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Submission to the Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care

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The professional body for remote & isolated health

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APPENDICES

1. Introduction

CRANAplus exists to ensure the delivery of safe, high quality primary healthcare to challenging and isolated areas of clinical practice. Providing over 30 years of education, support and professional services for the remote, rural and isolated health workforce of Australia**.** We are the only member based, national health organisation that has remote health as its sole focus, making us the remote health experts. This specialisation allows us to provide unique education and support services vital for clinicians to be suitably prepared to remain within the remote health workforce.

CRANAplus advocates for an extension to the access of MBS items billable for a broader range of health professionals, for the provision of high quality care and management of Chronic Disease.

Australia is a nation that has a huge landmass with dispersed populations and industries, necessitating the delivery of healthcare in some challenging areas and conditions. As a nation, our collective identity relates to our respect for the bush and the many iconic stories from our outback.

People in remote Australia have higher morbidities and associated mortality, yet have limited access to services that most Australians would take for granted. Remote communities in Australia most commonly do not have a local hospital or a private general practitioner.

It is widely acknowledged that the Aboriginal and Torres Strait Islander populations of Australia have a higher burden of diseases and subsequent reduced life expectancy, yet poorer access to equitable health services compared to the rest of the Australian population.

Aboriginal and Torres Strait Islander people make up only 1% of the population in cities, but approximately 26% of the population in more remote communities.[1]

Care is made available through access to Remote Area Nurses (RAN's) and Aboriginal and Torres Strait Islander Health Practitioners / Workers, supported by visiting Medical and Allied Health professionals, all of whom require advanced skills and knowledge.

The National Health Reform - progress and delivery report, (Commonwealth of Australia, 2011, Pg. 59), described the health burden in rural and remote areas as:

> *"People in rural areas of Australia have poorer health outcomes than their metropolitan counterparts. Life expectancy in regional areas is one or two years lower than in major cities, and for people in remote areas, life expectancy is up to seven years lower, due to higher rates of coronary artery disease and accidents. Poor health status also increases with remoteness."*

The status of the health of rural and remote communities has been re-validated in the recent *Medical Research and Rural Health Report* from the Garvan Institute. The report indicates higher mortality rates, lower life expectancy, higher prevalence of mental health problems including dementia and higher death rates from chronic disease for rural and remote populations. [2]

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As a result of the mal-distribution of general practitioners, medical specialists and other less frequently required services, Remote Area Nurses (RANs) are the primary provider of care to most people in the remote and isolated context and the complexities of their practice continues to expand. The CRANAplus *Framework for Remote Practice*, attached as Appendix 1, describes remote practice and the desirable standards that underpin safe, quality practice.

[1] Health Workforce Australia 2011

[2] **'Medical Research and Rural Health' – Garvan Report, 2015. The Garvan Research Foundation**

Remote Area Nurses work collaboratively with their local and virtual teams, using formulary and approved clinical guidelines to undertake the work of general practice, along with prevention, early detection, and case management of people with complex chronic conditions. In remote Aboriginal and Torres Strait Islander communities the RAN's work alongside the locally based Aboriginal and Torres Strait Islander Health Practitioners / Workers. These Remote Area Nurses are also the emergency service, unexpected birth, pre-hospital care, after hour's service and social/emotional wellbeing professional, for their community.

Australia has had this model of care in remote areas for many decades (commensurate with the birth of the Royal Flying Doctor Service), which CRANAplus continues to grow, prepare, support and professionalise to overcome the tyranny of distance. The nature of remote and isolated practice is a fertile field for innovation and the birth of new and improved models of care; necessity is the mother of invention.

By developing creative models, people in very isolated small locations have access to the Australian Healthcare System, which would never be attained using the standard private medical model of general practice.

2. Chronic disease

Aboriginal and Torres Strait Islander people have higher incidence of chronic disease predominantly diabetes, ischaemic heart disease, respiratory disease and chronic renal disease. Chronic disease prevention, early detection and treatment in the remote setting offers many challenges to health services and clinicians. These include challenges in addressing the social determinants of health in isolated areas, referrals and access to specialist services, an underprepared and highly transient health workforce and finally a model of healthcare funding that is metro-centric and medically focused.

For chronic disease prevention programs to be sustainable and provide quality health care they must be robust with good processes, good procedures, good systems and good communication to make them work. To ensure programs are sustainable, contextually driven, viable and evaluated, requires the implementation of an embedded CQI program.

The traditional medicalised management of Chronic Disease does not meet the needs of people living in remote Australia. Chronic disease requires a different way of thinking: a person/client centred, collaborative, multi-disciplinary team approach. Fundamental to the team is the resident Remote Area Nurse and Aboriginal and Torres Strait Islander Health Practitioner / Worker.

Best practice for Chronic Disease prevention and management in remote areas should be based on:

- Community based needs
- Funding models reflecting actual and potential burdens of disease
- Person/ client centred care
- Cross sectorial – based on Social determinants of health e.g Food security issues, housing, poverty, transport, education and access to services
- Care is coordinated at the local level

2.1 Examples of best practice in chronic disease prevention and management, both in Australia and internationally;

Australian examples referred to in Questions 7 & 8

2.2 Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management;

CRANAplus advocates for an extension to the access of MBS items billable for a broader range of health professionals, for the provision of high quality care and management of Chronic Disease. Currently patients cannot access nursing and allied health services, independent of GP linked MBS item numbers billable by GPs only (e.g. 715 ATSI health check; 721,723 GP management plans and Team Care Arrangements and 732 review of either).

Many individuals in remote and isolated (and even some regional) areas do not have regular access to GPs; they do have access to permanent staff, namely, registered nurses, nurse practitioners and Aboriginal and Torres Strait Islander health practitioners and workers.
CRANAplus Issue Paper: A shift in practice: *Improving access to health assessments across the remote and isolated health sector* outlines the challenges, issues and solutions in addressing the improvements for chronic disease prevention and management and the much-needed changes to the Medicare Benefit Scheme. Refer to Appendix 2

2.3 Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;

It is important that PHN's are responsive to the needs of their various communities, by engaging with the existing health services including their healthcare providers and consumers. Service planning must be locally based, with a consumer centred approach with a clear target audience to ensure it is relevant.

