Access to specialist services by refugees in Victoria

A report prepared for the Department of Human Services by the Victorian Refugee Health Network

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Acknowledgments

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- Leigh Rhode – Director Community and Integrated Care, Goulburn Valley Health
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This report was written by project consultant, Maree Kulkens in consultation with the project advisory group.
July 2009

Disclaimer

The information in this report is based on the information available at the time of its preparation. The writer accepts no responsibility for any errors resulting from unforseen inaccuracies.
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Executive Summary

Background
People of refugee background are recognised as one of the most disadvantaged groups in Australia. Under it’s Humanitarian program, Australia accepts some 13,000 refugees each year, of these, approximately 30% settle in Victoria. Newly arrived refugees are reported to have higher rates of long term physical and psychological problems when compared to other migrants. These issues often require specialist and sometimes multiple investigations and referral at a time when people are often least equipped to negotiate complex service systems.

This project was undertaken to explore existing care pathways for refugees requiring specialist health services in Victoria. It also sought to provide service delivery model options to inform departmental and service provider planning decisions.

This project contained the following elements:

- Review of Department of Human Services key policy and planning documents
- Review of the relevant international and national literature
- Examination of available health data, and
- Consultation with key stakeholders from elected refugee settlement areas.

Key findings
This project identified significant variance in health service response, capacity and frameworks across Victoria for refugee populations. Areas with more established history of refugee settlement typically evidenced greater coordination, better targeted and accessible services. Those areas with more recent refugee settlement were found to require further development to create services which were more accessible and responsive to the particular needs of refugees.

The critical nature of partnerships between specialists and primary care providers was a recurrent theme throughout this project. The development of robust referral and communication protocols were echoed in the policy, literature and stakeholder findings as necessary to effectively improve refugee health across the care continuum. The project also highlighted the need for innovative service models, which incorporate opportunities for family centred practices and strategies to build capacity in the wider health system to respond appropriately to refugee health needs. There are some excellent examples of these sorts of service models in Victoria, described in this report.

Service model options
A number of overarching features were identified through this project as required in building an effective and sustainable model of care for refugee populations. These include:

- Refugee health service models are integrated within the broader health system
- Services are easily accessible to key settlement areas
- Local context drives the application of regional service provision
- Services are affordable or free of charge for refugee families
- Adequate levels of administrative support are available to coordinate service delivery
• Availability of qualified interpreters
• Primary care involvement (including GPs and refugee health nurses) is essential
• Clear pathways between specialist and primary care services are established
• Clearly documented communication protocols between providers facilitate streamlined transition through the care continuum for refugees
• Care coordination for refugees with more complex health issues
• Service provision minimizes duplication and number of follow up appointments
• Consistency of screening / assessment processes
• Service models facilitate simultaneous care to both adults and children (i.e., family centered), and
• Clear pathways facilitating transition to culturally competent mainstream services are developed (e.g. mental health and maternity care).

Based on the findings, two service models are proposed:

• Visiting Specialist to local community health service (Sentinel Site Model for Refugees)
• Collaborative Care Model

The report outlines these models including clear descriptions, details of necessary care components, associated benefits, challenges, and key factors for successful implementation of each model.
Recommendations

The project identified a number of service delivery gaps as well as barriers to achieving best practice in the delivery of specialist services to refugees. Ten key recommendations have been developed in response to these issues, with a series of actions associated with each of these recommendations.

The first four recommendations relate to broader policy and programmatic reform and as such are of concern to State and Commonwealth Governments, the Victorian Refugee Health Network and other state-wide organisations. These are listed below under the heading State-wide recommendations.

The six other recommendations have a regional focus and as such are of concern to regional health services supported by relevant regional State and Commonwealth Government departments and state-wide organisations.

State-wide recommendations

1. Facilitate a state-wide forum to improve the acute health and primary care interface to better support refugee health needs

The Victorian Refugee Health Network in partnership with the Department of Human Services to facilitate a state wide forum involving acute and primary care providers from key settlement areas to:

   a. Present the recommendations and model options from the Access to Specialist Services by Refugees in Victoria report.
   
   b. Identify clinical and organisational champions to drive implementation of a refugee health response at the local level.
   
   c. Identify most appropriate mechanisms to facilitate, support and sustain service development at state-wide and regional level as outlined in this report.

2. Build Capacity in the wider health system

To enhance the capacity of the wider health system to respond to the health need of refugees including:

   a. Continue to review the capacity and roles of the refugee health nurse program to respond to refugee health needs and changing settlement patterns.
   
   b. Consolidate funding and provide formal recognition of key role of state-wide specialist refugee health services (Royal Melbourne and Royal Children’s Hospitals) including refugee fellows program, professional development, secondary consult support to GPs and specialists, research and provision of expert advice to government.
   
   c. Develop clinical guidelines that can be used as the basis for local protocol development.
d. Undertake collaborative work with universities, colleges and professional bodies to include refugee and immigrant health (including working with interpreters) in the curricula.

e. Workforce planning for specialist services provision in rural areas to take refugee settlement patterns into account.

f. Consider the capacity of the Medical Specialist Outreach Assistance Program to support specialist access in local areas to address refugee health needs.

3. **Increase access by primary care providers to medications and screening tests commonly required when assessing and treating refugees**

   a. Increase affordability of medicines commonly needed by newly arrived refugees by listing additional medications on the Pharmaceutical Benefits Scheme (PBS).

4. **Enhancing availability and use of professional interpreting services**

   a. Increase the availability of interpreters trained in the field of health care available onsite. Particularly in rural and regional areas.

   b. Funding structures to consider allowing for additional time during GP or specialist consultations when using an interpreter.

**Regional Recommendations**

5. **Strengthen regional system coordination between specialist services and primary care providers to enhance pathways of care for refugees**

   a. Development of clear and efficient referral pathways and clinical guidelines between settlement services, primary care and specialist services (build on PCP service coordination process, particularly to address specialist interface and response). This would include mapping of existing capacity for infectious diseases (including TB undertakings), paediatrics, mental health and maternity care.

   b. Development of communication protocols between service providers including agreed timelines, clearly defined responsibilities and information required.

6. **Develop a network of GPs and other primary care providers to build specialisation in working with refugees**

   a. Work collaboratively with Divisions of GPs to identify and train a network of GPs to work with specialist clinics/services in assessing and managing refugee healthcare.

   b. Provide training to networked GPs in undertaking comprehensive health assessments and care, including use and interpretation of diagnostic tests (e.g. RACGP accredited training module available through Foundation House, refugee health fellows).

   c. Development of greater opportunities for collaborative training and professional development (e.g. GP rotation into specialist clinics, refugee health fellows and the GP training).

   d. Identify nursing and allied health roles in community health to develop expertise in refugee health. Provide opportunity for identified primary care staff to participate in training.
e. Provide networked GPs and other primary care providers easy access to specialist advice to assist in managing more complex health issues.

