Plan Z to improve appointment attendance at Mt Isa

Christine Mann, Director of Cultural Capability and Engagement

Breakout Room 3: 15/06 11.30-12.00

Steve: Welcome, everyone. We will move on. I'm Steve Russell, I'm a member of the health consumers board. I'm your facilitator for this session. We have two speakers today, and bolt will speak for half an -- both will speak for half an hour and then we have half an hour allocated for questions. Both presenters deal with Indigenous related health matters and both have very practical solutions and ideas for improving the betterment of health for Indigenous communities. Firstly we have Christine Mann, the director of cultural capability engagement with the north-west hospital and health service. For those that dent know the north-west hospital service, it's way out there near Mount Isa and beyond, I think in fact as far as the Northern Territory border and up into the gulf as well. So an isolated area with a substantial Indigenous population. Secondly, Danielle Cross, the manager of strategic relations with the Metro north which is a little bit closer to town. But also has an Indigenous client tell. So firstly we will hear from Christine Mann and then we will follow up with Danielle. Christine, if you would like to take the podium or indeed wherever you would like to move. We will take it from there.

Christine: Thanks, Steve, for that introduction. I would like to commence today by acknowledging the Turrbal and Jagera people and their continued custodianship and connections to the lands. I pay my respects to elders both past, present and emerging and also like to further extend my respect to all Aboriginal Torres Strait Islander people here today.

Just on is that I would also like to thank my board chair Paul for making the trip up as well. We talked about executive and board leadership. I'm really produced we have an active Chief Executive and chair. By way of connection, a little bit about myself -- I'm a proud Poppaburra woman. I was raised on Kalkadoon country and proud to call Mount Isa home. My grandmother Josephine immigrated from Spain when I was a teenageer. My greater achievement, that's my two daughters, both five and four, back home and they are of annual Fijian heritage. Like many of us in the room aware many hats, wife, sister and aunty to many. My background is in social work. My day job and what brings me hear and

is I'm the director of cultural capability and engagement at north-west based in Mount Isa.

So, where on earth is Mount Isa. I know a lot of people do know where it is but it surprises me thank a lot of people don't in particular if you are on the phone to system support or some information technology support line. They say we can pop down to such and such. So let me take you on a journey. So our part of Queensland includes ancient flood plains within a very outback arid landscape of red dust and spinifex. In the wet season those dry desert channels with enough rainfall turn into flowing floodways and wash-outs, the bottom picture is a familiar one. It could be any other day out in the north-west in particular if you head to Doomadgee or the gulf via the back way you will definitely need those two spare tyres. It would also be remiss of me not to mention Mount Isa mines. For many Mount Isa -- it's the land of milk and honey for a lot of people. They will come out to Mount Isa and earn a bit of disposable income but also back in our backyard -- also in -- our backyard we have some worrying health statistics as well in particular for our Aboriginal and -- mostly or Aboriginal brothers and sisters.

The statistics -- to paint a picture of where Mount Isa is in relation to everywhere else. We're 900 kilometres by road from our tertiary hospital. We're 190 kilometres to the Northern Territory border and just under 2,000 Ks to here in Brisbane.

So the north-west, this is -- our HHS takes up a large area of north-west Queensland. We have got our gulf communities up the top there. Not very good at this.

So our gulf communities are Burketown, Doomadgee, Mornington Island, Normanton and can you remember rum bank, up there. On your left there is the border communities of calm Welander ran Dan gee. Down the bottom, Djarra and out towards Townsville. So that's Cloncurry, Julia Creek and in the middle there, ma kin lay. So you can see Doomadgee, the distance from Mount Isa to Doomadgee is 6700Ks. To Mornington Island it's 700 and obviously we fly in and out of there but if we have to get supplies up it's by barge via can you remember rum bank and then out towards Townsville, we go like I mentioned as far as Julia Creek and the distance is 260Ks there. So it's a bit of ground to cover. And -- in relation to our people, if I could just talk a bit about our lower gulf -- the lower gulf is the communities I shared. So Doomadgee and Mornington Island it's very remote with 93 per cent and 88 per cent respectively of Aboriginal, mostly Aboriginal population. We have high prevalence of diabetes, renal disease cardiovascular disease and one of the lowest median ages of death

nationally. Our people are dying 20 to 30 years earlier than those in south-east Queensland.

For Mount Isa clinics we have around 4,000 appointments made each month. The systems in place there are appointment letters offering phone calls to confirm. SMS reminders, phone calls from staff to follow up those who did not attend. I will ask you to just remember that little bit of information around the systems in place that try to get people to appointments.

Which leads me to what I'm going to share today. Which has an outpatient engagement context. It didn't go to plan, in fact a few plans actually but led some of our staff on a journey that I felt they needed to go on. And it led us to tapping into groups and gaining great insights. So the call for actions -- a couple there, were mandated by the accreditation process to make some improvements and we can do better in relation to consumer engagement. We were doing many things like continuing participation and participating in state-wide outpatient surveys, we had local engagement, ad hoc ... and really great pockets of fantastic examples. In fact, I could have talked about any one of those today around well established community engagement networks like in Cloncurry and Julia Creek.