PHN's should carefully consider the continuation of models that have worked effectively at a local level and learn from those that have been successful from other jurisdictions, all while considering for local adaptations. The programs must be inclusive of the multi-disciplinary team in remote areas, utilising all professionals to their full scope of practice.
The changing priorities of incoming governments often result in successful and well liked programs being ceased for political reasons, not the evidence. PHNs must work to prevent such regular occurrences.

PHN's need to be supported to ensure they have clear purpose and responsibility for targeted funding to prevent unnecessary duplication, fragmentation and ensuring service providers collaborate to deliver care.

2.4 The role of private health insurers in chronic disease prevention and management;

The potential for private health insurers to be involved in chronic disease prevention and management in remote areas is relatively limited as the rate of private health insurance decreases with remoteness. As reported through AIHW report in 2011 [3] on health expenditure by remoteness, 2007-08 rates of private health insurance (using self-reported data) was 57 per cent in major cities, 48 per cent in inner regional areas, and 41 per cent in other areas (which includes outer regional, remote and very remote areas).
For those people in remote areas that do have private health insurance, opportunities to benefit from it are limited due to very few private providers (i.e. Specialists, Allied health, or even gyms) working in the remote sector.

2.5 The role of State and Territory Governments in chronic disease prevention and management;

The disconnect between State/Territory and Federal Government in regards to the funding of health services needs to be addressed to drive better collaborative approaches and reduce the overlap and fragmentation of services.

Cost shifting between Governments leaves consumers bereft of vital PHC services. This is particularly noticeable with prevention programs that have demonstrated effectiveness, but regularly ceased without opportunity to show greater long-term effects and impact.

The Commonwealth primarily funds General Practitioners and Medical Specialists workforce in the PHC arena, whilst the services provided by Nurses is not recognised or understood in the delivery of remote chronic disease care. This is a significant barrier in the remote sector where Nurses are the primary provider resulting in a dearth of data around the burden of disease.

[3] Australian Institute of Health and Welfare 2010. *Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure*. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: AIHW. http://www.aihw.gov.au/publication-detail/?id=6442475421, accessed 26/7/15

The models of funding used in Remote areas need to be tailored to improve access to services that are appropriate to the characteristics of the community. This may be achieved through a pooled or partial capitation-funding model.

CRANAplus recognises that the respective roles of the Commonwealth and States in health care are currently under review as part of the Commonwealth Government's Reform of the Federation. This review has potential opportunity to find more efficient and effective models of service delivery.

An example of a successful model is the Healthy for Life Program.

2.6 Innovative models which incentivize access, quality and efficiency in chronic disease prevention and management.

There is significant diversity in the way specific programs and locations use incentives to target specific groups/ cohorts or communities. Ensuring that PHC programs are family centred acknowledges the critical role of the extended family and culture in the prevention and management of chronic disease.

Some examples have included:

- Sexual health checks for Adolescents provided with a pre-paid phone card
- $20.00 fresh food voucher (reliant on access to fresh food) to get your Adult Health Check done.
- Providing lunches and drinks during health screening groups
- School programs that provide breakfast (incorporate health activities**)**
- Subsidies for groups to accommodate exercise programs as a preventative strategy.
- Men's health checks using the "tune-up" analogy.

In one specific remote Aboriginal and Torres Strait Islander, community, the following programs built patient confidence and literacy and proved to be sustainable:

- One on one sessions especially with patients on insulin –they meet with the Nurse Practitioner and they are provided with education, a diabetic kit and encouraged to visit the clinic weekly for review with staff
- Group days – for example a movie night at the school with a pre movie trailer on Rheumatic heart Disease (RHD) and a supper of healthy food choices
- Special days for women - Makeup demonstrations & hair days. These activities engage with patients and provide an opportunity for health promotion and relationship building
- Cooking days where patients take the meal home to their family or you get to eat it and share the experience.
- Invitations for people to come to the clinic for a review. i.e. when the Cardiologist visits the community, the program manager visits each patient individually to invite them. This builds trust and promotes patient centred care, people feel valued and special. This small step improved compliance rates of prophylactic medication in RHD patients and update of ECHO's

2.7 Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and

Chronic disease management requires a collaborative approach, which incorporates multi-disciplinary teams of health care professionals engaging with the community and consumers.

An essential element to chronic disease care is consistent, empowered and robust co-ordination of the care.

In the APY Lands, Nganampa Health Care (NHC) use a Chronic Care Management (CCM) system that and ensures a patient centred plan is used to deliver effective treatment /management, promotes self-managed care and creates effective timely follow-up.

At the "heart" of the CCM are productive patient interactions between an informed empowered patient and a well prepared, proactive team. Productive interactions imply that every encounter is an opportunity to meet patients needs (not just the presenting complaint). It means that every time the health care service and the patient meet, the needs of the patient are addressed.

This clearly requires a well prepared team who are proactive in their approach and knowledgeable in chronic disease management using contemporary guidelines and treatments. A significant apsect of this is a consistent team and a well established relationship with the patients and community.

It is essential that visiting services entering an organisation be not merely seen as "stand alone services" but rather as "part of the team". At NHC the use of program coordinators, are the drivers of the program and an 'expert' to co-ordinate and facilitate the chronic disease program through a collaborative approach. This role ideally suits an Nurse Practitioner or an endorsed RAN.

The benefits of this approach are:

- Improved compliance and patient satisfaction
- Improved health outcomes
- Improved follow-up
- Improved staff satisfaction

Use of telehealth and remote diagnostics such as Point of Care (POC) testing are essential to on the ground services. This does not replace face-to-face care but does compliment it and prevent unnecessary travel / costs for consumers

2.8 Models of chronic disease prevention and management in primary health care, which improve outcomes for high end frequent users of medical and health services.

There are many examples in remote health settings where nurse led models of care exist and continue to evolve to meet the changing needs of their community.

Remote PHC centres are predominantly staffed by permanent RAN's and Aboriginal and Torres Strait Islander Health Practitioners and Health Workers with support of visiting Medical Officers and Allied health Services. These Nurse/ HW led models of care utilise evidence based guidelines such as CARPA and the Primary Clinical care Manual (PCCM) along with formularies and protocols to deliver best practice care. This model is not nationally consistent due in part to a lack of standardization between State and Territory Legislation (Drugs & Poisons) and inconsistent Health Service policy.