7. Enhance responsiveness of acute health specialist services to respond to refugee health needs
   a. Hospitals in key refugee settlement areas, where no specific response to refugee health issues has been established, identify specialists and other key staff to undertake training and professional development to better support refugee healthcare.
   b. Consider local responses to particular needs around diagnostics and pharmaceuticals e.g. paediatric x-ray, arrangements for TB undertakings and treatment, access to low cost vitamin D.
   c. Consider opportunities to co-locate specialist and primary care services for refugees informed by this report.
   d. Hospitals in key refugee settlement areas include an exploration of local refugee health needs and service gaps in their Statement of Priorities to the Department of Human Services.
   e. Ensure annual health services Quality of Care reports document work towards service responsiveness specific to refugee health needs.

8. Enhance access to care coordination support for refugees requiring specialist services
   a. Application and elaboration of the Primary Health Demand Management Framework for Community Health Services at the agency level to assist agencies to prioritise those refugees with higher needs and transition those who are at lower risk into other services for any ongoing care.
   b. At the agency level undertake a review of the roles and functions refugee health nurses are currently performing and consider if any of these could be performed by another role (e.g. allied health assistant, dietician or community development worker). This would add capacity to the refugee health nurse to focus on refugees with complex and multiple issues, by shifting non-clinical tasks to a more appropriate role, thereby mainstreaming refugee health care.
   c. In areas with smaller refugee populations, at the agency level identify a community health nurse who can participate in training and otherwise develop skills in refugee health to support this client group.

9. Development of an integrated information systems for appropriate and timely exchange of patient and health information between and among health providers
   a. Consider ways such as use of patient–held medical records and/or e-referrals to reduce risk of duplication of investigations, treatments and immunisations as well as enhancing continuity of care.
   b. Use of electronic system to share clinical practice guidelines and health information to support collaborative management of refugee health care between primary care and specialist (e.g. shared refugee client data base, RCH website – refugee clinical practice guidelines and email support provided through refugee health fellow program).
10. Enhancing availability and use of professional interpreting services

a. Training of all health providers in the appropriate use of interpreters and how to access these services (based on arguments of best practice and risk management) (e.g. using DHS Language Services Policy and DHS training resources).

b. Greater promotion by all health providers of availability of interpreting services for refugees as a means of minimising risk (as outlined in the DHS Language Service Policy).
Project Background

The United Nations High Commissioner for Refugees defines a refugee as “someone who has left his or her country and cannot return to it owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country”\(^{(2)}\).

For the purposes of this report the term ‘refugee’ is used to describe all people from refugee like background, this includes humanitarian entrants, asylum seekers (who are seeking protection but have not had their refugee status determined), there are also migrants from refugee sources countries, who arrive through the Family and Skilled Migrant streams, who may have experienced persecution and violence\(^{(3)}\).

Overview

People of refugee background are recognised as one of the most disadvantaged groups in Australia (4). Under its Humanitarian program Australia accepts some 13,000 refugees each year. Of these, approximately 3,500-3,800 settle in Victoria\(^{(5)}\). Many of these individuals have specific health care needs which are the consequence of experiences of persecution, torture and other forms of trauma, deprivation, unhealthy environmental conditions and disrupted access to health care (6). Refugees entering Australia are reported to have higher rates of long term physical and psychological problems when compared to other migrants. These issues often require specialist and sometimes multiple investigations and referral at a time when people are already faced with significant challenges associated with the early settlement period and are often least equipped to negotiate complex service systems\(^{(7)}\). Failure to provide appropriate specialist and primary care within the initial stages of settlement, may lead to an overreliance on emergency care services and/or people seeking assistance only after they have become significantly unwell. Specialist services provide an important part of the care continuum for all Victorians. Providing specialist services which are accessible and integrated within the health system presents an important challenge\(^{(8)}(9)\).

Changing source countries of refugee populations

The changing national origin of refugees brings greater complexity in presenting health issues, differences in cultural understandings of health and requires the health system to be responsive and flexible to these changing needs. Despite changes in source countries, a significant number of newly arrived refugees are arriving with multiple and complex health concern requiring specialist intervention\(^{(10)}(11)\). Table 1 outlines the top 10 countries of birth for refugees settling in Victoria from 2006-09.

Dispersed settlement of refugee populations

While significant gains have been made in Victoria to develop health care services that are more accessible and responsive to the needs of people from a refugee background, access to primary and specialist services continues to be an issue for many\(^{(7)}(6)(12)\). In sites of established refugee settlement, service models continue to evolve in their efforts to adequately respond to the health
and well-being needs of these individuals and families, including access to primary and specialist services. In contrast, in many newer settlement areas, such as outer metropolitan and rural and regional areas of Victoria, models of care which adequately address refugee access to primary and specialist services are yet to be developed (13).

While the majority of newly arrived refugees have settled in metropolitan Melbourne, particularly the inner north and west and the south eastern suburbs, recent years have seen a increasing number of refugee and humanitarian entrants settling in outer metropolitan and rural and regional areas of Victoria (13) (14). In addition to current governmental policies which encourage settlement in regional areas, many refugees are moving from metropolitan Melbourne to rural areas seeking more affordable housing and employment and educational opportunities (15). In 2007, around 10% of newly arriving refugees and humanitarian entrants settled directly to rural Victoria, with settlement in at least 10 rural areas. Health services to address the unique health needs of refugees in these areas however, are not always readily available, nor do they always have the necessary experience or expertise to deal with the particular health needs of refugees (15)(16).

Why focus on refugee access to health services?

Refugees have complex and multiple health needs

While it is acknowledged that service access issues can be present for other population groups, the diverse and complex health and well-being needs of people from refugee backgrounds necessitates specific attention (17) (18) (11) (19). Although refugees represent a relatively small population within Victoria, they experience a significant burden of chronic and infectious disease (20). Refugees who arrive in Australia have had a wide range of experiences that have caused them to leave their home countries and seek protection. The majority of refugees originate from countries where even the most basic resources for health such as safe drinking water, shelter, adequate food supply and education are scarce. For a significant number of these refugees, previous poor access to curative and preventative health care may mean many of these health conditions have been untreated requiring specialist and sometimes multiple investigations and referral once they have arrived in their new country of resettlement (19).

Refugees entering Australia have a relatively high rate of long term physical and psychological conditions, tend to report a poorer state of well-being and visit health care providers more frequently than the general population. Health issues such as malaria, Hepatitis B, schistosomiasis and other parasites, Vitamin D deficiency and latent tuberculosis are common for many (21) (18) (17). Larger family sizes and issues such as malnutrition, hookworm and other parasites can play a part in the developmental delay of some children. Additionally, incomplete or at least undocumented record of immunisations is also an issue for many (22)(19).

