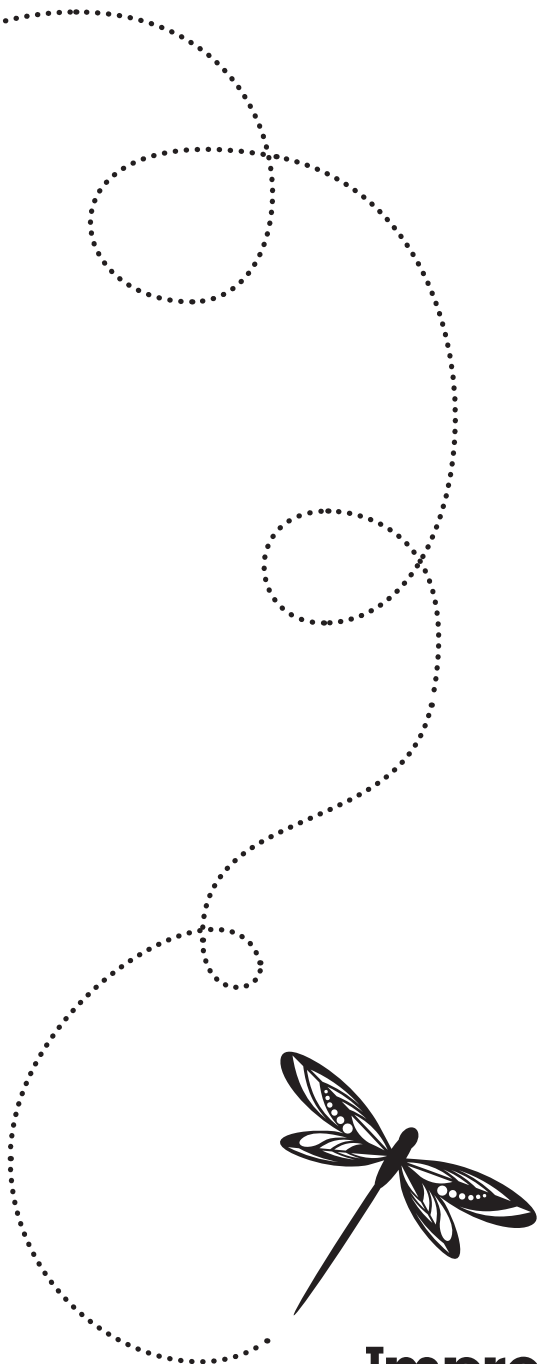




Improving the Patient Journey:

Achieving Positive Outcomes for Remote Aboriginal Cardiac Patients

Monica Lawrence with Zell Dodd, Shane Mohor, Sandra Dunn, Charlotte de Crespigny, Charmaine Power and Laney MacKean



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Foreword

Australian policymakers are now grappling with the challenge of closing the 17-year life expectancy gap between Indigenous and non-Indigenous Australians. It is a monumental challenge that will take time, effort, funds and plenty of goodwill on all sides. But, above all, this critical national challenge will require quality research evidence to inform both government policy and clinical practice.

We are learning, from a growing body of evidence, that the systematic changes necessary for improved health outcomes for Aboriginal and Torres Strait islander peoples will not always require large financial investments. Indeed, often relatively small investments in solving systemic issues can lead to substantial improvements in health and wellbeing.

This report focuses on one such piece of research by Adelaide-based cardiac nurse Monica Lawrence, who started with a belief based on her own hard-won experience that improved liaison between the healthcare system and Aboriginal cardiac patients living in remote areas could lead to improved patient care and substantially reduce both costs and waiting times.

This small and inexpensive action research project was driven by the initiative and passion of a single individual, whose determination allowed her to overcome some of the challenges inherent in bringing about necessary change. This determination and tenacity led to the trialling in early 2007 of a Pilot Remote Nurse Liaison Service for Aboriginal patients living in remote Northern Territory communities who needed to travel south for life-saving heart surgery.

The Pilot Service resulted in a dramatic decline in cancelled surgery – due to ‘no shows’ or poor patient preparation – from more than 50 per cent of remote area patients to zero, with flow-on effects in improved operational efficiencies within the hospital and cost savings on patients’ travel bills.

Support for the activity has come from a range of quarters, including the Cooperative Research Centre for Aboriginal Health, Flinders University, Adelaide and the Australian Nursing Federation.