A "Getting better at chronic care in North Queensland" [4] program was a trial utilising the community based health worker as lead case managers. This program produced favorable results demonstrating significant and favorable impacts on some diabetes control, however researchers believe a longer-term evaluation is required to create robust evidence to drive future reform.

[4] McDermott et al. BMC Health Services Research **(2015) 15:68** ,*Community health workers improve diabetes carein remote Australian Indigenous communities: results of a pragmatic cluster randomized controlled trial*

Health promotion is an underfunded, under-resourced but extremely important aspect of chronic disease prevention. Large long-term national public health campaigns focusing on the National priorities should be delivered. Resources should be expended on campaigns that target the young, health literacy, CALD peoples and other marginalized groups as a priority

CRANAplus improving remote health

Appendix 1.

A Framework for Remote and Isolated Professional Practice

Authors:

Christopher Cliffe

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Revised August 2014

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INTRODUCTION

CRANA*plus* is the peak professional body for remote and isolated health, providing advice to Government, service providers, clinicians, and consumers on equitable access to safe, high quality health care.

CRANA*plus* believes it is imperative to have nationally consistent standards of practice for remote health service delivery to improve health outcomes for those living and working in remote areas, and such as, has developed A Framework for Remote and isolated Practice, underpinned by safe and quality care principles.

FRAMEWORK FOR REMOTE AND ISOLATED PROFESSIONAL PRACTICE

The framework consists of five elements which are aimed at all health professionals providing care in the community, based upon 'fly-in fly-out' (fIfo), 'drive-in, drive out' (dido) mining and all other settings.

FRAMEWORK FOR REMOTE and ISOLATED PROFESSIONAL PRACTICE

- Definition of remote and isolated areas
- Describing remote practice
- Characteristics of remote health services
- Pathway for Remote Practice for Nurses/Midwives
- Validating remote professional practice

DEFINITION OF REMOTE AND ISOLATED AREAS

CRANA*plus* defines remoteness as a complex subjective state, the causal factors of which are:

- geography and terrain limiting access and egress
- being socially and culturally isolated
- environmental and weather conditions resulting in isolation
- isolation due to distances
- being isolated from professional peers and supports
- isolation as a result of infrastructure, communications & resources

We believe no one remoteness classification system can adequately cover the complexity in which our members practice.

Discussion

Defining remote areas has traditionally been based on Commonwealth Government categories of remoteness, using a range of classifications:

- RRMA (Rural, Remote and Metropolitan Areas) classification
- ARIA (Accessibility/Remoteness Index of Australia) classification (based on ARIA index values)
- ASGC (Australian Standard Geographical Classification) Remoteness Areas (based on ARIA+ index values—an enhanced version of the ARIA index values).

The current classification system used by Department of Health is the ASGC-RA system: based on road distance from a locality to the closest service centre in each of five classes of population size.

Areas are classified as:

- RA1 - Major Cities of Australia
- RA2 - Inner Regional Australia
- RA3 - Outer Regional Australia
- RA4 - Remote Australia
- RA5 - Very Remote Australia[1]

In general, when inner regional and outer regional are taken together we use the term **regional**. When remote and very remote areas are taken together we use the term **remote**.

The use of geographical classifications in reference to remote and isolated health care is of limited value. This relatively singular interpretation of 'remoteness' fails to take into consideration other factors that impact on the access to and availability of quality health services in any given community.

CRANA*plus* **believes the following factors need to be considered:**

- **Geography and terrain limiting access and egress:** mountainous terrains and islands can result in isolation from resources and limit access but still be within an area designated through the classification system as non remote e.g. Bruny Island (TAS)
- **Being socially and culturally isolated:** where living and working in a cultural different to your own / or where social networks are limited or different to your usual supports and networks.
- **Environmental and weather conditions resulting in isolation:** natural disasters such as flooding or inclement weather like snow and storms, result of other natural disasters
- **Isolation** due to vast distances, distance and the time to access services can vary due to the mode of transport or the quality of the roads.
- **Setting for practice:** such as operating in the aeromedical environment where altitude is the isolation factor along with limited resources, or where security procedures is an isolating factor e.g. prisons
- **Being isolated from professional peers and supports,** this includes health professionals working in non health organizations e.g. detention centres, tourism, mining, industry
- **Isolation as a result of infrastructure, communications, security processes that limit access** e.g. Defense forces, International development (AID workers). Unreliability of communication systems and referral pathways.

[1] Department of Health: Doctor Connect: *Australian Standard Geographical Classification: Remoteness Area (ASGC- RA*): Australian Government website: http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/ra-intro

DESCRIBING REMOTE PRACTICE

The Setting

Remote health professionals work in a variety of setting as described in CRANA*plus'* definition of Remoteness.

Remote health professionals are an integral part of the health care system in Australia. Remoteness, in and of itself, is a social determinant of health.

Remote and isolated practice areas present particular challenges to the delivery of quality services, including:

- dispersed population,
- poor health status,
- diverse cultures
- social erosion
- geographic isolation,
- problematic transport,
- poor infrastructure,
- small economic base, poverty, high unemployment
- limited political influence,
- harsh extremes of climate and
- high turnover of workforce across all disciplines
- limited opportunities for private models of health care

Remote health professionals are employed in a range of settings including, but not limited to:

- State and Territory Government health services
- Community controlled health services
- Aboriginal Medical Services
- Primary Health Care Services / Clinics
- Multi-purpose centres
- Private general practices
- Mining and other industries
- Mobile and fly-in fly-out (fifo) services
- Private and Non Government Organisation (NGO) health providers

It is widely acknowledged that the remote and Indigenous populations of Australia have a higher burden of diseases and subsequent reduced life expectancy, yet poorer access to equitable health services compared to the rest of the Australian population.

The Workforce

There is limited data currently available around the remote and isolated health workforce in Australia that accurately reflects the numbers, vacancy rates, characteristics and settings/facilities in which they work. In a series of papers by Lenthall, et al (2011)[2] the characteristics of the nursing workforce in remote has been described. The data available reflects that remote Australia has a disproportionately lower number of health professionals per head of population, in comparison to urban and rural Australia.

This mal-distribution is across all health professional groups and whilst nurses are the most evenly distributed across all geographical areas and comprises 50 % of total workforce; their numbers and those of midwives are decreasing in remote areas. Remote health workforce, work longer hours, and are older comparative to the urban workforce.