Psychological problems such as depression, anxiety and post-traumatic stress disorder are also prevalent for many refugees as a result of their exposure to war, violence and / or prolonged insecurity (17) (4) (21). It is important to note that often these psychological issues do not cease when refugees reach their country of settlement. In fact for many, psychological distress may intensify as they deal with the stressors of the early resettlement period (23)(19).
Refugee children and young people

From the period 1996-2007, children and young people aged 0-19 years represented approximately 47% of the total Humanitarian entrants in Victoria. Interstate data indicates that between 50-80% of refugee children and young people require a referral to a specialist following initial health assessment \(^{(10)}\). A diverse array of complex health issues are evident within this group including; tuberculosis (generally latent), vitamin D deficiency and associated complicated rickets, parasitic infections, dental disease, iron deficiency anaemia and a range of behavioural and mental health problems. Given the significant cohort of refugee children and young people settling in Victoria and their burden of disease, attention needs to be given to the development of models of care which appropriately incorporate child and young peoples’ issues \(^{(24)}\).

Refugees experience a number of issues when accessing health care

Refugees settling in countries such as Australia are faced with many challenges in accessing effective health care. While recent research indicated that in Australia refugees accessed the hospital system at roughly the same rate as the general population, the increasing evidence of poorer health status and higher prevalence of a range of health problems found among the refugee population suggests this group are potentially not accessing appropriate levels of care. A consideration of issues of access is required \(^{(12)}\).

Although some well-established specialist services exist to meet the specific health needs of refugee people in Victoria, the majority of service provision occurs in primary healthcare services, with general practitioners in particular being one of the first points of call \(^{(21)}\).

A range of barriers and access issues to specialist and primary care services by newly arrived refugee people have been highlighted in the literature, which would require attention in the development of any health care service model. These include issues such as:

- Language and cultural differences \(^{(25)}\) \(^{(8)}\) \(^{(26)}\)
- Financial barriers \(^{(21)}\) \(^{(8)}\)
- Literacy issues \(^{(19)}\) \(^{(27)}\)
- Availability of effective health care close to where people live \(^{(4)}\)
- Transport and childcare limitations \(^{(20)}\)
- Reduced ability to trust service providers owing to prior experiences \(^{(19)}\)
- A lack of awareness of service and limited ability to negotiate often complex health care systems, and
- In some situations lack of health provider understanding of the complex health concerns of refugees \(^{(8)}\) \(^{(27)}\).

For refugees settling in rural or regional areas of Victoria, these issues are often compounded as specialist health care is often less accessible and more expensive than in major cities \(^{(28)}\). Consistent with the Department of Human Services (the department) policy which articulates that health and wellbeing services be accessible to where people live, it is important in rural and regional areas that services be located locally in a sustainable manner. Although current refugee settlement rates in these areas may not be sufficient to support the establishment of specialised refugee clinics,
government policy requires that issues of access, availability and service appropriateness be explored in creative and sustainable ways to respond to the specific needs of this population group.

**The Victorian Refugee Health Network**

The Victorian Refugee Health Network has identified four inter-related factors, which need to be addressed, in order to provide better service access to primary and specialist services for newly arrived refugee populations. These include:

1. General access issues for refugees; including aspects such as having systems in place for accessing interpreters, interpreting appointment times and reminder calls using an interpreter, cross cultural sensitivity by front of house and direct care staff and location of service sites

2. Development of simple referral pathways between settlement, primary care and specialist services

3. Health care coordination and related support for refugees with more complex health needs, both between and within services, and

4. Building the specific clinical expertise of a range of specialists to respond to the needs of refugees, particularly in outer metropolitan and rural/regional areas. Those services in highest demand include:
   - Infectious diseases including tuberculosis assessment and treatment services
   - Paediatrics
   - Maternity Care, and
   - Mental Health [13].

Available evidence suggests that by linking refugees into effective services which are linguistically and culturally appropriate in the early stages of resettlement will lead to substantial benefits for refugee health, promote public health and be cost effective in the longer term (27) (8) (26).
Project Objectives and Scope

Project objectives
The objectives established for this project were to:

- Document current specialist health service delivery models that exist within Victoria including the relationships between partner services (including both specialist and primary care partners), highlighting strengths and weaknesses and existing referral patterns
- Examine effectiveness of existing service delivery models against ‘best practice’ national and international evidence and departmental policies, including identifying areas which require further strengthening such as evidence of potential inaccessibility for refugees or lack of necessary key expertise or service partners
- Focusing on issues of accessibility to health care and specialist expertise in the provision of refugee health, prepare a range of service delivery model options for integrated models of care.

Project scope
The project was specified to include:

- Mapping of current service provision
- Examination of national and international best practice evidence
- Examination of available data
- Identification of areas where greater integration and family-friendly approaches may be possible
- Development of realistic service model options for consideration, and
- Development of basic cost indicators for each service model option.

Project methodology
A multi-method approach was used to gain information for this report and support service model options proposed, including:

- A brief overview and background to this project
- A literature review from published and ‘grey’ literature to identify ‘best practice’ service model options
- An analysis of key departmental policies regarding provision of health care for all Victorians, and using these to inform model development to enhance provision of specialist health care service for refugee communities
- Onsite visits and consultations with key stakeholders from 10 health care service providers in selected key settlement sites across Victoria, with a particular focus on rural and outer metropolitan areas that have experienced more recent settlement, and
- Working with a project advisory group to provide advice on the scope and conduct of the project and the content of the report.
Policy Context

This project was undertaken in the context of a number of Victorian Department of Human Services (‘the department’) policy and planning documents. In these documents the department has outlined its vision to provide comprehensive, planned, quality and integrated health care for all Victorians, whilst prioritising the needs of disadvantaged groups such as refugees. The department aims to support the provision of timely and accessible services to assist people to attain the best possible health and well-being. This includes a health care system that is person and family centred, based in community settings and responsive to the needs of local populations. The following departmental policies and initiatives provide direction for improving access to specialist services for refugees in Victoria:

Refugee health and well-being action plan 2008-2010

A policy and planning framework which recognises people from refugee background often have specific health and well-being needs related to experiences of prolonged deprivation, dislocation, their exposure to violence and conflict. The policy outlines that services promoting the health and wellbeing of refugees are in the interests of refugee communities and the broader community, in particular as it maximises refugees’ capacity to deal with issues during the trauma of resettlement. The action plan identifies three strategic priorities, namely:

- Providing timely and accessible services for refugee new arrivals
- Building capacity and expertise of mainstream and specialist services and health care practitioners in the area of refugee care
- Supporting and strengthening the ability of individuals, families and refugee communities to improve their health and well-being outcomes.

