to manage their chronic and complex care needs.

## Appendix

ACDLO - Aboriginal Chronic Disease Liaison Officer

ACR – Albumin Creatinine ration

HbA1c – glycated haemoglobin

ICD – Indigenous Chronic Disease

MBS – Medicare Benefits Scheme

PENCAT – Pen Clinical Audit Tool

## Presenters

**Anne Vail** moved to Dubbo in 2001 from Western Queensland and has been working in primary health care for over 20 years. Anne has been managing the Rural Outreach Programs for the Western NSW Medicare Local and the Dubbo Plains Division of General Practice prior, for 6 years. Part of this role involves overseeing the clinical governance of the Kelso Indigenous Chronic Disease Clinic. She has a Masters in Nursing from Queensland University of Technology. Anne has had a long attachment to primary care nursing in rural and regional Australia through previous roles in general practice nursing and community nursing.

**Jacqueline Gibbs** is 24-year-old Gamilarray/Yuwalaraay woman from Goodooga, a community located in north-western NSW. Better known as 'Jack' to her clients, she has been running the Kelso Indigenous Chronic Disease Clinic for four years, since its inception. With Jack at the helm, the clinic has evolved from a primarily diabetes-centred clinic into a wider chronic disease clinic. In 2014, Jack completed the Indigenous Youth Leadership Program challenging her to 'step out of her comfort zone' with a highlight being completing the Kokoda Track walk.