[2] Lenthall S, Wakerman J, Opie T, Dunn S, MacLeod M, Dollard M, Rickard G, Knight S: (2011). Nursing workforce in very remote Australia: characteristics and key issues: *Australian Journal of Rural Health* 19(1): 32-37.

The remote communities are becoming increasingly reliant on overseas trained professionals, short-term placements and fly in fly out services.[3]

Remote health professionals are typically 'hard-working', flexible, adaptable, resourceful and passionate about their work. Their practice encompasses all of the challenges, and the considerable rewards, of this unique and specialised field of healthcare.

Remote health professionals are guided by 'health' as being a whole-of-life concept, encompassing physical, spiritual and emotional well-being of individuals, family, community and the environment.

Remote health professionals in accordance with their scope of practice, are specialist practitioners who provide and/or coordinate a diverse range of health care services for the entire population.

Scope of Practice

CRANA*plus* supports the following definition of Scope of Practice:

> *A profession's scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorized to perform.*
>
> *The scope of professional practice is set by legislation — professional standards such as competency standards, codes of ethics, conduct &practice and public need, demand and expectation. It may therefore be broader than that of any individual within the profession.*
>
> *The actual scope of an individual's practice is influenced by the*
> - *context in which they practice*
> - *consumers' health needs*
> - *level of competence,*
> - *education, qualifications and experience of the individual*
> - *service provider's policy, quality and risk management framework, and*
> - *organisational culture.*[4]

[3] AIHW (2010c) *More doctors and nurses, but supply varies across regional and rural areas.* Media release October 2010. Website accessed June 2012 URL: http://www.aihw.gov.au/media-release-detail/?id=6442464894 .

[4] Australian Nursing and Midwifery Council: National framework for the development of decision-making tools for nursing and midwifery practice, September 2007.

CHARACTERISTICS OF REMOTE HEALTH SERVICES

CRANA*plus* identifies two key principles, which are essential for a robust, safe and sustainable remote and isolated health service:

- **Comprehensive primary health care model of care**
- **Robust remote clinical governance framework.**

CRANA*plus* supports the following definition of Primary Health Care:

> *Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximizes community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation[5].*

CRANA*plus* supports the following definition of Clinical Governance:

> *The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimizing risks to consumers, and for continuously monitoring and improving the quality of clinical care[6].*

Staffing

CRANA*plus* supports the concept of minimum ratios of staffing in remote PHC services, taking in to consideration the population, size of the community, remoteness from other significant health services and the ill-health burden experienced by its population.

Standard of Health Service Staff[7] to Population Ratios by Community Size.

Pop range	AHW's	Nurses	Doctors
>3,000	1:350 (9)	1:500 (6)	1:1,000 (3)
1,300 – 2,999	1:250 (5 – 9)	1:450 (3-6)	1:1,000 (1.5 – 3)
800 – 1,299	1:200 (4- 6)	1:300 (2.5 – 4.5)	1:800 (1 – 1.5)
400 -799	1:100 (4- 8)	1:200 (2- 4)	1:600 (1)
250-399	1:75 (3.5 – 5.5)	1:200 (1.5 – 2)	1:400 (1)
75 - 249	1:75 (1 – 3.5)	1:150 (1 – 2)	1:400 (0.5)
<75	1:50 (1.25)	1:150 (1)	1:400 (0.5)

(Numbers in brackets estimated number) Table 1

Table 1: Standard of Health Service Staff to Population Ratios by Community Size (p7), uses the basic staff to population ratios of AHW 1:50, Nurses 1:200 & Doctors 1:400 and modifies according to size of communities, whereby

[5] Australian Primary Health Care Research Institute (APHCRI)
[6] Australian Council on Healthcare Standards, (2004) ACHS News Vol. 12 1-2 Sydney.
[7] Bartlett B,,Duncan P : Top End Aboriginal Health Planning Study*: Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum.* April 2000, PLANHEALTH Pty Ltd, NSW.

in larger communities, economies of scale and access to other human services (health & otherwise) means that fewer numbers can be effective as opposed to the smaller communities with smaller population numbers

In addition to this narrow mix of health care providers, CRANA*plus* highlights the need for inclusion of a system to ensure access to Midwives, Oral Health Professionals, Nurse Practitioners, Allied Health Professionals, mental health workers and Specialists medical services in any model.

Remoteness and Isolated Practice within a Health Context[8]

The definition below provides a succinct summary of the characteristics, different settings and models of care, differentiating remote workforce practice from rural and urban workforce practices.

Remote Health practice in Australia is characterised by geographical, professional, and often social **isolation** of practitioners through:

- geography and terrain, limiting access and egress
- cultural and social isolation
- environmental and weather conditions resulting in isolation
- isolation due to long distances
- professional isolation from colleagues, peers, and supports
- isolation as a result of infrastructure, communications and resources.

Remote Health is carried out in **contextually different settings**, including but not limited to: government health services; community controlled health services; aboriginal medical services; primary health care centres; multi-purpose centres; private general practices; mining; and other industries like tourism; mobile and fly-in/fly-out services; as well as private, and non-government organisation health services.

Remote Health practice is **delivered through**:

- health service models catering for highly mobile populations
- predominantly Nurse-led models of care
- collaborative multidisciplinary approaches, in partnership with community and stakeholders
- an understanding of the community within its cultural context
- overlapping, and evolving advanced and extended roles of team members
- integrated comprehensive primary health care approach, inclusive of acute and emergency care, chronic disease and public health across the life span
- scopes of practice that are informed by the identified needs of, and engagement with the community.

[8] CRANA*plus* 2013: Adapted from Wakerman J: Defining Remote Health: Australian Journal of Rural Health, 210–214: (2004) and Malone G, Cliffe C: Framework for Remote Practice: CRANAplus (2012, Jan 4) This definition is the work undertaken by the National Standards Advisory Group (2013).

PATHWAY TO REMOTE PRACTICE FOR NURSES/MIDWIVES

CRANA*plus* believes that Nurses and Midwives who work in remote and isolated practice need a generalist approach using a broad scope of practice, to address the diverse needs of their entire community.

A Remote Area Nurse/Midwife is defined as *a registered nurse whose day-to-day scope of practice encompasses broad aspects of Primary Health Care and requires a generalist approach. This practice most often occurs in an isolated or geographically remote location. The RAN/M is responsible, in collaboration with others, for the continuous, coordinated and comprehensive health care for individuals and their community*[9].