This document can be located at: www.dhs.vic.gov.au/multicultural/downloads/refugee_act_pln_web.pdf

Care in your Community: A planning framework for integrated ambulatory care (2006)

A policy and planning framework for ongoing development of the Victorian health services. The framework encompasses all community-based health care services. The vision is for a flexible, integrated and person-centred health system aimed at meeting the future needs and expectations of communities and individual users of health care services, and to provide integrated and accessible services in local communities.

This document can be located at: www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf

Directions for your health system: Metropolitan Health Strategy (2003)

This policy document provides a framework for the provision of health care services across metropolitan Melbourne to meet the growing and changing demands on the health system. This policy highlights the need for Community Health Services (CHS) to provide safe, high quality, appropriate, sustainable and accessible services.

As community health services are located in the community, they provide a potentially useful resource in any model of care to improve access to specialist services by refugees.

This document can be located at: www.health.vic.gov.au/metrohealthstrategy/strategy.pdf
Health Independence Programs Guidelines (2008)

These guidelines were developed to provide direction for and facilitate the alignment of Post Acute Services, Sub-Acute Ambulatory Care Services and the Hospital Admission Risk Program. These guidelines provided an understanding of the integrated, person-centred health independence and service delivery model the department is working towards and which informed planning and service development for these services.

These guidelines can be located at: www.health.vic.gov.au/subacute/hip-manual08.pdf

Rural Directions for a Better State of Health (2005)

This document provides a framework for the development and enhancement of rural health services across Victoria. The priorities included safe, planned, high quality and coordinated services designed to meet the changing needs of communities. This document highlights the specific health care needs of refugees given rural and regional areas of Victoria are acknowledged as key settlement sites for refugees.

This document can be located at: www.health.vic.gov.au/ruralhealth/downloads/rural_directions1_a4.pdf

Primary Health Branch: Towards a demand management framework for community health services (2008)

This framework applies to all services from CHSs, and aims to improve and consolidate current practices in managing service demand. The framework served to:

- Improve the consistency of practices in measuring and managing demand, providing improved data that can be used for benchmarking, service planning and funding allocation
- Support fair and equitable access to services based on equal access across the state for equal needs, with disadvantaged people provided priority or access to reduce inequality in health status
- Provide improved access to services for clients by assisting CHSs to provide high quality, efficient, effective, evidence-based services.

This framework identifies refugees as having unique and greater health needs than the general population and endorses the prioritisation of services to this population group.

This document can be located at: www.health.vic.gov.au/communityhealth/downloads/demand/demand_management_framework_feb08.pdf

Primary Care Partnerships strategy 2006-2009

The Primary Care Partnership (PCP) strategy aims to:

- Improve the experiences and outcomes for people who use primary care services via the service coordination initiative
- Reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people’s need for support.

More than 800 services have come together in 31 PCPs across Victoria to progress the reforms.

The PCP Strategy includes the following:

Service Coordination:

Service coordination is designed to enable service providers to develop protocols and processes to improve consumers experience and provide more streamlined pathways through the service
system. More specifically service coordination aims to eliminate duplication and inefficiencies, improve management of client waiting lists, provide early identification of clients needs, improve cross-program coordination and response and ensure clients receive services according to their needs.

**Integrated Health Promotion (IHP):**

IHP refers to collaborative work across a catchment aimed at improving the health of local communities, especially those with the most disadvantaged and poorest health status.

**Integrated Chronic Disease Management (ICDM):** ICDM includes:

- Planned and proactive care to keep people as well as possible
- Empowering, systematic and coordinated care that includes regular screening, support for self-management, and assistance to make lifestyle and behaviour changes
- Coordinated care by a range of health services and practitioners
- Care over time through the disease progression

Analysis of data

This section provides an overview of settlement data for refugee populations and available data relating to refugee hospital usage patterns by region. This data provides useful information to inform policy and service planning decisions regarding refugee settlement patterns. It also serves to identify key trends in use of hospital services by this population group across regions in Victoria.

Settlement patterns across Victoria

The Commonwealth Government accepts some 13,500 people from refugee background through its Humanitarian Program (inclusive of onshore and off shore entrants) each year. The state of Victoria receives approximately 30% of Australia’s refugee intake, from a wide range of countries such as Burma/Myanmar, Sudan, Afghanistan and Iraq.

It should be noted that settlement data showing country of birth does not reflect the ethnicity of significant numbers of refugees. For example in 2005-2008 refugees born in Thailand were actually Burmese or Burmese minorities, not Thai. Similarly, most Humanitarian entrants with Egypt and Kenya as country of birth were Sudanese (4).

Table 1 indicates the top 10 countries of birth for people of refugee backgrounds settling in Victoria in the period 2006-09.

Table 1: Top 10 Countries of Birth

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burma (Myanmar)</td>
<td>22.1%</td>
</tr>
<tr>
<td>Sudan</td>
<td>10.7%</td>
</tr>
<tr>
<td>Iraq</td>
<td>9.1%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>9.2%</td>
</tr>
<tr>
<td>Bhutan</td>
<td>8.6%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3.4%</td>
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<tr>
<td>Malaysia</td>
<td>3.1%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2.9%</td>
</tr>
<tr>
<td>Iran</td>
<td>2.4%</td>
</tr>
<tr>
<td>Kenya</td>
<td>1.5%</td>
</tr>
<tr>
<td>Others</td>
<td>11.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Settlement patterns continue to change in Victoria. Where some localities have seen significant growth, others have seen numbers decline. These patterns are often influenced by factors such as availability of affordable housing, employment and lifestyle factors such as communities wishing to consolidate in particular areas. There has been an increasing trend with significant growth in settlement in outer metropolitan and regional Victoria in this period. In 2007-2008 approximately 10 per cent of new arrivals settled in rural and regional Victoria (including Geelong, Shepparton and eight other rural locations).

Table 2 indicates the top 10 local government areas for refugee settlement (with associated percentage of Humanitarian intake) for the period 2006-09.
Table 2 - Top 10 Local Government Areas
Includes: Migration Stream: Humanitarian - Refugee; Humanitarian - Special Assistance; Humanitarian - Special Hum Program; Onshore: Humanitarian; Settlers Arriving from 1 Jan 2006 to 1 Jan 2009.
Data extracted from DIAC Settlement Reporting database June, 2009

Characteristics of refugee entrants
In the period 2006-09 a significant proportion of refugees settling in Victoria were children and young people. From the period 1996 – 2007, children and young people aged 0-19 years represented approximately 47% of the total Humanitarian entrants in Victoria (10). Data also indicates that refugees tend to come from larger family units. Such large numbers of children and young people has significant implications for planning and delivery of health services.

