Watto Purrunna Rheumatic Heart Disease Management CQI Project

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Government of South Australia
SA Health

Acknowledgements

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Watto Purrunna

Aboriginal Primary Health Care Service

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Watto Purrunna

- Three service delivery teams:
  - **Kokotina Tappangga** – Clinic team – Multi-disciplinary
  - **Purrunna Waiingga** – wellbeing and health promotion
  - **Kanggawodli** – sub acute inpatient facility
- Operate from three sites:
  - **Muna Paiendi** (Elizabeth Vale)
  - **Maringga Turtpandi** (Gilles Plains)
  - **Kanggawodli** (Dudley Park)

Watto Purrunna Aboriginal Primary Health Care Service

Who are we?

>Watto Purrunna provides culturally specific primary health care services

>Multi-disciplinary team approach, including Aboriginal Clinical Health Workers

>ACHW, GP, Podiatrist, Nutritionist, Social Worker, RN, Speech pathologist, Occupation Therapist, Diabetic educator Visiting specialists

>Groups programs, Community information and education, Social support

Overview of current RHD patients

- 16 Current RHD patients
- 2 severe (priority 1)
- 3 moderate (priority 2)
- 11 mild (priority 3)
- 7 patients receiving regular penicillin prophylaxis

Why did we do the CQI Project?

Describe how the decision was made to do the CQI project…

- Acknowledge Mark and Teresa
- RHD wasn't a priority for the organisation
- Low awareness about what RHD is
- Patients weren't being managed according to the RHD guidelines

Evidence of a problem (2012)

- Recommended services received
  - 14% of clients had evidence of a dental check within 2 years
  - 14% had a record of having an echo within 3 years
  - 28% had a record of seeing a cardiologist within 2 years
  - 57% had an influenza vaccination in the last 12 months
- Medical information missing
  - 14% had a priority classification document
  - 0% were on the RHD Register (new to SA)

What did we do?

- Aim: Improve staff knowledge of ARF/RHD

Strategies:

- RHD Coordinator deliver training to staff
- Clinic team to complete training package
- RHD guidelines made available in all clinics and online

What we did Cont'd

- Aim: Provide more accurate and timely recall of our RHD/ARF clients

Strategies:

- Develop standard recall for our clinical software
- Get codes approved by MD working group
- Ensure every RHD client has a priority classification

What we did cont'd

- Aim: Further investigate barriers from a clients to follow-up care of RHD.

Strategies:

- Interview with RHD clients to get an understanding of the barriers from their perspective

What we did cont'd

- Aim: Increase the clients understanding of ARF/RHD and the recommended management

Strategies:

- Make current educational materials available to client with RHD
- Hold information session at service for RHD client

Implementing care plans and recalls

- Making sure that people had a priority classification
  - Send them to the cardiologist
- Making sure recalls were set
- 6 monthly program reviews to check recalls and follow-up

Barriers

- Difficulties in getting to see the specialist (Transport etc)
- People moving between Adelaide and home communities
- Knowledge about why they need to have injections or see a specialists
- *(Examples: Ray, Brent, Mark, Natasha)*

Education

- Education for staff
- Education for patients

Why are we better now (2014)?

- Confident that new clients will be identified, the process for recalls and follow-up will be implemented
- Skilled ACHWs
- RHD co-ordinator
- Organisation: core business

How can you help each other?

- Clear recommendations following guidelines
- Ensuring patients have a priority classification
- Good communication between all health providers

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