Remote area Nurses and Midwives have varying career backgrounds. There are some professional pathways that will prepare individuals for working in remote, isolated and resource poor environments, such as:

- Emergency care
- pre-hospital care and/or in a critical care area.
- Rural and regional health settings
- Community nursing roles or Practice nursing

New graduates may enter the remote health workforce through a dedicated graduate program that has a specific focus on preparing for a rural and remote context.

Each remote health role will differ, depending on the unique needs of each community. Specific roles and extended scope of practice may require preparation in:

- Maternal and Child Health
- Mental Health
- Women's and Men's health
- Community Capacity Building / Health promotion
- Chronic disease management
- Emergency care
- Workplace Health & Safety

To maintain competence in the workplace requires nurses/midwives to embrace the concept of 'life long learning' to gain the necessary knowledge, skills, attitudes and behaviors to meet their obligation to provide ethical, effective, safe and competent practice. [10]

> *Continuing professional development (CPD) is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.* [11]

CPD activities may be informal and formal, broad and varied to maintain competence in the workplace. Possible examples may include, but not limited to:

- Post graduate Education
- Short courses
- Conferences

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[9] CRANA*plus* 2013*:* Adapted from Sabina Knights definition of Remote Area Nurse (1993). This definition was the work undertaken by the CRANA*plus* Credentialing Pilot Project Advisory Group (2012-13).

[10] Nursing and Midwifery Board of Australia: Frequently Asked Questions: *Continuing professional development for nurses and midwives:* Updated May 2014: accessed 4 July 2014
website: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx

[11] Nursing and Midwifery Board: Continuing Professional Development: Registration Standard (2010) (p1): Accessed 8 July 2014
website: http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

- Webinars
- Forums
- journal club
- mandatory workplace activities – cardio pulmonary resuscitation, fire training

Continuing professional development activities must have relevance to the individual' scope of practice with clear aims and objectives that meet the individual's self assessed requirements. [12]

Minimum CPD required for annual renew of registration by NMBA[13]

Type of Registration	Minimum Hours	Total Hours
Registered nurse or Enrolled nurse	20 hours	20 hours
Midwife	20 hours	20 hours
Registration as a registered nurse and midwife	Registered nurse – 20 hours Midwife – 20 hours	40 hours
Registration as an enrolled nurse and midwife	Enrolled nurse – 20 hours Midwife – 20 hours	40 hours
Nurse practitioner (Registered nurse with endorsement)	Registered nurse – 20 hours Nurse practitioner endorsement – 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Midwife practitioner (Midwife with endorsement)	Midwife – 20 hours Endorsement – 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Registered nurse with scheduled medicines endorsement (rural and remote)	Registered nurse – 20 hours Scheduled medicines -10 hours	30 hours
Eligible midwife (Midwife with notation)	Midwife – 20 hours Notation – 20 hours relevant to the context of practice and across the continuum of midwifery care	40 hours
Endorsed eligible midwife (scheduled medicines) (Eligible midwife with endorsement)	Midwife - 20 hours Endorsement –20 hours (e.g.10 hours relating to continuum of midwifery care and 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral).	40 hours
Registration as a nurse and endorsed eligible midwife	Registered nurse – 20 hours/Enrolled nurse – 20 hours Midwife – 20 hours Eligible midwife with a scheduled medicines endorsement – an additional 20 hours (e.g.10 hours relating to continuum of midwifery care and 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral).	40 hours

Topics relevant to remote and isolated practice

[12] Nursing and Midwifery Board of Australia: Frequently Asked Questions: *Continuing professional development for nurses and midwives:* Updated May 2014: accessed 4 July 2014
website: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx

[13] Ibid p3.

The Topics relevant to remote practice may include, but not limited to:

- Cultural Safety
- Emergency Care
- Primary Health Care
- Immunisation
- Pharmacology (Endorsement for scheduled medicines)
- Chronic disease courses i.e. Diabetes, Asthma, Renal
- Workplace Health & safety

Postgraduate education or qualifications are beneficial for remote and isolated practice. Courses, which are more relevant to the remote context include:

- Remote / rural health practice
- Public health
- Primary health care
- Health promotion
- Critical care (Emergency care)

CRANA*plus* recommends all nurses and midwives working in remote and isolated health services, be provided the opportunity to undertake a comprehensive introductory and orientation program(s).

**Recommended courses that can be undertaken pre- employment or within the first year:

- Remote Emergency Care (REC) or equivalent**
- Advanced Life Support (ALS) **
- Pharmacotherapeutics for RAN/M's**
- Non Midwives: Maternal emergency care (MEC) or equivalent**
- Midwives: Midwifery up skilling (MIDUS) or equivalent**
- Immunisation**
- Driver education courses 4x4**
- Cultural education**
- Annual Core Mandatory competencies – through eRemote or equivalent
  - Fire & Evacuation
  - Manual Handling
  - Drug Calculation
  - Basic Life support

The frequency of re-certification will be dependent upon health service requirements, personal CPD needs and professional recommendations.

It is important to note:

- ALS generally needs to be updated / re-certified every year, this is dependent upon the provider's recommendations.
- Emergency courses i.e. REC and MEC to be undertaken with a maximum interval of 2 years, to maintain competence.
- Jurisdictional or employer specific requirements, such as:
  - Queensland Health, Remote and Isolated Practice Registered Nurse (RIPRN) Course
  - Northern Territory, Department of Health, prerequisites for Remote Health nursing/midwifery employment.

VALIDATING REMOTE PROFESSIONAL PRACTICE

CRANA*plus* undertook a Credentialing Pilot Project for Nurses/Midwives (2012-2013) with the intent of informing the implementation of a sustainable CRANAplus Credentialing program. Whilst the project was relatively small in numbers and did not eventuate in the adoption of a formal credentialing program, there were several positive outcomes arising from this project. Specifically, the development of the Professional Standards of Remote Practice: Nursing and Midwifery.

The purpose of credentialing is to assure professionals and the public that the individual nurse has achieved agreed levels of practice and experience, has recency of practice in the specialty/area of nursing practice, and has met agreed levels of education and continuing professional development requirements[14].