At the core of Ms Lawrence’s work are the principles of patient-centred care, cultural respect and systemic continuous quality improvement, which proceeds on the basis that different patients have different needs which must be acknowledged in respectful systemic adaptations in order for the best outcomes to be achieved. In the case of remote area Aboriginal patients, meeting these needs draws on cultural translators, community mentors, institutional respect for traditional belief systems and system adaptations, which include improving tracking and communication between the acute and primary settings and implementing clinical/culturally tailored pre- and post-surgery procedures.

As a direct result of Ms Lawrence's efforts, the hospital now has a full-time remote nurse liaison position, and continues to explore options to support culturally competent practice. The pilot is serving as an example to other hospitals across Australia that deal with remote area Aboriginal and Torres Strait Islander patients suffering from a range of chronic conditions.

The research has broad implications. So far it has informed the development of 'Step-down' programs for Aboriginal patients and has also been used to underpin an ongoing national push to improve the various Patient Assistance Transport Schemes (PATs) operating throughout the States.

Monica Lawrence's work is a wonderful example of the sort of positive changes that can be achieved within the existing healthcare system at low cost. By implementing these principles using simple, evidence-based changes on a national scale, governments can go a long way towards achieving their goal of eliminating differences in life expectancy and health outcomes across Australia.

The challenge is on for Australia's hospitals to respond to the clear evidence presented in this report. It is now time for these hospitals to establish similar Remote Nurse Liaison positions that have already been shown to produce benefits to patient care and improvements in surgical efficiency.

Ged Kearney

Federal Secretary
Australian Nursing Federation

Mick Gooda

Chief Executive Officer
CRC for Aboriginal Health



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Sincere respectful and heartfelt thanks to 'Bella' past resident of Elcho Island, Northern Territory (NT): my personal and professional life has certainly been enriched as a result of knowing and caring for 'Bella'. This experience has been pivotal in providing me with the 'fire in the belly' to explore the issues around health care for remote area Aboriginal people who are required to travel through cultural and geographical boundaries to access tertiary-based care.

Heartfelt thanks also to Professor Sandra V. Dunn, Chair of the Academic Board and Professor of Nursing at the Institute of Advanced Studies, Charles Darwin University, NT (previously Clinical Chair of Nursing, Flinders University / Flinders Medical Centre and Director of Nursing and Midwifery Research, Flinders Medical Centre), for her unrelenting personal and professional support in helping me to navigate through the 'difficult terrain'.

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Many Aboriginal people, especially those living in remote areas, are required to travel vast distances to hospitals for surgery, often with life-threatening conditions. Language issues, poor inter-agency coordination, cultural misunderstandings, emotional and physical stress, travel and financial problems all make this a potentially emotionally draining, dangerous and inefficient process with implications for both the patient and the health system.

Summary

It is now universally acknowledged that Australia needs to do much more to improve the health of Aboriginal people and, by doing so, to close the unacceptable life expectancy gap between Aboriginal and non-Aboriginal people.

Aboriginal patients from remote areas have special needs when interacting with health systems, and these needs must be met for safe care practices and optimal health outcomes to be achieved. A growing body of evidence suggests that relatively small modifications to existing systems and practices can lead to substantial improvements in health outcomes for these Aboriginal people.

This quality improvement, action research project aimed to establish if Aboriginal people living in remote areas who need to travel to a major metropolitan hospital for life-saving cardiac surgery benefit from improved arrangements around their journey to and from the hospital.

The research was based in the cardio-thoracic ward at Flinders Medical Centre, Bedford Park, South Australia, and was partly funded by the Cooperative Research Centre for Aboriginal Health (CRAH). It included the trial of a pilot Remote Area Nurse Liaison Service during the first half of 2007. Results from the research project demonstrated that improved cultural competency in a clinical setting led to:

- improved clinical/cultural liaison;
- increased cultural respect for remote area Aboriginal patients;
- improved patient care;
- enhanced patient safety;
- reduced travel costs;
- less disruption in the hospital system; and
- improved hospital efficiencies.

These outcomes have already created opportunities to influence national healthcare policy, most notably through a well-received submission to a 2007 Senate Inquiry (Parliament of Australia 2007). Recommendations for future action include:

- Creating clinical/cultural liaison positions within hospital units to track remote area Aboriginal patients throughout their trajectory of care from their homelands to the hospital setting and then back to their homelands. These positions would be in addition to Aboriginal liaison officers already operating in the public health sector.
- Putting a formal process in place to prepare remote area Aboriginal patients both for their journey and their treatment.