The other call for action was more importantly we were identifying there were high fail to attend rates in outpatients. So on average in 2016, 13 per cent across all clinics in Mount Isa. We knew there was an issue there, some people weren't getting their follow-up appointments which is incredibly important. But without consumer advice and participation, would to change?

So, if plan A doesn't work the alphabet does have 25 more letters and be reassured I don't have 25 examples here to get through.

In fact I will probably finish early. But the changing development of engagement strategy to improve the attendance. So when something is not working, what do you do?

The usual approach is to develop a strategy. And try and respond.

So what our business improvement officer did was did some analysis of attendances at Mount Isa outpatients for a three-month period, ending in February 2017. She looked at wanting to do a focus group by randomly selecting around 50 patients generated from the high business can you say data from clinics with the highest fail to attend volume and larger clinics, so antinatural and cardiology. The focus groups they was trying to pull together was going to be a range of demographics that affected a mixture of gender, ableists, remoteness and age groups. In

February 2007 I had only just joined the HHS and spent the last 11 years in child protection as the manager of the Mount Isa gulf child service centre. Only a few exwoulds into joining the health service when the business approval officer came along and talked a bit about the outpatient situation (health, not child) and about her idea of doing this focus group and inviting people to come along.

So I was still orienting myself but I didn't want to squash the idea of course because I had only been there five minutes but I did share some reservations about people turning up if they aren't actually turning up to their outpatients appointment, would they necessarily turn up to a focus group we invite them to. I was also doubtful for some of our Murri consume yours, would they come along without having any sort of warning or connections made. But nonetheless it was actually going to do no harm to run this example and to organise the focus groups. So there was no -- there was low risk in having a go.

So, she did a lovely invitation up, sent it out. Surprise. You are invited. And then surprisingly the day came, we had a beautiful room over at Tarabata house, part of James Cook University, lovely catering available, but we had zilch people turn up on the day. So we had a scenario where those who failed to attend their outpatient appointments failed to attend the fail to attend focus group. So it was a built of a hoot really. So whilst we were sitting there ating the wonderful -- eating the catering I was maybe temped to say I told you so, I shared with you my reservations, but I didn't have to as our business improvement officer was humble enough and absolutely committed to wanting to make improvements and understand what we can do better to get people to have their follow-up appointments in time -- and timely medical care. She had asked about those existing groups in a you had mentioned -- that had you mentioned. Can you tell me more about that and in particular some of those harder to reach community members.

But first, she had a little idea that she would like to still phone -- maybe do a phone around of the people invited to the focus group that didn't attend. She went away and did a personal follow-up call of all of those invited along to our failed little focus group. And as you can see at a glance the results are not reflective of the success story but actually in fact the information here was gold.

So, 26 per cent of those contacted found there was no phone recorded or the mobile was since disconnected. I remember one of the systems in place as to how we let people know of their appointments, some of those access is around phone.

53 per cent, there was no response. So the phone rang out. Or there was nil response left to the message.

That was left.

And then 21 per cent actually did answer and provided some feedback directly to our officer.

So plan C was a bit of a better start. It was talking together about the relationship that I had with existing groups. And making connections for our business improvement officer with them and going out to some of those places.

We also did some localised patient surveys which she did with Gigi Hilli, our Aboriginal health service in Mount Isa and have now expanded into the lower gulf. They are a wonderful partnership. We do some wonderful work together. So they came on board. Some of the other partnerships that I talked and made connections with her was DATSIP, department of Aboriginal and Torres Strait Islander partnerships, the riverbed action group, Kalkadoon community, Gigiee healing and the Murri mention group. This involved with a wonderful collaboration with Brother Marty. He is part of the team at the north-west Queensland Indigenous Catholic social services. He is the manager of the justice team helping men and women navigate through the Court system including arrest courts, Childrens Court and our Murri court. He is a weekly attendee of the Murri mention group and a really wonderful ally for our home ... and in particular our Murri men especially when some of our men come out of custody or come back from jail from various parts of Queensland. You can bet he is always there to be a familiar face for them and connect them into accommodation, back with family and services.

So our business improvement officer approached brother Marty about seeking feedback from the Murri mention group and was incredibly supportive of taking the surveys back to the men for them to discuss together as a group.

A couple of weeks passed when brother Marty came back, came back to the hospital and he met with Narelle with about 18 completed surveys by the men. These results were looked at and analysed along with the other surveys they received from others. The highest volume amongst the suggested improvements related to access. It was the feed -- the feedback was don't rely on phone calls, the SMS exit is are not particularly successful in particular if people don't have credit or change phones every other fortnight or what have you. And silent numbers -- I think there is probably a few of us in the room with a silent number -- if

it's a silent number we don't pick up and that's reflected on a lot of surveys, that you have got a silent number and they don't pick up. A big one was transport barriers as well. So Mount Isa doesn't have public transport. We don't have a bus system, it's pretty much taxis.

