

Adult Health Checks: Comprehensive early detection for chronic conditions in Aboriginal people

Making prevention everybody's business

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The Darling River: Home of the Paakantji



Maari Ma Health
Aboriginal Corporation:
Working with our
communities and partners
to overcome past mistrust
and disadvantage

Aim

- The AHC provides an opportunity for local health services to screen clients for chronic conditions in order that the condition can be detected early and managed successfully.
- The local health service also aims to access community members who have not been to the health service for a long time.
- Local Aboriginal Health Workers (and community members) are vital for the success of AHCs.

2 Different Approaches to AHC

- The “big sweep” approach in the smaller communities:
 - Run over 1 – 2 weeks, held in a “suitable” location
- An AHC day each month at the Maari Ma PHC service (in Broken Hill):
 - Target well population; average 12 people per AHC day; has a GP assess all clients; and a dentist present to commence treatment
 - Recruitment – invites, transport, walk ins.

Nature of the Problem

- Maari Ma, local health services (and our partners) are identifying ways to:
 - help people stay well
 - detect and manage chronic health problems
 - provide an opportunity for people to discuss their health concerns
 - check whether people are staying well or if they need referral for treatment or advice (best practice)

Extent of the Problem

- The Adult Health Check evolved from the Well Person's Health Check (WPHC), which was originally developed in Northern Queensland in 1998. The AHC has been run in Menindee, Ivanhoe, Wilcannia, Balranald, Dareton and Broken Hill.
- The AHC includes the HIC's requirements of the 'Aboriginal and Torres Strait Islander Adult Health Check' (MBS item 710) as evidence of best practice.

Covered in the Check

- Oral health examination
- Assessment for
 - smoking
 - alcohol
 - nutrition
 - physical activity
 - social & emotional well-being
- Opportunity for sexual health testing (aged 15 – 30)
 - Chlamydia / Gonorrhoea PCR
- Pathology
 - Fasting blood sugar and lipids
 - Urinalysis
- Physical assessment
 - BP, pulse and rhythm
 - height, weight, BMI
 - waist circumference
 - ear and hearing exam
 - visual acuity
- Opportunity for women's health referral
 - Pap smear
 - Mammogram

Strategic Importance

- AHC is a partnership.
 - Local health service workers
 - Maari Ma Health regional staff
 - GWAHS staff
 - Dentist

- Other key partners are the
 - Royal Flying Doctor Service
 - Local GPs
 - The University Department of Rural Health
 - The community

Chronic Disease Strategy summary table

	Healthy Start	Keeping Well
Prevention	<ul style="list-style-type: none"> ▪ Healthy mothers and babies program ▪ Immunisation ▪ Oral health promotion ▪ School based programs 	<ul style="list-style-type: none"> ▪ Smoking cessation and prevention programs ▪ Physical activity, weight loss and nutrition programs ▪ Brief interventions for lifestyle and risk factors
Early detection	<ul style="list-style-type: none"> ▪ Population list, recall system and standardised antenatal check and follow-up ▪ Population list, recall system and standardised child health check and follow-up 	<ul style="list-style-type: none"> ▪ Population list, recall system and standardised annual adult health check and follow-up
Care	<ul style="list-style-type: none"> ▪ Medical Practitioner clinics ▪ Oral health clinics 	<ul style="list-style-type: none"> ▪ Disease register, recall system and standardised vascular health management protocol ▪ Self management program ▪ Non-government organisation sponsored community support groups ▪ Complication screening services ▪ Medical Practitioner clinics
Health service support		
	<ul style="list-style-type: none"> ▪ Business planning ▪ Supportive information systems (FERRET, standardised medical record forms) 	<ul style="list-style-type: none"> ▪ Staff orientation and training ▪ Data collection, reporting and feedback (ABCD, SDRF, community reports)

Strategic Importance

- Opportunity for this partnership to work together to support individuals, families and communities to protect, promote and maintain health.
- The early detection and ongoing collaborative management of chronic conditions (and S&EWB) is imperative to improving the quality of life of our clients and their families.
- It also provides the remote workforce with important positive outcomes.

Planning and Implementing Solutions

- The AHC targets Aboriginal people aged between 15 – 54 years who are not known to the local health service as having a chronic condition.
- Clients have follow-up arranged.
- For all clients, whether or not a positive test result was detected, appropriate information and/or brief intervention on keeping well is offered.
- A large focus of the AHC is on health promotion and education: SNAP, S&EWB, dentist, physical assessment.

Outcomes and Evaluation

- We found
 - 104 (15%) people had raised blood sugar
 - 379 (53%) had raised cholesterol
 - 126 (18%) had raised blood pressure
 - 90 (14%) had poor kidney health
 - 317 (45%) scored medium or high on a 'mood scale'
 - 367 (52%) people required follow-up dental care.
 - 50 (14%) required this care as a 'high priority'

Outcomes and Evaluation

Indicator	AHC	NSW
Smoking	44%	20%
Current drinkers	74%	
Overweight or obese	66%	50%
Unhealthy waist	75%	
Pap smear in last 2 years	44%	Current NSW: 57% NSW target: 75%
Mammogram in last 2 years	57%	Current NSW: 50% NSW target: 70%

Outcomes and Evaluation

- All people with abnormal results are referred to the RFDS / local GP
- The number of people with diagnosed chronic conditions has increased
 - Significant increase of 15% ($p < 0.001$) as of September 2007

Sustaining Change

- ABCD study has shown that the management of clients with chronic disease has improved
 - ‘Scheduled services delivered’
 - 51% in 2005
 - 58% in 2006
 - 2007 have commenced

Future Scope

- In conjunction with annual auditing the management of people with chronic condition can be monitored and the environment reviewed and adapted in order to improve the quality of life of our clients and their families
- Incorporating self management principles / tools
- Emphasis on social and emotional well-being; alcohol; smoking; data recall and case management
- Structured CD clinics – community access