Table 3 - Sex and Age Distribution
Includes: Migration Stream: Humanitarian - Refugee; Humanitarian - Special Assistance; Humanitarian - Special Hum Program; Onshore: Humanitarian; Settlers Arriving from 1 Jan 2006 to 1 Jan 2009
Data Extracted from DIAC Settlement Reporting database June, 2009
The Victorian Health Data Standards and Systems (HDSS)

Data regarding refugee use of health services was obtained from the Victorian Health Data Standards and Systems for the period 2003-2008. The Department of Human Services collects data from hospitals within Victoria. This data is divided into two sections.

*Note: The data drawn from the HDSS does not include outpatient data as this is not consistently reported.

**Victorian Admitted Episodes Data Set (VAED)**

The department collects de-identified morbidity data on all patients admitted to Victorian public and private acute hospitals including rehabilitation centres, extended care facilities and day procedure centres on admitted patient activity.

**Victorian Emergency Minimum Data Set (VEMD)**

This data set contains de-identified demographic, administrative and clinical data detailing presentations at Victorian public hospitals with 24-hour Emergency Departments.

As refugee status is not specifically recorded in these data sets, data was extracted using the Top 9 refugee source countries for Victoria. These included:

- Iraq
- Iran
- Afghanistan
- Thailand
- Burma
- Sudan
- Ethiopia
- Kenya
- Nepal
The generated data reports sought to demonstrate the following:

- Reasons for emergency department presentations and hospital admission for people from refugee source countries, and
- Where people from refugee source countries access health services in relation to where they live.

**Reasons for emergency department presentations and hospital admissions for people from refugee source countries:**

An investigation was undertaken into the reasons why people from identified refugee source countries presented to emergency departments and why these groups were admitted to hospital. A report was generated using the VEMD and VAED datasets for the period 2003/4 – 2007/8. This data was compared to the top 20 reasons for people from non-refugee source countries presenting at emergency departments as well as being admitted to hospital. The data is provided in the appendices (see Appendix 2-3) and revealed a number of issues and trends of relevance to this report:

**Emergency presentations (VEMD data)**

- The data indicated similar reasons for emergency department presentations for people from the identified refugee source countries and those from non-refugee source countries. When the top 10 reasons for people from each refugee source country were combined, 16 of the resultant 26 reasons were identified in the top 20 reasons for people from non-refugee source countries presenting to emergency departments.

- One significant difference was the number of presentations where the reasons for the presentation were ‘unknown and unspecified causes of morbidity’. Persons from refugee sources countries represented 21% (n=2988) of the total emergency presentations where the primary reason for attendance was ‘unknown and unspecified causes of morbidity’ (N=14231). A number of possible explanations for this particular statistic present themselves. These include: people from refugee backgrounds may experience difficulties in accurately communicating their health concerns when presenting at emergency departments or that the health concerns these populations are presenting with are more complex in nature. Further investigation of this issue is warranted.

**Hospital admissions (VAED data)**

- VAED data illustrated that 60.6% (i.e., seven of the combined top 10 reasons; n=5887) of hospital admissions for persons from the identified refugee source countries were for maternity related issues. Whereas it represented only 2 of the top 20 reasons why non-refugee source country people were admitted to hospital. This is consistent with demographic data for refugees which indicate refugees typically have larger family sizes. This suggests the need for both maternity and paediatric services that are accessible, affordable and culturally competent in their service delivery. Further investigation is warranted to explore the utilisation of maternity and utilisation of maternity and paediatric services by refugee populations.
While a strong correlation was evident in reasons for emergency department presentations for people from refugee source countries versus people from non-refugee source countries, little correlation was noted regarding reasons for hospital admissions between the two groups. One possible explanation for this trend is the average age of refugee source country populations being generally younger in comparison to the broader Victorian population. Further study is required to consider these possibilities, particularly in relation to those conditions that are unrelated to maternity and paediatric services.

Where people from refugee source countries access hospital services compared to their identified places of residence:

An analysis of where people from refugee source countries accessed hospital services in relation to where they reside was undertaken to identify if refugees were travelling to receive health care. This data represents combined results for emergency presentations and hospital admissions for this population group. Table 5 describes the numbers of people from refugee source countries, the regions in which they receive services and the regions in which they reside.

As can be evidenced by the data, the majority of people from refugee source countries were identified to have accessed hospital services within their region of residence (i.e., overall 82% of all relevant admissions). Indeed, in four of the eight regions the data indicates more than 85% of admissions were in the region where the person lived, with the Barwon South West region evidencing 95%. The Eastern Region also evidenced the greatest proportion of persons who travelled outside the region to receive hospital services. Only 51% of admissions for people living in the Eastern Region were provided in the Eastern region (31% of those persons from refugee source countries who reported residing in the Eastern region accessed services through Southern region hospitals and 15% of this group accessed services through North Western region hospitals). Further evaluation of this data would be useful to ascertain why people are travelling to receive hospital services. Additionally, a comparison between people from refugee source countries and people from non-refugee source countries is suggested to identify any differences between these groups in accessing hospital services within the region they reportedly reside.
Table 5: Percentage of people from refugee source countries who receive hospital services within the region in which they live

<table>
<thead>
<tr>
<th>Residence-Region</th>
<th>Barwon South West Region</th>
<th>Eastern Metro Region</th>
<th>Gippsland Region</th>
<th>Grampians Region</th>
<th>Hume Region</th>
<th>Loddon-Mallee Region</th>
<th>North-West Metro Region</th>
<th>Southern Metro Region</th>
<th>Other</th>
<th>Total</th>
<th>% of refugee admissions residing within region</th>
<th>% of refugee admission from outside of region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campus-Region</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barwon South West Region</td>
<td>554</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>19</td>
<td>6</td>
<td>7</td>
<td>585</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>Eastern-Metro</td>
<td>33</td>
<td>6512</td>
<td>52</td>
<td>2</td>
<td>20</td>
<td>9</td>
<td>2637</td>
<td>1212</td>
<td>117</td>
<td>10594</td>
<td>61%</td>
<td>39%</td>
</tr>
<tr>
<td>Gippsland Region</td>
<td>0</td>
<td>25</td>
<td>659</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>117</td>
<td>3</td>
<td>810</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>Grampians Region</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>187</td>
<td>0</td>
<td>7</td>
<td>79</td>
<td>0</td>
<td>2</td>
<td>284</td>
<td>66%</td>
<td>34%</td>
</tr>
<tr>
<td>Hume</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>834</td>
<td>9</td>
<td>29</td>
<td>5</td>
<td>48</td>
<td>929</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>401</td>
<td>8</td>
<td>10</td>
<td>25</td>
<td>457</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>North-West Metro</td>
<td>24</td>
<td>1902</td>
<td>11</td>
<td>14</td>
<td>87</td>
<td>54</td>
<td>28438</td>
<td>1248</td>
<td>253</td>
<td>32031</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Southern-Metro</td>
<td>10</td>
<td>4302</td>
<td>42</td>
<td>17</td>
<td>17</td>
<td>10</td>
<td>609</td>
<td>21161</td>
<td>261</td>
<td>26415</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>628</td>
<td>12748</td>
<td>765</td>
<td>226</td>
<td>969</td>
<td>490</td>
<td>31825</td>
<td>23759</td>
<td>716</td>
<td>71410</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>% of refugee people who live within the region and were seen within the region</td>
<td>88%</td>
<td>51%</td>
<td>86%</td>
<td>83%</td>
<td>86%</td>
<td>82%</td>
<td>89%</td>
<td>89%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Current health service provision for refugees