- Providing a full-time Aboriginal interpreter/translation service within hospitals, including on weekends.
- Improving the Northern Territory's (NT) Patient Assistance Transport Scheme (PATs), both in its operation and its funding.
- Transferring the Remote Area Nurse Liaison Service to other disciplines that provide health services to Aboriginal people.
- Using the research findings as a basis for reviewing the hospital accreditation standards of practice for Aboriginal inpatients in all Australian hospitals.
- Funding further research to identify the health outcomes of an improved patient journey for Aboriginal people living in remote areas.



Introduction

What drove this research?

Our research was underpinned by a desire both to improve health outcomes for remote area Aboriginal patients and to enhance hospital efficiencies, based on accepted quality improvement principles. The need and potential for improvement (both clinical and cultural) was initially recognised, and later driven, by Project Leader Monica Lawrence, a clinical nurse passionately motivated by her own experiences of working within a surgical ward at a large metropolitan hospital.

What did we want to find out?

1. How to improve clinical practice and health system performance when working with Aboriginal people required to travel from remote settings to receive cardiac surgery and treatment in the hospital setting.

Previous experience had shown that such patients were often either ill-prepared for their journey to the hospital or were actually lost to the hospital system entirely. For instance, during a six-month period in 2004–05, out of 48 NT remote area Aboriginal patients scheduled for lifesaving cardiac surgery at the hospital, 21 were 'no shows'. That is, the patients were booked to travel but did not present to the hospital for admission. Not only did this have potentially life-threatening consequences for the patients themselves, it also had cost implications for the hospital by reducing its ability to function efficiently.

2. More about the needs of remote Aboriginal people, their perspectives on their experiences of medical and surgical treatment, and their ability to provide advice to health professionals that will contribute to improvements.

For instance, Project Leader Monica Lawrence in her Master of Nursing thesis (2007:72) reported comments from one of the Aboriginal men involved in her research who 'adamantly pointed out' that family members must be contacted and brought into the hospital, as this will give strength to the acutely ill person:

But you gotta make sure that when you really crook and you're not gonna make it, that you go and get your family that will make you stronger. You know but you know you don't tell 'em that he's really crook. Because... [pause] it's against their law, you can't tell them.

To summarise, our primary objectives were to:

- Document cultural aspects of care important to delivering high-quality care to Aboriginal patients from remote areas. This included describing, from an Aboriginal perspective, patients' perceptions and experiences, and the important cultural elements that need to be responded to.
- Provide advice to health professionals from the perspective of remote area Aboriginal patients about the trajectory of their cardiac care from the transition from their home community to a major metropolitan teaching hospital, to their return home.
- Coordinate communication between service providers responsible for providing care to Aboriginal patients required to travel from remote communities to hospital for treatment.
- Inform clinical practice in both the acute and community healthcare settings, particularly in relation to the continuity and cultural appropriateness of care from primary healthcare settings to tertiary-based care and back.

How was the research done?

Our research was undertaken between 2005 and 2007 in a surgical ward of a large metropolitan hospital. The researcher (a non-Aboriginal clinical nurse) used community development and action research approaches within a framework of quality improvement and cultural respect.

Research activity included:

- Identifying areas of potential improvement in the patient pathway (up to 2005).
- Conducting case studies of patient pathways, focusing on the experiences and circumstances of four patients, their relevant healthcare providers and associated other service providers. The case studies aimed to explore, from the patients' perspectives, all dimensions of the pathway: from the remote setting, to the hospital for surgery and then the return to the remote setting. A particular focus of the case studies was exploring the extent of patients' understanding about what was happening to them.
- Piloting a Remote Area Nurse Liaison Service in early 2007 that focused on achieving continuity of care through the engagement of a clinical/cultural approach that would ensure patient pathways provided high-quality, safe and culturally appropriate care. This involved ongoing liaison with external agencies and service providers associated with each patient's preparation, transport and post-operative care, to identify and develop appropriate resolutions to both clinical and cultural issues.

Ethics approval for the case studies was gained from appropriate bodies including the Aboriginal Health Research Ethics Committee. Case study candidates were drawn from a group of 36 Aboriginal patients from remote areas of the Northern Territory who attended the hospital for cardiac surgery during the period November 2006 to 30 April 2007. The research candidates had to meet the following selection criteria:

- self-identified as Aboriginal Australians;
- over 18 years of age;
- admitted to the hospital for cardiac surgery;
- able and willing to give informed consent either in writing or verbally;
- living in a remote Aboriginal community;
- medically stable;
- appropriate and culturally acceptable interpreter available; and
- willing to participate in the research.

From the larger group, five research candidates were identified as suitable research participants according to these criteria; however, one person subsequently elected to withdraw for personal reasons. The final group of research participants included two women and two men who communicated in English as their third, fourth and fifth languages. Each participant was interviewed four to five days post operatively by the researcher accompanied by the hospital's Aboriginal Services Officer.