Overall Outcomes of the Credentialing Pilot Program (2012-2013)

- The development of a professional initiative that will become CRANA*plus* policy on remote area workforce development and quality health care for the remote community.
- Confirmation of the professional standards for remote practice.
- The development of tools to support a future program
- A central and consistent source of communication about the credentialing program, as well as support for participants.
- The development of policy and processes associated with the program.

Move from Credentialing to Validating Program

Whilst not pursuing a 'formal credentialing program', we believe it is important to pursue a process for recognition of individual registered nurse/midwife who meets the Professionals Standards of Remote Practice that **validates** their status as an Advanced Practice RAN/Ms.

CRANA*plus* believes the benefits of validating include:

- **The setting of clear nationally consistent standards for remote health practice, to promote safety and quality in practice.**
- **The provision of a workforce benchmark for Governments, employers, and education providers**
- **Clarity around the career pathway for RAN/M's**
- **Recognition by the profession and health industry as specialist area of nursing**
- **Recognition of Advanced Practice RAN/Ms by their colleagues and the profession as clinical leaders of remote and isolated nursing/midwifery practice**

A peer review process, coordinated by CRANA*plus*, will be undertaken for the assessment of a registered nurse/midwife professional portfolio, inclusive of the nine 'Professional Standards of Remote Practice'. The nine Professional Standards each with set criteria necessitates the individual to show demonstrated evidence as to how they have met the criteria requirements.

This process is voluntary for the individual. An individual registered nurse/midwife may choose or be nominated to undertake the assessment against the Professional Standards. For the recognition and acknowledgement of their practice and validation of their status of Advance Practice Remote Area Nurse. CRANAplus will invite the individual to be a Fellow of CRANA*plus*.

[14] Coalition of National Nursing Organizations, Project to Develop a National Nurse Credentialing Framework, (May 2011): Accessed 7 July 2014: website: http://www.conno.org.au/images/stories/PDF/Meetings/Aug11/conno_credentialling_framework_final.pdf

CRANA*plus* has an Application Package, which sets out the requirements to meet the criteria of the Professional Standards. A volunteer peer review panel consists of remote nursing/midwifery professional experts will assess the evidence provided.

Professional Standards of Remote Practice

In 2013 the 'Professional Standards of Remote Practice: Nursing and Midwifery' was endorsed by **CRANA*plus*** as a National Standard. The Professional Standards were then, revised by the Pathway to Remote Practice Advisory Group (June 2014) to reflect contemporaneous remote and isolated nursing/ midwifery practices.

Standard 1
Has appropriate registration and endorsements for practice and works in accordance with the Professional Standards for the Nurse/Midwife (NMBA).

Standard 2
Maintains own health, wellbeing and resilience within a professional, safe working environment.

Standard 3
Practices within a culturally respectful framework

Standard 4
Practices within a Comprehensive Primary Health Care model of service delivery

Standard 5
Works within care pathways, and develops networks of collaborative practice.

Standard 6
Has a level of clinical knowledge and skills to safely undertake the role.

Standard7
Has a period of recent clinical practice in a remote and isolated location within the past 5 years.

Standard 8
Has an ongoing commitment to education relevant to practice in the remote environment.

Standard 9
Practices within a Safety and Quality Framework.

The professional standards are available on CRANAplus website

Version Control	Date	Summary
Original document	June 2012	Authors: Geri Malone, National Coordinator of Professional Services, CRANA*plus* Christopher Cliffe, President of Board of Directors CRANA*plus*
Reviewed V2	February 2013	Updated
Revised V3	September 2013	Inclusion of Credentialing for Nurses and Midwives and Professional Standards of Remote Practice: Nursing and Midwifery
Revised V4	August 2014	Whole document

Appendix 2.

ISSUES PAPER

A shift in practice: Improving access to health assessments across the remote & isolated health sector.

This Issue Paper proposes the need for a shift in remote health practices as a consequence of ongoing challenges and lack of success in the access and uptake of Child and Adult Health Assessments, and the subsequent link to poorer health outcomes. As a response to this challenge, consideration needs to be given to a change to current practices within the existing service arrangements. Thus enabling Remote Area Nurses (RANs) access to the Medical Benefits Scheme (MBS) as part of the exemptions under s19(2) of the Health Insurance Act 1973.

The model of primary health care in remote and isolated communities differs from urban and regional general primary care practices. In urban and regional areas private general practice is the most common form of service delivery. Whilst in remote and isolated areas, medical practitioners are often employed on a 'fly in, fly out' basis, with short-term contracts, resulting in minimal or no time for comprehensive health assessments to be conducted (refer to figure1). Leaving the patients disadvantaged and the resident health workforce (RANs) frustrated.

A change to the exemptions under s19(2) of the Act to enable RANs access to selected MBS items, and having an MBS Provider Number for health assessments would create a shift in remote health practice. This would optimize service delivery and contribute to the 'closing the gap' strategy, but would also provide a more efficient use of limited funds for reducing and preventing the burden of future chronic disease within these communities.

The current situation sees many remote clients disadvantaged as a result of a lack of access to the Medicare safety net, due to the control function embedded in only on professional group, the difficult to access Medical workforce. This lack of access to 'Health Assessments' prevents targeted preparation of a GP management plan, and resultant lack of access to MBS subsidised allied health services. The disadvantaged become more disadvantaged, through systems not reflecting the true health workforce arrangements in remote Australia.

Section 19(2) of the Health Insurance Act 1973 (the Act) prohibits the payment of Medicare benefits where other government funding is provided for that service. The '*19(2) exemptions*' Initiative allow exempted eligible sites to claim against the Medicare Benefits Schedule (MBS) for non-admitted, non-referred professional services provided in emergency departments and outpatient clinics.

The Initiative recognises that many patients in small rural and remote towns have limited access to primary health care services and that in response to a lack of private practices,

many rural and remote public hospitals have employed medical officers to make traditional GP services available'.1

At the Committee for Economic Development of Australia (CEDA) Conference held on the 19th February 2014, the then Minister for Health, Mr. Dutton addressed a number of priorities, specifically, his desire to making smarter use of limited funds to provide better care, moving from managing supply to managing demand, and ensuring that those least able to look after themselves are still cared for.2

The Minister for Health's statement sits very comfortably with the remote sector's opinion that consideration be given for changes to the exemptions under s19(2) of the Act. This view is premised on the belief that RANs are predominately the permanent health professional residing within remote communities, are well known and have established relationships with community members. This favorable situation provides for RANs 'on-the-ground' to have the capacity to be opportunistic in managing local health demands including providing comprehensive Child and Adult Health Assessments.