In recent years Victoria has benefited from some significant investment in improving primary care services for refugees. Such developments have included the introduction of Medicare Benefits Schedule (MBS) items for GPs undertaking refugee health assessments by the Commonwealth Government, the establishment of the refugee health nurse program that includes regional areas, a number of specialist refugee health clinics and visiting specialist/specialist outreach programs.

GP access - Refugee Health Assessments

In May 2006 the Commonwealth Government introduced the new MBS item numbers 714 and 716 to provide initial health assessments for refugees and other humanitarian entrants within the first 12 months of arrival. The health assessment includes medical history, a physical examination and investigations as required, development of a management plan and additional referrals to specialists for follow-up assessment and management as required. The purpose of the health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system as soon as possible after their arrival to Australia. These items have acknowledged the unique and often complex health concerns for refugees allowing for longer consultations and enhanced care planning by GPs.

The uptake of the new MBS item in Victoria has been significantly higher than other states. Table 9 indicates for the period July 2007 – June 2008, a total of 2090 (714 and 716 inclusive) claims were made by GPs in Victoria which constitutes approximately 60% of refugee new arrivals having had a health assessment.

Medicare Benefits Scheme item number report

Table 6 demonstrates the numbers of Comprehensive Health Assessments being undertaken for refugees and other humanitarian entrants within the first 12 months of arrival (MBS item number 714 and 716). The information indicates the uptake of these item numbers have been higher in Victoria than in other states.

<table>
<thead>
<tr>
<th>Item number</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>714</td>
<td>1,175</td>
<td>2077</td>
<td>539</td>
<td>1000</td>
<td>99</td>
<td>265</td>
<td>96</td>
<td>3</td>
<td>5254</td>
</tr>
<tr>
<td>716</td>
<td>10</td>
<td>13</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>totals</td>
<td>1185</td>
<td>2090</td>
<td>543</td>
<td>1000</td>
<td>100</td>
<td>265</td>
<td>96</td>
<td>3</td>
<td>5282</td>
</tr>
</tbody>
</table>

Table 6: Medicare item report (item numbers 714 and 716) by state from the period July 2007 – June 2008.

The Victorian Refugee Health Nurse Program (RHNP)

The Victorian RHNP was established in 2005 and focuses on the early assessment of newly arrived refugees, assisting and referring people to other primary and specialist services. The program has three aims:

- Increase refugee access to primary health services
- Improve the response of health services to refugees needs, and
• Enable individuals, families and refugee communities to improve their health and wellbeing.

As of 2008-09 the program operated in the following local government areas:

**Metropolitan local government areas:**

• Greater Dandenong (Greater Dandenong Community Health Service, Southern Health)
• Brimbank (ISIS Primary Care)
• Maribyrnong (Western Region Health Centre)
• Moonee Valley/Melbourne (Doutta Galla Community Health Service)
• Hume (Dianella Community Health)
• Darebin (Darebin Community Health)
• Maroondah (Eastern Access Community Health)
• Wyndham (ISIS Primary Care)

**Rural local government areas**

• Ballarat (Ballarat Community Health Centre)
• Colac-Otway (Hesse Rural Health Service)
• Shepparton (Goulburn Valley Community Health Service)
• Warrnambool (South West Health Care)
• Latrobe Valley (Latrobe Community Health Service)
• Mount Alexander (Castlemaine and District Community Health Service)
• Greater Geelong – Corio (Barwon Health)
• Bass Coast (Bass Coast Community Health Service)

The operation of the RHNP is supported by:

• The Statewide Refugee Health Nurse facilitator based at Western Region Health Centre who provides secondary consultation to nurses and organisational advice to RHNP host agencies
• A training and skills development program coordinated by the VFST, available to not only nurses under the RHNP, but also any nurse working with refugees.

**Specialist Services**

**State-wide tertiary services**

(Please refer to the Appendix 5 for a full service description of these services)

Two state-wide tertiary specialist refugee services exist within Victoria including:

• Royal Children’s Hospital Immigrant Health Service
• Royal Melbourne Hospital Refugee Health Service

These services are an essential part of the continuum of care and journey for many refugee patients with complex needs. These clinics provide planned outpatient services that provide a focus for refugees’ healthcare within the acute sector and provide access to medical specialists
for assessment, diagnosis and treatment of complex conditions. In addition to providing a tertiary referral service for refugees, these services provide a range of workforce development and capacity building activities for the wider health system including:

**Professional development and education to GPs and specialists working with refugees**

- Secondary consultation support and professional development to any practitioner involved with refugees. This work has been further enhanced by one-off funding provided by the department to establish part time refugee fellows. RMH and RCH specialist refugee clinics host these positions.
- Development and dissemination of clinical guidelines to support consistent and quality management of refugee health issues.
- A 24 hour phone number providing specialist advise to service providers (RCH provide a weekday telephone support service).

**Research and government policy advocacy**

- As leaders in the field these specialist clinics contribute to the evidence base by undertaking research and innovative practice in the field of refugee health.
- Contribute to policy discussions to inform decision making and to identify gaps in responding to refugee health.

**Regional specialist services**

There are a number of models of care which have been developed in local areas to respond to the more complex health needs of refugees. Two such models are:

**Specialist refugee health clinics.**

These services are typically delivered in a hospital setting and provide a focus for care coordination in the region, as distinct from the state-wide specialist tertiary services at RMH and RCH. The regionally based specialist clinics in Victoria include:

- Dandenong Hospital Refugee Health Clinic and Asylum Seeker Medical Clinic
- Barwon Health (Geelong Hospital) Refugee Health Clinic

(Please refer to the Appendices for a full description of these service models)

**Refugee health team located in a community health centre with the support of visiting specialist services**

In this model a key healthcare coordination role is undertaken by a refugee health nurse to support specialist referrals and care. These services include:

- Western Region Health Centre
- ISIS Primary Care (Sunshine)
- Darebin Community Health Service

A range of additional specialist outreach arrangements are in place which currently involve paediatricians providing refugee health clinics in community health settings. These include:

- Melton -Djerriwarrh Health Services – due to commence 2009.
Findings from stakeholder consultations

This section of the report is based on information gathered through consultations with key staff involved in the provision of specialist services within nominated settlement sites in Victoria. Additional information was obtained through written documentation made available at the time and via the projects advisory committee.