Culturally appropriate questions, devised in consultation with the Aboriginal Advisory Group, comprised semi-structured, open-ended questions that were transcribed verbatim from an audiotape. Verbatim transcripts were analysed for major themes and grouped accordingly. This revealed the patients' emotional responses as well as general perceptions about travel, health, knowledge, care and support, and self-efficacy.

Consultations also occurred with medical officers, nurses and other health professionals at both the primary and tertiary locations regarding each patient's trajectory of care. Information gained via this process fed directly into the operation of the subsequent pilot Remote Area Nurse Liaison Service.



Background

What was known about how Aboriginal patients from remote areas deal with the journey to hospital?

- Aboriginal patients who need to travel vast distances for cardiac surgery find the process a daunting prospect that can cause great anxiety, confront them with unfamiliar surroundings and customs, isolate them from family and social supports, and be overwhelming, humiliating, confronting and/or confusing.
- Aboriginal patients' natural anxiety about travelling away from their home communities for treatment is compounded by their experience of witnessing others who go to hospital and either never return or come back in a fragile physical and emotional state.
- Patients and their carers/escorts experience emotional and physical exhaustion as a consequence of travelling vast distances between their homes and a metropolitan area. This may be compounded when surgery is cancelled on arrival at hospital, thus making the experience more overwhelming and distressing due to the generally meagre financial resources of patients.
- Patients and their families find the personal financial outlay required when travelling vast distances difficult to manage, especially as such travel is often undertaken at short notice and includes family and/or friends.
- The PATS is difficult for remote area Aboriginal people to access, given that the scheme's forms are written in English and need to be received by the relevant hospital service within one month of treatment.
- Even when PATS is accessed, the financial subsidy is generally insufficient to pay for travel and accommodation costs and then often only covers the patient, but not the accompanying family members and/or friends.

What was known about how Aboriginal patients from remote areas experience hospitalisation and the hospital environment?

- Language and culturally based misunderstandings, often influenced by inadequate explanations of Western medical concepts, impact on communication between health professionals and remote area Aboriginal patients about their treatment and what it will entail.

- Non-Aboriginal healthcare workers in the hospital environment may be unaware of, and therefore fail to respond to, an Aboriginal patient's actions or attitudes that originate from cultural practices. For example, some patients may request the services of a Ngangkari, an Aboriginal traditional healer.
- Misunderstanding of cultural proprieties by non-Aboriginal healthcare workers can impact adversely on patient treatment. For instance, a preference by Aboriginal patients not to maintain eye contact during verbal communication may lead to the inaccurate perception by a non-Aboriginal person that the patient was uninterested or disengaged, when, from a cultural perspective, this action is more likely to be a show of respect or of shyness.
- Informed consent to treatment may not have occurred. For example, Aboriginal people's experience of colonisation, together with inadequate communication (as outlined above), may mean that they agree to a treatment simply because a non-Aboriginal 'expert' has suggested that it would be best.
- Aboriginal patients who have no family and/or friends accompanying them suffer greater anxiety than those who do.
- Patient release processes from public hospitals can be *ad hoc* with little attention paid to remote area patients' needs during the return journey to their home communities.

What was known about how Aboriginal people from remote areas cope with the consequences of their treatment on return to their home community?

- Conventional rehabilitation advice does not adequately protect patients on their return to the remote community post-surgery. It might not take into consideration their engagement in culturally based activities that are central to the lives of remote area Aboriginal patients, such as fishing and hunting.
- Lack of primary healthcare and specialist services in remote communities may mean that opportunities for post-operative healthcare follow-up are either infrequent or unavailable.
- Language and culturally inadequate information can mean that remote area patients may not fully understand what is required of them in terms of post-operative 'care and maintenance'.
- Remote area Aboriginal patients often do not have access to appropriate facilities to manage their condition adequately post-release. For example, a lack of reliable refrigeration facilities in remote areas can affect patients' ability to maintain post-operative medication regimes.



What Was Learned?

Cognitive control

The term 'cognitive control' refers to an individual's ability to formulate and process events relating to spiritual beliefs and self-determination. Research analysis showed that remote area Aboriginal patients who were not psychologically prepared for travelling vast distances for remedial cardiac surgery were likely to suffer a loss of cognitive control, which can lead to delayed recovery, post-operative complications and increased length of hospital stay. Discussions with the research participants revealed that, in cultural terms, losing cognitive control amounted to being lost spiritually; it was described as losing memory or, as one participant said, *'they don't know where they're going'*. In contrast, patients who were prepared well for travel ahead of surgery showed a greater ability to maintain cognitive control. This helped reduce anxiety and fear, fostered family cohesion and community integrity, and improved the patient's ability to recover from surgery.