Demographics

Australian Institute of Health and Welfare (AIHW)3 has captured the data that demonstrates the demographic need of Health Assessments (Checks) by using Medicare Local peer groups. Medicare Locals vary considerably in terms of size, remoteness and population characteristics. This makes comparisons between them difficult. To make it easier to compare Medicare Locals fairly, the National Health Performance Authority (NHPA)4 allocated each Medicare Local to one of seven peer groups.

The peer groupings are based on socioeconomic status and remoteness, including the average distance to the closest large capital city and major hospital.

The seven peer groups are:

- Metro 1
- Metro 2
- Metro 3
- Regional 1
- Regional 2
- Rural 1
- Rural 2 – equates to remote and isolated areas

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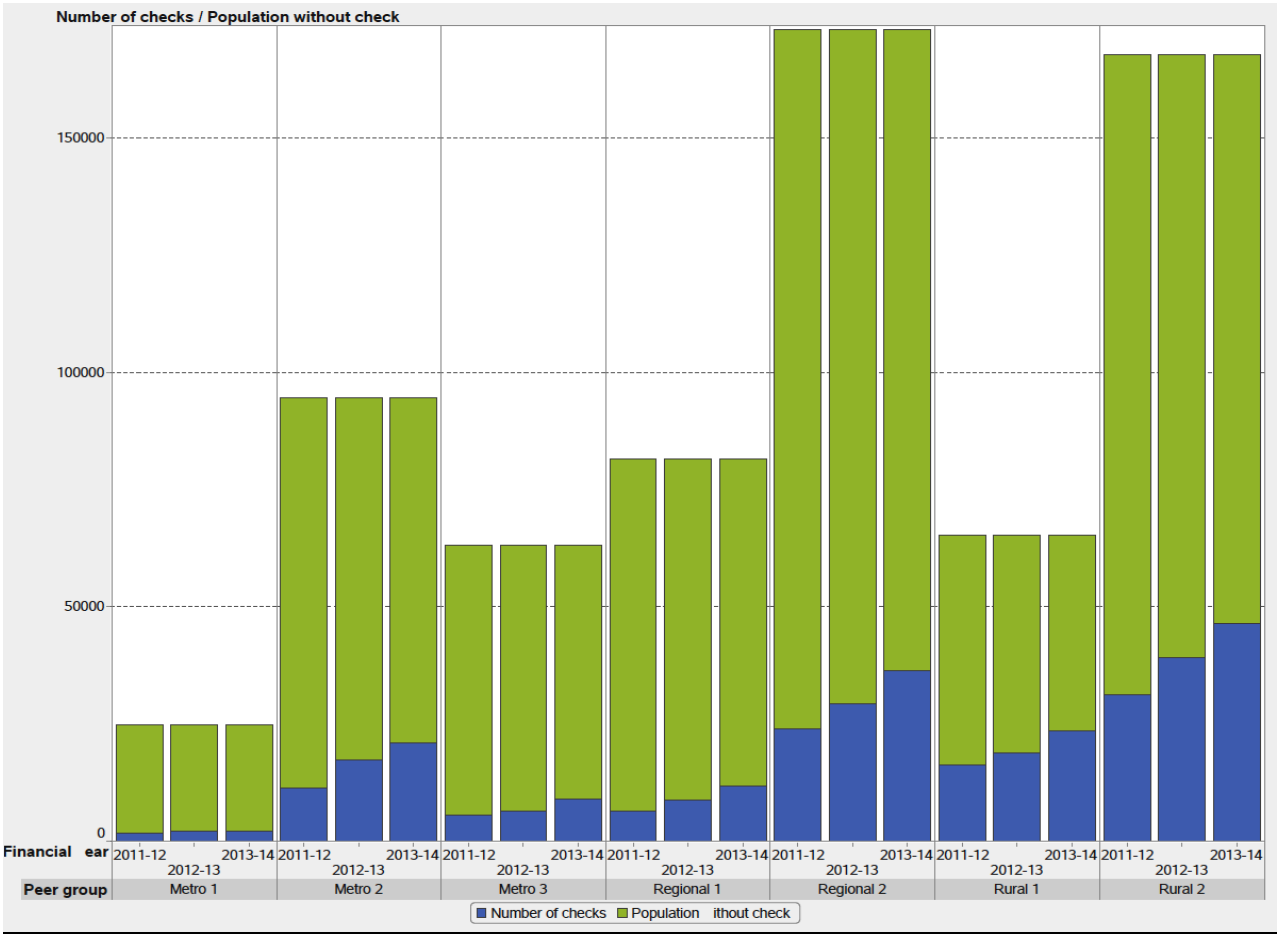
1 Department of Health, Rural and Regional Health, Australian Government, website: http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/COAG_Improving_Access_to_Primary_Care_Services_in_Rural_and_Remote_areas-s19_2_Exemptions_Initiative, accessed 4/2/15

2 The Honorable Peter Dutton MP, Minister for Health, Minister of Sport, Speech: Address to CEDA Conference February 19, 2014, accessed 15 December 2014,
Website: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-dutton001a.htm

3 Australian Institute of Health and Welfare: AIHW Indigenous Health Check data tool, (MBS item no 715) website: http://www.aihw.gov.au/indigenous-australians/indigenous-health-check-data-tool/#t12, accessed 3 February 2015

4 National Health Performance Authority: Healthy Communities, Australian experiences with primary health care in 2010-11, Technical Supplement, accessed 3 February 2015.
website: http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Technical-Supplement-Healthy-Communities-Australians-experiences-with-primary-health-care-in-2010-11

Figure1: Peer Group data by financial year: Number of checks and Indigenous without Checks – (MBS item 715)



Source: AIHW Indigenous Health Check data tool

This graph shows that although the general uptake of Indigenous health checks is poor, remote & isolated areas where the burden of disease is greatest has worse uptake. This is also despite a large amount of effort and financial investment being put into improving medical access to these communities.