The purpose of these consultations was to develop a comprehensive understanding of current specialist health service delivery models and to identify needs and opportunities to improve access to specialist services by refugees. The consultations included existing refugee service providers and service providers from nominated areas where a comprehensive service response for refugees requiring specialist support is yet to be developed (refer to Appendix 4 for a full list of those consulted). The second group were selected to represent a cross-section of settlement areas in the outer metropolitan and rural and regional areas of Victoria. These consultations were undertaken between March and May 2009. Information obtained during these consultations has been included as either stakeholder identified issues and opportunities or used to inform service descriptions for each nominated area (see Appendix 5 for detailed service descriptions by location).

A summary of the issues from consultations with key stakeholders

This section of the report summarises the key issues and opportunities identified through these consultations. This has been divided into two sections including findings from existing refugee health service providers and findings from nominated areas where no specific response to refugees requiring specialist referral has yet been established.

Responses from existing refugee health service providers

The following specialist clinics were consulted during the course of this report:

- Royal Melbourne Hospital: Victorian Infectious Disease Service (VIDS)/ Refugee Clinic
- Dandenong Refugee Health Clinic
- Barwon Health Refugee and Immigrant Health Clinic
- Western Region Community Health Centre Vitamin D Clinic
- Royal Children’s Hospital: Immigration Health Service
- ISIS Primary Care

Summary of facilitating and challenging issues for providing specialist refugee health clinics

Facilitating factors

Service delivery

- Specialist clinics benefit from being built around a clinical champion – building on both their interest and expertise (e.g., ID specialist, paediatrician).
- Access to pathology, pharmacy and radiology onsite (hospital clinics only) reduces number of follow-up appointments required and use of resources (such as interpreters).
- Access to onsite professional interpreters reduces consultation times and need for follow up.
• Adequate levels of administrative support to operate clinics, including time for making appointments, reminder calls, booking interpreters and referrals to other services.
• Need for strong leadership and organisational support for the refugee health clinic.
• The importance of services with capacity to offer a family centred and flexible approach to service delivery, including the capacity to assess families together.

**General Practitioners**

• Strong network of GPs and other primary care providers (i.e. refugee health nurse) to work collaboratively to manage refugee health care.
• Being highly responsive to, and use of effective communication with, referring GP’s.
• Ensuring streamlined referral from GPs to specialists to provide a referral point as well as specialist secondary consultation support to GPs as required.
• The important role of the Refugee Health Fellows in building GP capacity.

**Care Coordination**

• Critical role of refugee health nurse, clinic nurse or other suitably trained allied health staff in providing support in following up on screening results, liaising with GPs and other agencies, assisting refugees to attend appointments etc.

**Networks**

• Availability of a good network of services to identify and manage refugee health issues locally.
• Utilising GP Divisions to identify those GPs keen to work with refugees and for providing ongoing training and support to those GPs.

**Issues and gaps identified with current specialist service provision**

**Service delivery**

• Variance in the quality and consistency of initial health screenings conducted by GPs requiring specialist clinics to spend significant time following up health screening results.
• The lack of an appropriate information management system to facilitate the exchange of client information between specialist clinics and with primary care providers. Such a system would assist in timely referrals, enhance communication between sectors, monitor refugee patients who move areas during treatment and increase the level of consistency in practice for managing refugee health.
• Certain medications and health screening tests commonly used with refugees can be more expensive and limited in their supply outside of hospitals. As a result referrals to hospital-based specialist clinics are made at times to simplify access to medications, leading to unnecessary demand on these services.
• Providing specialist services to refugees is resource intensive and appropriate levels of administration support are needed to deliver these services.
• Service where there is no resources to support a reminder system experience a high failure to attend rate, which can have impacts on clinic viability. Often these services attempt to manage this by overbooking allocated appointments.
• Access to onsite professional interpreters is reportedly limited, particularly for those services outside of metropolitan Melbourne.
Case complexity

- Referral rates for refugees onto a specialist are high following initial health assessment, particularly for children.
- Assessment or investigation for one issue will often lead to numerous other issues being diagnosed or identified, generating multiple referrals and need for follow up screening. This requires flexible consultation times and adequate levels of medical, nursing, allied health and administration support to manage this issue in a manner which works to minimise the number of follow-up appointments required.
- Refugee family units are often quite large and can prefer to be seen together. This also requires flexibility and clinic space which enables this to take place in a confidential and professional manner.
- Mental health issues are emerging as a significant concern among refugee children and adults.

Building capacity of mainstream health services to respond to refugee needs

- Lack of awareness of refugee health needs and cultural issues beyond specialist clinics within the acute sector.
- Inconsistent use of interpreters and translated information (e.g. hospital signage) in other departments.

Responses from nominated settlement sites where a comprehensive service is yet to be developed

In addition to existing refugee specialist health clinics, a number of other areas in Victoria were identified by the Refugee Health Network for consultation. These areas were identified as a cross section of significant settlement sites for refugees and most were acknowledged as newer settlement areas. These areas included:

- Mildura
- Ballarat
- Shepparton (some response already in place)
- Bendigo
- Latrobe Valley
- Outer Eastern metropolitan area

A summary of issues and needs where identified by these providers which would assist in developing a more coordinated response to refugees requiring specialist services.

Issues and gaps identified with current service provision in nominated areas:

Service delivery

- Need for greater systems coordination: Preference for local level planning and system development. Suggestion to identify service providers from primary care and specialist services who have an interest in refugee health and formalise partnerships between these providers. Proposed documentation of simple:
  - Well defined referral pathways to specialist services
  - Communication protocols
  - Referral tools, and
  - Clinical treatment guidelines to support shared care arrangements.
• Need to strengthen health service links with existing refugee networks (e.g. settlement planning committees). In some areas it was suggested that leadership and management positions be identified and linked into these existing networks to support a more coordinated response to local refugee health issues.

• Lack of integration and communication between settlement services and health services in some nominated areas. Identified need to build these relationships to develop a better understanding of roles and responsibilities and to work together to build the health literacy of new arrival refugees.

• Inability to share client information across primary care and specialist sectors: suggested need for information systems which enable efficient exchange between services regarding refugees health needs and treatment (e.g., shared data base, hand held patient record).

• Identified difficulties with access and use of interpreters. Outside of metropolitan area it is reportedly very difficult to access suitably qualified interpreters for onsite appointments.