Financial costs associated with travel

Although the financial impact of travel differed from patient to patient, the research found that the support offered by PATS was difficult to access for remote area Aboriginal patients and generally inadequate to cover costs. For instance, under the existing PATS guidelines that came into effect on 1 July 2008:

- Patients and their eligible escorts are entitled to be reimbursed \$35 a night per person for paid accommodation. This is well below the actual cost of accommodation in most Australian cities, which on average is around \$110 per night.
- PATS covers the cost of accommodation in Aboriginal Hostels, but assistance towards most other accommodation and all on-ground travel costs comes in the form of reimbursement. This means patients (and their eligible escorts) must cover the costs in the first instance and keep all receipts to ensure reimbursement.
- Out-of-pocket accommodation costs can mount up as patients—along with their carers—are only covered by PATS for one night's accommodation before admission and one night's accommodation after discharge and upon medical clearance from the treating specialist. Patients often need to spend several more nights in paid accommodation after release from hospital before feeling well enough to travel long distances back home.

- Patient escorts are only funded for certain treatments at the referring doctor's discretion, and the doctor's recommendation for an escort can then be overruled by NT Health administrators.
- Depending on the circumstances, a cancelled hospital admission can mean that patients must bear the whole cost of travel for re-admission. This may mean that remote area patients elect to forgo their treatment.

Language interpreters

The research identified a gap in the provision and utilisation of appropriate language interpreters at the hospital. Although there are limitations on the number of interpreters available within the Aboriginal community, the two main barriers identified by this research were:

- access to language interpreters on weekends; and
- inadequate funding to provide an effective service.

Communication/health education

Two main issues were identified in relation to providing appropriate health information to remote area patients:

- Despite the cardiac rehabilitation information provided to nursing staff, the transient nature of staffing within the NT healthcare system led to gaps in the provision of culturally appropriate health education to the recipients of cardiac interventions.
- A lack of resources and culturally appropriate knowledge at the hospital is leaving Aboriginal patients with a poor understanding of the rehabilitation process despite all the information and follow-up care given to them. Anecdotally, even people with a good grasp of the English language have difficulties with receiving and processing information during times of acute stress and hospitalisation.

Systemic issues

The research identified a number of shortfalls within the healthcare system:

- **Lack of 'tracking' of patients' journey from home to home.** There is currently no process whereby the system can track whether patients travelling from remote areas have left their communities, arrived in Darwin, left Darwin and presented at the hospital they were scheduled to attend, or presented at another hospital in that city in error. The 'costs' associated with these circumstances were multi-faceted, and caused disadvantage both to the potential surgical patient and to the healthcare system. For instance, patient safety can be compromised, and the healthcare system can lose the opportunity to use operating time created by 'no shows' for another patient.
- **Inadequate pre-operative clinical preparation process.** Currently, there is no formal process for pre-operative clinical preparation and screening, and pre-operative preparation of Aboriginal patients prior to leaving their remote communities. This means that remote area patients are more likely to experience unforeseen delays or outright cancellation of their surgery, due to the presence of undetected/ untreated/uncontrolled health problems other than the admitting cardiac condition—such as MRSA (Methicillin-resistant Staphylococcus Aureus) dental disease and medication-related coagulopathies—and/or a lack of pre-operative psychological preparation. Consequently, patients frequently have to leave and return home before surgery can take place. In one month alone (September 2005), five patients admitted to the hospital—and their escorts/ carers—returned to their remote Top End communities after having their surgery delayed as a result of inadequate pre-admission preparation and assessment of co-morbidities.
- **Inadequate post-operative follow-up processes.** Patient safety and surgical outcomes were being compromised as a result of gaps in the post-operative follow-up process, sometimes leading to further interventions and more expense. For instance, Aboriginal patients who returned to their communities in the NT post-cardiac surgery were often 'discovered' accidentally by Remote Area Nurses or Aboriginal Health Workers. Discharge letters, travel details and prescriptions were often not communicated to the relevant travel and care providers, which meant that appropriate medications and ongoing patient monitoring within home communities were not provided.



What Improvements Can Be Made?

