Study Newsletter

Improving Secondary Prophylaxis for Rheumatic Heart Disease

Issue 3
April 2015

Self-management support is “on the map” in NT health care

Have you read the NT Chronic Conditions Self-Management Framework 2012 - 2020? Although clinicians are very busy, it is a worthwhile read. This framework guides health professionals with self-management support (SMS) i.e., empowering patients to be active in their own health care. It can help you develop this focus in your health care activities. Rheumatic Heart Disease (RHD) is one of 7 conditions being focused on for prevention in the NT, and we all have a part to play in achieving these goals any time we have contact with a patient.

The Self-Management Framework recognises that supporting self-management is challenging in remote Aboriginal communities for a range of reasons. In our study we have found that not many health professionals have integrated self-management support concepts into their activities. One of the aims of our project is to find out just what it means to support Acute Rheumatic Fever (ARF) and RHD patients who are on the long term Bicillin injection regimen. We have found that patients and their families are very keen to work together with clinics once they realise just how long the treatment needs to go for. This has led to requests for calendars and other tools to help them plan for the injections in their specific life routines, and a desire to hear ‘the full story’.

In two of our study sites, some clinicians are trialing SMS partnerships with young Aboriginal ARF & RHD patients who are on Bicillin. Another site is working on an electronic self-tracking/reminder system for patients on Bicillin. As described in the Framework, remote community clinicians need to understand how Aboriginal patients’ preferences, values and culture impact on their health and health seeking behaviour. By having the ‘person-centred view’ in this small trial, we hope to discover more about how to support our patients on the Bicillin regimen.

Link to: NT Chronic Conditions Self-Management Framework 2012-2020

Did you know?

More than 46% of RHD SP patients in the NT received over 80% of their needles in 2014.

This is a big improvement from 2013 when 32% of patients received over 80%.

(Data NT RHD Register)

Welcome to the third newsletter from the Improving Secondary Prophylaxis (SP) for Rheumatic Heart Disease (RHD) research project. In our quarterly newsletter we share stories from participating health centres: What works in their community, how they are improving their processes for RHD care, and how the project is supporting their work.

What is the project about?

Our project is titled ‘Improving delivery of Secondary Prophylaxis for Rheumatic Heart Disease.’ The aim of our study is to assist health centres to maximise efforts to deliver Secondary Prophylaxis.

What do we do?

We are implementing a package of activities to optimise clinical care and quality improvement in NT health centres to increase adherence to SP.

Our project team visits each participating clinic 2-3 times during the beginning of the project to learn about SP processes. Together with clinic staff we develop a tailored Action Plan which includes a variety of activities, all designed to improve SP delivery. We then visit each clinic monthly for 15 months, to support the staff to implement their Action Plan.

What is our goal?

If successful, the activity package we are testing could be used by health centres across the NT and beyond - which would hopefully see significant reductions in Acute Rheumatic Fever recurrence rates and severity, and prevalence of RHD.

Who do we work with?

We are working with ten health centres across the NT, in collaboration with the NT RHD Control Program, RHD Australia and other stakeholders.

Participating Health Services

Anyinginyi Health AC
Danila Dilba Health Service
Gunbalanya Health Centre
Julanimawu Health Centre
Laynhapuy Health
Maningrida Health Centre
Pintupi Homelands Health Service AC
Wurli-Wurlinjang Health Service
Yirrkala Health Centre
Yuendumu Health Centre

Partners & Affiliations

Telethon Kids Institute
NT Department of Health
University of Sydney
Baker IDI
RHD Australia

Administering Institution

University of Western Australia

Secondary Prophylaxis Action items

In our last newsletter we highlighted some action items that are being trialled at participating health centres. Your feedback and interest was very positive, and inspired us to share more of the activities that health centre staff are working on to improve SP.

- **RHD Australia online modules for health workers and clinicians**
  Several clinics have added these modules to the mandatory education schedule for staff.

- **Cooperating with the local school**
  Having an agreement between the health centre and the local school has been effective for some health centres. Once consent is received from the parents, children can receive Bicillin injections at the school.

- **RHD Working Group**
  Danila Dilba Health Service has successfully established a RHD working group, comprised of clinicians, Aboriginal Health Practitioners and relevant staff involved in RHD. The aim of the group's monthly meetings is to collaboratively improve RHD care coordination within the health centre.

- **Trialing reminder systems**
  Across our participating health centres staff are testing various reminder cards - in language or in English, generic or specifically designed for the community. Staff are also sending SMS reminders, setting alerts in patients' phones, and providing wall calendars to patients.

NT RHD Register and Control Program

Our project team works very closely with staff at the NT RHD Control Program. The RHD Control Program plays a key role in the prevention of ARF and ongoing management of patients who have had ARF or currently have RHD. The RHD Control Program aims to reduce recurrences of ARF and ease the burden of RHD amongst the people of the NT. Control Program staff also manage the NT RHD Register. This is a confidential database that collects information on people with ARF and RHD. Health Centre staff (e.g. RHD Coordinators) can request access to this database. This can assist in the planning and monitoring of the clinic's RHD care.

RHD SP Project Officer Sagen and RHD Coordinator David from the Yuendumu Health Centre reviewing the clinic's patients on the NT RHD Register.

Did you know?

4-weekly LAB injections = 13 needles per year
3-weekly LAB injections = 17 needles per year

Q & A with RHD Coordinator: Kathryn

1. What is your role at Pintupi Homelands Health Centre?
   I am a Remote Area Nurse and RHD Coordinator.
2. How long have you been working with RHD SP Clients?
   I have been working with RHD SP clients for 6 months. This is the first time I have worked with RHD SP clients.
3. What do you think is most important in the care for RHD SP clients?
   I think that regular attendance to the clinic and timely follow-up by clinic staff are very important when caring for clients receiving LABs for RHD.
4. What changes has your health centre made to RHD SP care since working with the project?
   I have been focusing on doing more active individual adherence promotion by going out into the community and reminding RHD SP clients when they are due for their next LAB, and reinforcing education for both staff at the clinic and clients.
5. If you could give colleagues at other health centres one bit of advice in regards to RHD SP what would that be?
   I think it is important to focus on individual relationships. I am trying to build the foundation of trust with clients and to encourage them to take ownership of their health issues and ongoing care.

RHD Coordinator Kathryn (left) and colleague Dafna

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