So, we are still grappling with that one because regardless of how advanced your medical care is, if people can't get to the hospital or the health facility it's redundant really. So transport access was one that came up there.

That's just a little bit of a summary as I mentioned. So confirmed some of the focus groups -- the paper surveys confirmed what was said on the ones that did pick up on the phone when they were called.

I guess when thinking about it we need to listen to people's experience and not assume what needs to be changed and as I mentioned the highest volume there -- the issues related to access.

So words to action -- what are we doing about some of these things?

We've got an -- allocated a health worker. Aboriginal health worker role for outpatients, which is funded and being recruited to. The request for an outpatient's health worker was also identified by one of our more established groups in the hospital and health service, recalledders advisory group who also identified it would really be helpful to have an Aboriginal health worker in outpatients connecting with people as they come through but also maybe possibly to be used in the pharmacy section as well, because there's a -- it's quite an issue, we know that around people understanding the medication, when it's explained to them by a pharmacist. So there was -- that was certainly identified, support with a culturally safe environment. I have been working on a guideline in meeting with -- and meeting with agencies around local partnerships to improve transport. We don't have public transport but what we do have is a few agencies in town with buses that -- where we're meeting together to see if we can't use the existing resources in a way that meets community needs, because whilst we are big we are still small enough to possibly do that idea.

Back in that pie chart, that round circle, it talks about some of the detail in that service was around parking. Something we have done since then was increase the dedicated patient parking. We have been able to open up extra car marks in that respect. And positive distractions in the waiting room as well as an identifiable phone follow-up. So there is no more private number. We have been able to take that off the phone line that we do when we're contacting people.

I guess in summing up I wanted to reflect on some of those principles in particular at health consumer Queensland -- that health consumer Queensland identify. And that is around -- in relation to partnerships I guess what I want to share, this particular example, as opposed to one of our -- many other examples I could have shared, it was around the internal partnerships. So the business practice improvement officer seeking out myself on guidance on what options could work in light of those failed focus group attempts. And the external partnerships. So just by talking, I was able to suggest and connect her with groups and suggest using these already existing groups within Mount Isa.

In relation to respect and dignity -- I felt this was in terms of the Murri men's group -- I feel like we didn't need to leave the process and be present -- lead the process. So I acknowledge that for many Aboriginal people there is still fear, distrust and anger at the actions of government and that's including health.

So we are committed to changing the prevalence and effects of that dynamic and by handing over that control to brother Marty who has the relationship and the existing relationship and trust with the men -- we trusted that he understood what we needed and left it with him to see how he thought the best way was to stalk with the men and share the information back to us.

I think it was Naomi Poole yesterday who mentioned in her address there is no single approach and strategy in how we partner with consumers. So whilst we -- the consumer network we establish and support and have frameworks around are incredibly important there are other strategies too where we don't need to rely on people coming to us but we need to go out to them where the cultural safety might exist in this particular example.

Inflection -- in reflection on inclusiveness -- moving on from the focus group attempts, wanting to ensure inclusiveness and reach out to people in their space. Sorry, I just mentioned that as well and tap into their existing networks where they feel safe. This context with the murrey mention group, it could be the same for example for a migrant women's group, not having the expectation that they will come to us. But there could be occasions where we could go to them in their space. I do acknowledge a point made I think by Susan Michaels yesterday, I think she said yesterday morning around meaningful partnering and creating that space that is safe, secure and allows that partnership to flourish. I think we aspire to that and we're creating that, so whilst this example is early last year, when I reflect from where we were in February last year to June this year out in north-west, we have got those frameworks in

place and we have got additional community advisory groups happening and there is some amazing stuff happening. But on this example, yes, again, probably labour the point around there is always a place where we can go to other people.

In reflection -- the principal intent underpinning was obviously improvement. We absolutely wanted to and particularly for business improvement officer who -- her whole role as she sees that data but she is a wonderful gorgeous lady and it's not just data, these are people that are not attending their appointments and that were not provide -- that we're not providing care to. So, underpinning that all was certainly about improvement.

In terms of plan Z, the outcome -- still some early days. We're trending down -- there has been a reduction in training provided by health with -- sorry, training provided by health consumers Queensland. So it's great having Jo providing training to staff and consumers. It was just disappointing, it was the weekend that the cyclone floated around the gulf. So our consumers that were booked and ready to travel down from can you remember rum bank and Mornington island had to cancel. Instead it went right up north. So onwards and onwards with our partners.

I think that's about it. But happy to answer some questions a bit later on.

APPLAUSE

Steve: Obviously the tyranny of distance is still a real issue in the delivery of health services. Also importantly there is an increasingly important reliance on technology. That might be okay out here in the south-east corner but obviously it's a major shortcoming in places like the north-west district health service area.

Christine, thanks for that. Most informative. Our next speaker is Danielle Grant-Cross and her able assistant Les Batson. They are representing the men's shed, creating a wonderful opportunity and experience for their participants.

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