Broadly, a four-way communication approach needs to be established, with the following key parties involved:

- The surgical ward at the hospital—to improve the hospital's understanding of the patient's health status and circumstances, in terms of travelling to the hospital as well as both pre- and post-operatively;
- The hospital/health service administrators—to provide them with the information they need to ensure that the arrangements for remote area patients are resourced properly throughout their trajectory of care, and to build collaborative partnerships with key health agencies across jurisdictions;
- The community-based organisations involved in the patient's healthcare—to ensure they have accurate information about the patient's journey arrangements as well as pre-operative and post-operative care requirements; and
- The Aboriginal patient, their escort and/or family—to support them to be an active partner in their healthcare, which includes providing personal medical information.

To support this broad goal, specific improvements can be made by all parties. The surgical ward needs to:

- Provide a dedicated role focusing on clinical/cultural liaison to help nursing and medical staff gain insight into the lifestyle and environment of the remote area Aboriginal patient, supported by appropriate training around cultural safety/ respect. Clinical workers' understanding of the patient's home environment is fundamental for appropriate discharge planning, safe return to community and optimal rehabilitation: for example, knowing whether the patient lives in a house and has access to running water and refrigeration, as well as their level of access and mode of travel to healthcare services.

The hospital/health service administrators need to:

- Embed a Remote Area Nurse Liaison Service (as piloted) within the acute system, ensuring it has a quality improvement mandate and operates within a clinical/ cultural framework.
- Provide a fully funded, full-time interpreter service that is available most hours, especially on weekends.

- Develop collaborative partnerships with the NT Centre for Disease Control and Rheumatic Heart Disease Register to inform it of remote area patients' impending valve surgery. This would allow patients to be prioritised according to the severity of their heart disease.
- Implement secondary communication with the NT Centre for Disease Control and Rheumatic Heart Disease Register to identify patients for post-operative follow-up, for instance, by facilitating ongoing treatment with intramuscular Bicillin® medication.
- Improve the monitoring and assessment of remote area patients when discharged to a step-down unit (for those who need less monitoring than those in the critical care or intensive care units) or Aboriginal hostel.

The community-based organisations need to:

- Improve processes for preparing patients for surgery *prior to travel*. This includes ensuring patients are dentally fit for surgery, identifying their MRSA status and providing culturally appropriate information that allows the Aboriginal patient, and their family/friends, to engage effectively in informed consent processes and fully participate in their care.
- Engage with community Elders and/or those community members who have experienced surgery in the past, and/or understand the surgical process, to assist with the provision of culturally appropriate health education/communication to patients and their family.
- Implement systems to prevent people running out of medications after returning to their remote communities. As it stands, hospitals only supply seven days' worth of discharge medications. It might take patients up to 10 days to return home (including post-operative recovery in paid accommodation), and their remote area clinic may only have limited cardiac medications in stock.
- Adapt rehabilitation advice to the specific needs of patients, contingent on their particular circumstances and lifestyle.

The Aboriginal patient, their escort and/or family need to:

- Engage in a unique clinical / cultural process of care to enable them to fully comprehend their roles and responsibilities.
- Understand that they are responsible for their actions and the implications of not adhering to treatment plans.
- Take responsibility for passing on what they have learnt to their community.
- Take the opportunity to ask questions along the patient journey process.

Box 1: Bridging the Communication Gap

The CRCAH has already been involved in research to improve communication between Aboriginal client groups and healthcare workers through two separate projects:

- *Sharing the True Stories (STTS)*, which ran for five years from 2001 to 2005.
- *Improving Access to Kidney Transplants (IMPAKT)*, which began in 2004 and finished in 2008.

Both projects identified communication barriers at all levels of patient/provider interactions that impact on the effectiveness of health interventions.

STTS has implemented strategies to build the capacity of patients, providers and interpreters to communicate more effectively, while IMPAKT is developing education packages targeted at Aboriginal client groups. It is hoped that the outcomes of both projects will be used to enhance clinical practice relating to remote area Aboriginal patients in healthcare settings around Australia.

To find out more, visit:

www.crcah.org.au/research/sharingthe_true_stories.html

www.crcah.org.au/research/impakt.html



What Has Been Achieved So Far?

Improved clinical/cultural liaison around patient care

A pilot Remote Area Nurse Liaison Service began at the Flinders Medical Centre in early 2007 as part of this research project. It aimed to address recognised problems in the existing process for treating remote area Aboriginal cardiac patients, which were compromising both patient safety and the efficiency of the hospital system. The pilot service worked hard to establish links with remote communities, Aboriginal Health Workers and key care providers, as well as exploring gaps in the cardiac care process. As a result of this service, aspects of patient care and safety, hospital efficiencies and cultural respect have improved.

