Royal Flying Doctor Service

Practical delivery of primary health care programs
MULAN CLINIC (KIMBERLEY)
Access

• Type of service
• Location
• Frequency
• Sustainability
• Appropriateness of service
• Funding
Barriers to Effective Primary Care

- Funding
- Staffing – doctors, nurses, dentists
- Distance/Remoteness/Isolation
- Culture
- Patient Transport
- Communication
- Ignorance of services available
- Continuity/Compliance/health message reinforcements
- Speciality
Model of Service Delivery

- Evidence based - directed, focussed, sustainable
- Holistic or a disease focussed model
- Teamwork and Integrated Services
- Continuity of Care
- Preventative, Vaccination, Screening – Antenatal, preschool, school, community
- Early Intervention
- Lifestyle focussed – eg “Healthy for Life”, “Making our Families Well”, “Healthy mothers, healthy babies”
Model of Service Delivery

- Partnerships in delivery - Government, Community, ACCHO, RFDS, Business
- Community controlled/community based
- Culturally appropriate programs
- Respect
- Flexible
- Cost effective/appropriate
- Advocacy
Staffing

- World wide shortage of trained health professionals
- Significant shortage in rural and remote areas
- Options for adaptability
- Culturally appropriate staffing and staff training
Social Imperative

- Comprehensive Social Policy Frameworks
- Housing
- Environment
- Nutrition
- Substance abuse
- Education
- Chronic Illness management
General

- Medical Records
- Facilities
- Research
- Strategic planning
- Government policy
Resources

- NACCHO *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* (2005)
Requirements for screening

- The condition has a recognisable early phase and early treatment can be shown to improve prognosis.
  - Effective treatment is possible and available.
- The test for the condition should be relatively simple, not harmful and acceptable to the patient.
  - The test should achieve a balance between false positives and false negatives which is related to the severity of consequences of wrong diagnosis both for the health care system and the patient.
- Screening must be sustainable once introduced and not just part of a limited specific initiative.

Wilson and Junger, 1968, adopted by WHO
Levels of Evidence

• I  Systematic review of all relevant randomised controlled trials
• II  At least one RCT
• III  Pseudo RCT, comparative studies, etc
• IV  Case series
• V  Opinions of authorities, expert committees

Adapted from NHMRC1998 Guide to development implementation and evaluation of clinical practice guidelines
Strength of Recommendation

- A  good evidence supporting
- B  fair evidence supporting
- C  poor evidence, but included on other grounds
- D  fair evidence against
- E  good evidence against

Adapted from 1996 US Preventive Task Force *Guide to clinical preventive services*
Screening before birth

• Pre conception visit:
  - Rubella serology all (B), with follow up vaccination
  - Fragile X testing if increased risk (A)
  - Preventive measures(A, B): Folic acid, cease smoking, limit alcohol, listeria education
  - STIs in at risk populations

• All Antenatal tests including Down Syndrome testing
Screening in Childhood

- **Newborn screening and examination (B)** Includes hypothyroidism, PKU, CF screening.

- **1-24 months: Child health surveillance**
  2, 4, 6, 12, 18 months (B) Includes growth, hearing, vision, speech screening by Community Health Nurses.

- **2-5 years: height and weight** 6-12 monthly (III, C), hearing, speech and vision as above.

- **6-13 years: assess ht, wt, waist** 1-2 yearly (III B)
ANTI-SMOKING CLASS
Adolescence

• STIs

• Scoliosis screening not recommended (D)

• Limited evidence for opportunistic screening

including:

  - Presence of health risk behaviours
  - Depression and suicide
  - Psychosocial issues
Screening in the Elderly (65+yrs)

- **FALLS** Screen all for risk factors for falls 12 monthly (I A)
  - Follow up with risk reduction strategies

- **VISION** 12 monthly Snellen chart screening (II B)
  - 12 monthly vision for ATSI from age 50 (NACCHO)

- **HEARING** 12 monthly whisper test or query about hearing (III B)

- Dementia and depression: no evidence to recommend screening.

- **OSTEOPOROSIS** screening for targeted group over 45y using 2 bone mineral desitometry.
Screening for “SNAP”

- Ask about smoking 12 monthly for all aged over 10 years (I A), 6 monthly for increased risk population incl ATSI and mental health patients (I A)
  - follow up “brief intervention”

- 2 yearly BMI and WC, 12 monthly for increased risk (I A)

- 1-3 yearly assessment of alcohol intake (II B, IA)
Blood Pressure

• Measure BP every 2 years from age 18, if <120/80 (I A)

• Measure BP 6-12 monthly if risk factors or established disease (I A, II A)

• ATSI : at least annually, begin at age 15 (V A) 6 monthly if diabetic (NACCHO, RACGP)
OUCH !!
Cholesterol and lipids (fasting)

- General population: every 5 yrs from age 45 (A for men, C for women)
- High risk for IHD: every 1-2 yrs (I A)
- Very high risk including diabetes, established vascular disease, CRF, familial hypercholesterolaemia: annually (I A)
- ATSI annual from age 18 (V) (NACCHO)
Type 2 Diabetes

- Screen all every 3 years from age 55 (III B)
- Women with previous GDM
- If first degree relative with DM, from age 45
- ATSI commence screening age 15-18 yrs if in a high prevalence area for early onset (V) (NACCHO)
- HBA1c and capillary BSL not recommended methods (III) (NACCHO), but random venous BSL can be used.
Screening for Renal Disease

• 12 monthly BP and urinalysis (III B) for smokers and all over 50yrs

• ATSI, diabetics, FHx: from age 35

• NACCHO recommends annual dipstick for proteinuria from age 15-18 (V)
Lions Cancer Institute Inc

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Saving Lives in our Communities through Research

MOBILE SKIN CANCER SCREENING FACILITY

This project made possible through the cooperation of:

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