Discussion

The MBS defines a Health Assessment as "*…a means that the assessment of a patient's health and physical, psychological and social function and consideration of whether preventive health and education should be offered to the patient, to improve that patient's health and physical, psychological and social function5.*"

MBS item no 715 for health assessment has an exemption under the subsection 19(2) Health Insurance Act 1973; granting Aboriginal Community Control Health Services or State/Territory Government Health Clinics the ability to claim items, for services provided by '*medical practitioners*' salaried by, or contracted to, the Service or health clinic.

[5] Medicare Benefits Schedule – Item 715: Health Assessment for Aboriginal and Torres Strait Islander People (last updated 5 November 2013): Australian Government: Department of Health, accessed 15 December 2014, website: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

CRANAplus asserts that Remote Area Nurses have recognised advanced practice, underpinned by Professional Standards and Primary Health Care models of care, with capabilities and expertise to undertake initial health assessments and follow-up checks as part of the prevention, early detection and intervention of chronic diseases.

To leaver a shift in remote health practice there needs to be changes to MBS items:

- 715 - child, adult and older persons Health Assessments: for Aboriginal and Torres Strait Islander;
- 701, 703, 705, 707 for non Aboriginal people,

By ensuring this the local RANs can undertaking the full process of care for their patients, while making them an affordable additional resource for employers (i.e. an AMS) to meet their health service goals.

Whilst Adult and Child Health Assessments are intended to be used as risk identification they are often used as clinical chronic disease management tool creating a MBS payment for medical practitioners. It is acknowledged that Health Assessments are designed to focus clinicians on the preventable risk factors, thereby reducing or preventing, the burden of future chronic disease.

CRANAplus acknowledges that the exemption under sub-section 19(2) of the Health Insurance Act 1973 allows relevant health services to access the MBS item numbers through a Medical Provider number and then re –invested into the health service, is a positive initiative. However, due to the limited availability and access to medical practitioners in remote areas the proposed changes to allow RANs to access specific MBS Items, would encourage greater uptake of the health assessment process.

The advantages of this change would ensure a quality approach, better utilization of a limited workforce, improved efficiencies of remote health care services, with improved accessibility to initial Health Assessments, improved prevention, early detection and management of Chronic Disease.

The Coroner of the NT, Mr Greg Cavanagh has repeatedly identified the need for more common and uniformed access to health checks to prevent poor outcomes:

"It is simply vital that young Aboriginal people, and men in particular, go to the clinic regularly for a thorough check up which involves cardiac risk assessment as part of as Adult Health Check. Only by doing this will the problem that Mr XXXX had be identified and dealt with." Inquest into death of 28 yr old Aboriginal Man, Gapuwiyak, NT November 2014.

"I recommend that a coordinated strategy be embarked upon by the Department of Health for the purpose of screening of heart disease in young Aboriginal people, especially in remote areas … a proactive approach be taken in this regard and that it extend to the NGO sector … I recommend that the Department of Health engage in a coordinated strategy to educate medical practitioners and nurses in this field to engage in proactive testing and screening…" Inquest into death of 24 yr old Aboriginal Man, Ngukurr, September 2014.

Benefits

A change in the current practices would provide the following benefits:

- Improved health outcomes through:
    - Appropriate use of the Health Assessment to prevent Chronic Disease and apply life style changes / brief interventions by those that are most likely to influence change (residential RAN).
    - Contribute to 'Closing the Gap' strategy by improved access and uptake of Health Assessment by Aboriginal and Torres Strait Islander people.
    - Refocus the provision of service delivery by the resident permanent workforce to address the risk and burden of Chronic Disease.
- Will ensure the availability and accessibility of health assessments to some of the most disadvantaged Australians (Remote, Isolated and Aboriginal Torres Strait Islander (ATSI) communities).

- Improved data collection
    - Improve the 'up load' (with clients approval) to the Personally Controlled Electronic Health Record (PCEHR) as a requirement of the Health Assessment and MBS, will quickly generate a critical mass of data, into this national initiative, for some of the most hard to reach, yet most able to benefit parts of the Australian community.

- Improved revenue and reinvestment in local health services
    - Cost effectiveness of this approach in comparison to the current method would provide:
        - Better use of the limited health workforce in remote and isolated areas
        - Visiting medical workforce to be utilised in a more focused way
        - MBS item for Nurse-led health assessment item to be possibly less payment than that for a medically generated item payment.
        - Will facilitate a broader capacity (cost benefit analysis) for different models of remote healthcare to be provided by for examples, Private Primary Care providers, Aboriginal Medical Services, Remote located businesses - such as mines, tourism, and local councils.

- Improved utilisation of workforce
    - A recognised extension and enhancement of the current RAN practice enabling them to work to their full scope of practice.
    - Better use of the entire workforce and facilitates access to very small isolated communities where the community numbers prevent them from having regular access to a regular visiting medical practitioner, but are consistently serviced by RANs.

Skill Development

CRANAplus the peak professional body for remote health, as a Registered Training Organisation and experienced education provider for the remote and isolated workforce, in partnership would develop and deliver a mixed method short-course, that will provide two functions:

1. Ensure national standardisation and skills development across the RAN workforce
2. Provide a control mechanism for government regarding access to the MBS item via completion of an accredited course.

Conclusions

The shift in Remote Health Practice, refocusing of the remote health workforce, specifically RANs to undertake health assessments is a positive response to the modernisation agenda of Medicare. Thus providing better care, moving from managing supply to managing demand, and ensuring that those least able to look after themselves are still cared for. Therefore, the proposed changes would improve the prevention, early detection and management of Chronic Disease(s).

Recommendations

CRANA advocates that there is urgency in addressing this matter and consideration be given to changes to the exemptions of subsection 19(2) of the Act and recommends that:

- Changes to the current exemption to the legislation to subsection 19(2) to expand the responsibilities from medical practitioner to include 'remote area nurse' under the term 'health practitioner' working in remote and isolated areas across Australia' who have undertaken an accredited course.
- Changes to the Medicare Benefits Scheme to include initial Child and Adult Health Assessments to be undertaken by remote area nurse for the prevention and early detection of chronic diseases.
- Key Improvement targets created to measure the accessibility processes for Child and Adult Health Assessments for very remote and isolated consumers
- CRANAplus be commissioned to develop and deliver an accredited course to qualify remote area nurses/midwives to provide Health Assessments services to remote and isolated communities.

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