Improved patient care/safety, hospital efficiencies and cultural respect

Patient care and safety

- Community mentoring is now in place to support appropriate pre-admission and assessment interventions including patient/community education, informed consent and medication management.
- Opportunities to negotiate patients' choice of appropriate carer/escort depending on the nature of the surgery have improved.
- Pre-operative and discharge communication with travel providers, Remote Area Nurses, Aboriginal Health Workers and key care providers located in home communities has improved.
- Patient safety during travel to and from hospital has been enhanced.
- Travel costs have reduced and there has been less disruption in the hospital system.
- There is greater commitment from health authorities to maintain and expand service networks, protocols and procedures to improve patient safety and continuity/quality of care.

Hospital efficiencies

- Patients intending to decline surgery are identified before leaving their community, thereby facilitating implementation of conservative care and rescheduling of travel and surgery where appropriate.
- Zero 'no shows' for remote area cardiac patients at the hospital in 2007. For example, prior to the pilot an estimated four out of every eight clients in a one-month period had surgery cancelled at the ward level. However, in the 12-month period following implementation of the pilot, only two out of 80 clients had to have delayed surgery. In addition, cancelled surgery was managed in a timely way at the community level, with rescheduling of the elective surgical waiting list. This meant that clients were not lost to follow-up.
- Comprehensive pre-operative clinical (including dental) and psychological preparation of patients has reduced delay and cancellation of surgery, resulting in greater patient throughput for the hospital. Prior to the pilot, the majority of clients scheduled for surgery were not dentally fit, which meant cancelling the surgery pending necessary dental extractions and restorations.
- Reduction of surgical ward 'down time' due to improved remote area patient liaison and pre-operative preparation. For example, less bed days were used for psychological and clinical preparation that should have been addressed at a community level.
- Reduction in re-presentations and re-admissions to hospital due to improved post-discharge follow-up. For example, improved post-discharge communication with key care providers (such as Remote Area Nurses) led to more effective sharing of post-discharge information. This enhanced continuity of care and follow-up at a community level helped to avoid adverse events.
- Demonstrated cost savings through improved pre-admission screening and post-discharge follow-up, for instance, by cutting back on unnecessary travel/accommodation costs both for patients and escorts.
- Improved cardiac surgery and cardiology databases to support audit and research.

Cultural respect

- Cultural awareness and competency of nursing staff and other healthcare providers has improved.
- Hospital protocols and processes—for example, informed consent processes, travel arrangements and communication—have been adapted to enable more effective identification of, and response to, the culturally based needs of patients.

Box 2: A Welcoming Ward

A research project to foster reform in hospitals, so that they become more culturally appropriate environments for Aboriginal people, is currently in progress. The project, *Improving the Culture of Hospitals for Aboriginal Patients and their Families*, aims to link necessary reforms to continuous quality improvement processes.

The first stage of this CRCAH-funded project involves documenting processes and protocols (tools) currently used in selected 'best practice' hospitals around cultural reform for Aboriginal patients in these environments. The second stage will develop these tools that, in the third stage, will be implemented using continuous quality improvement processes with 14 hospitals nationally.

By improving the cultural appropriateness of hospital environments, which includes enabling hospitals to collaborate more effectively with Aboriginal communities, the project should lead to improved service provision for Aboriginal patients and contribute to improvements in Indigenous health.

To find out more, visit:

www.crcah.org.au/research/improving_culture_hospitals.html

Influencing national healthcare policy

The outcomes of the pilot Remote Area Nurse Liaison Service were presented—in a submission prepared by Project Leader Monica Lawrence—to the Senate Standing Committee on Community Affairs (the Committee) in 2007. This resulted in the committee recognising the project's potential to increase patient safety and reduce costs and confusion in the treatment of remote area Aboriginal patients suffering from a range of conditions.

In its report on PATS, *Highway to Health: Better Access for Rural, Regional and Remote Patients*, released in September 2007, the committee stated it was 'impressed' by the pilot program's results and 'its potential for benefits in other Aboriginal health areas' (Parliament of Australia 2007:99). The committee noted that 'a number of positive outcomes were achieved ensuring additional patient safety, reducing travel costs and the incidence of unnecessary travel in the first half of 2007' (Parliament of Australia 2007:100). The committee also noted the project team's belief that the pilot model could be used for Aboriginal patients accessing other specialty services such as oncology care, renal dialysis, ophthalmology and neonatal care (Parliament of Australia 2007:100). An updated response from the Department of Community Affairs is currently pending.

In the meantime, raising the bar on quality and safety of care has progressed significantly in a clinical service model that was developed to inform transitional care for Aboriginal people at a new 'step-down' facility in metropolitan South Australia. More recently, a unique care model is being developed at a site closely affiliated with Flinders Medical Centre, and other primary care settings, to facilitate a culturally respectful holistic model of care in a healing environment in response to the health needs of metropolitan, rural and remote Aboriginal people.

The committee's positive response to the project's findings was reflected in the following recommendation (Parliament of Australia 2007:150–1):

Recommendation 16

That State and Territory Governments, in consultation with Indigenous representatives and Indigenous Health Services, identify and adopt best practice standards and develop programs to improve Indigenous patients' access to medical services by:

- *Ensuring continuity of care for Indigenous patients by establishing liaison services and improving coordination in, and between, remote communities and treatment centres;*
- *Accommodating the cultural and language needs of Indigenous patients from remote communities, particularly in respect to the provision of escorts and translators; and*
- *Expanding access to appropriate accommodation services.*

In establishing these best practice standards and programs, government and Indigenous representatives should:

- *Identify and build on existing examples of good practice by health services in Indigenous communities and State and Territory programs; and*
- *Establish clear governance and administrative arrangements for the delivery of programs, including consideration of the most appropriate bodies to provide day-to-day administration of services (for example, a government body or community-managed Aboriginal and Torres Strait Islander health services).*



What Else Needs to Be Done?

Action is suggested in a number of areas. These include:

- Creating national and local clinical/cultural liaison positions within the public health sector to champion point-to-point contact in tracking patients to ensure that surgery and treatment are followed up in a timely manner. This transfer of knowledge would link together primary and tertiary care providers to maintain continuity and cultural appropriateness of care in a seamless process, and foster new training and employment opportunities for Aboriginal nurses.
- Providing a fully funded, ongoing translating service to assist with the education of Aboriginal patients, similar to the system currently available to migrants.¹
- Improving PATS so that accommodation and travel funding for both remote area patients and their carers/escorts is increased to more realistic levels, and that it remains available even when a remote area patient's surgery is cancelled and must be rebooked.
- Exploring possibilities of telemedicine as a specialist area to support follow-up with health workers back in the community, as well as with patients who have gone home.
- Piloting the transferral of the Remote Area Nurse Liaison Service and clinical/cultural approach of care to other disciplines—such as renal and endocrine, neonate, ophthalmology, and oncology—that provide health services to Aboriginal people from remote areas.
- Using the research findings as a basis for reviewing the hospital accreditation standards of practice for Aboriginal inpatients in all Australian hospitals to ensure appropriate cultural respect of Aboriginal patients and their needs, including the practices used for those coming from remote settings.
- Funding further research to identify the outcomes of implementing an effective, culturally appropriate service for remote area Aboriginal patients travelling long distances to receive specialist care.

¹ The Translating and Interpreting Service of the Australian Government's Department of Immigration and Citizenship.

Conclusion

When we started our research the first question we asked ourselves was: if our current healthcare system requires Aboriginal people living in remote communities to travel long distances for life-saving treatments, what can we offer such patients to improve the fit between their health/cultural requirements and the clinical environment?

Our research suggests that the answer lies, in part, in a series of small, simple but effective steps such as putting in place dedicated liaison officers at key points within the healthcare system, improving culturally competent practice in clinical settings, raising the cultural awareness of healthcare practitioners, improving the operation of PATS, and funding a better in-hospital interpreter service.

Where this has happened, the early evidence is that patient safety has been enhanced, hospital efficiencies have improved, and better communication and continuity of care throughout the patient journey has saved on 'costs' both financial and psychological for all concerned.

This project demonstrates how much can be achieved in one setting to improve the healthcare trajectory for Aboriginal people living in remote areas, through the adoption of a continuous quality improvement approach that synthesises clinical and cultural respect frameworks. Activity since completion of the research also suggests that the key elements of this approach are adaptable to a range of other settings.

It is hoped that the lessons learned from this research will be applied more broadly within the national healthcare system in the short-to-medium term. We also look forward to more comprehensive research that investigates how an improved patient journey can affect health outcomes for Aboriginal people living in remote areas throughout Australia.

A decorative dotted line starts from the top left, loops around, and extends towards the top right where it ends near a dragonfly illustration. The dragonfly is positioned in the upper right corner of the page.

References

Lawrence, M. 2007, *Do you Understand? How Does the Aboriginal Person from the Remote Community Experience Their Trajectory of Care for Cardiac Surgery at a Metropolitan Teaching Hospital*, Master of Nursing thesis, Flinders University, Bedford Park, SA.

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