**Care coordination**

• Where a RHN role does not exist, services highlighted the need to fund a position that can provide a care coordination or “navigation” role between services. A lot of follow up support reportedly needed to ensure refugees attend specialist appointments and ensure appropriate information is available (health screening results).

• Limited capacity of some refugee health nurses to undertake case coordination role for all refugees requiring specialist support due to demand. Suggested the need for a demand management framework to support refugee health nurses to prioritise those refugees with greatest need and to transition those with relatively low needs onto mainstream services.

**Building capacity of mainstream health services to respond to refugee needs**

• Suggested identifying and training GPs to work with refugees in newer settlement areas. Highlighted need for good training, support and referral pathways to be in place to encourage this involvement as the MBS remuneration for comprehensive refugee health assessments does not cover the time required to follow up refugee patients.

• Build capacity of hospital based service to respond in a culturally competent manner (i.e. work force development during orientation and training on how to access interpreters).

• Request for relevant and regular information to feed into management level regarding local level refugee needs and health issues.

Table 10 outlines identified opportunities and capacity to provide specialist services for refugees from each of the nominated settlement sites.
<table>
<thead>
<tr>
<th>Site</th>
<th>Ballarat</th>
<th>Bendigo</th>
<th>Shepparton</th>
<th>Latrobe Valley</th>
<th>Outer eastern</th>
<th>Mildura</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk-billing GP(s) in Community Health</td>
<td>Ballarat Health Service (attached to the hospital) &amp; Ballarat Community Health Centre</td>
<td>Bendigo Community Health (Multi-location organisation but only 1 location with GPs – Eastlake – must live in the catchment to access GPs). Limited capacity through some private bulk-billing clinics</td>
<td>GV Division of GPs working to re-establish new GP clinic at LCHS for refugees (Due to commence May 2009)</td>
<td>Melbourne Uni School of Rural Health planning to open Refugee Health Assessment clinic (Planned for Oct 2009)</td>
<td>A number of GP Clinics providing bulk billing service. There are a number of language specific GPs but access is limited.</td>
<td>A large private GP clinic providing bulk billing service has recently opened in Mildura providing good access at present. Bilingual GPs also available in relevant community languages.</td>
</tr>
<tr>
<td>Refugee Health Nurse Program in Community Health</td>
<td>0.5 EFT</td>
<td>not available</td>
<td>0.5 EFT</td>
<td>0.5 EFT (commenced 2009)</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>High dose Vitamin D</td>
<td>Some availability</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Community Health Counselling</td>
<td>Ballarat Community Health Service provides generalist counselling services</td>
<td>Bendigo Community Health (at most locations – could organise access) provides generalist counselling services</td>
<td>Generalist counselling services also available</td>
<td>Latrobe Community Health Service provides generalist counselling services</td>
<td>Eastern Access Community Health provides generalist counselling services and Victims Assistance and Counselling Program</td>
<td>Sunraysia Community Health provides generalist counselling and Victims Assistance and Counselling Program</td>
</tr>
<tr>
<td>Foundation House Short term Torture &amp; Trauma Counselling</td>
<td>Ballarat Community Health Service</td>
<td>St Lukes Anglicare</td>
<td>Goulburn Valley Community Health Service</td>
<td>La Trobe Community Health Service Inc</td>
<td>Foundation House</td>
<td>Centacare Mildura</td>
</tr>
<tr>
<td>Specialist Mental Health Service</td>
<td>Area mental health service based in Ballarat Health Service &amp; Ballarat Community Health Centre</td>
<td>Bendigo Healthcare Group</td>
<td>Goulburn Valley Health provides a range of services: inpatient and community mental health for aged, adults, adolescents and children</td>
<td>Latrobe Regional Hospital provides 8 community MH services across LV. Inpatient services also at Traralgon</td>
<td>Eastern Health provides a full range of services: Adults, aged, adolescent &amp; children , primary mental health and inpatients services</td>
<td>Ramsay Health Hospital provides a full range of services: Aged, adult, adolescents and children, inpatients, and community outreach.</td>
</tr>
<tr>
<td>TBU Physician</td>
<td>No system currently in place for TBU</td>
<td>Limited capacity. Currently have visiting specialist from the Austin Hospital who runs a clinic 1x month. Assess children but refer to RCH for follow up treatment</td>
<td>Goulburn Valley Health Local Physician Sees refugee patients through private rooms – bulk billed</td>
<td>No system currently in place. Currently patients with TB travel to metro areas. No system currently in place. ID clinics operate weekly at Box Hill and Maroondah campuses. These clinics currently have limited capacity to see children</td>
<td>No system currently in place. ID clinics operate weekly at Box Hill and Maroondah campuses. These clinics currently have limited capacity to see children</td>
<td>No system currently in place. However a physician based at Ramsay Health has TB experience in indigenous populations and has some capacity.</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Ballarat Health provides a full range of paediatric services. No specific refugee response</td>
<td>Bendigo have full complement of paediatric services, but no specific refugee response</td>
<td>A local paediatrician provides bulk billed appointments for refugees in private clinic and is a VMO at Goulburn Valley Health</td>
<td>Paediatrics Home and Community care shared care arrangement between milderfes and paediatricians. In patient services. No specific refugee response</td>
<td>Eastern health provides a generalist range of paediatric services. No specific refugee response</td>
<td>VMO paediatrician who sees a wide range of paediatric pathology. No specific refugee response</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>Ballarat Health provides a full range of antenatal care services</td>
<td>Bendigo health provides a full range of women’s health services. Antenatal clinic, maternity support, Gynaecology clinic</td>
<td>Goulburn Valley Health provides an antenatal clinic involving block booking with interpreters in main language groups</td>
<td>Latrobe regional hospital provides full range of maternity services</td>
<td>EH has full range of inpatient / outreach maternity services. EACH provides well-women’s clinic including reproductive and sexual health info. &amp; checks, HIV and Hep. testing available</td>
<td>Ramsay health provides inpatient and outreach antenatal service.</td>
</tr>
<tr>
<td>Infectious Diseases Physician / Capacity</td>
<td>Some expertise within Ballarat Health Service, however no ID specialist</td>
<td>Some expertise within Bendigo Healthcare Group Hospital (Hospital) – focus mainly on Hep C. VMO from Austin Hospital provides wider ID capacity</td>
<td>Some expertise within Goulburn Valley Health to undertake ID screening and treatment</td>
<td>No physician or capacity available. Patients must travel to metro areas for screening treatment</td>
<td>Eastern health has ID physicians providing screening and treatment. At Box Hill and Maroondah campuses</td>
<td>Limited capacity through Ramsay health (hospital) 1 physician with ID expertise and capacity.</td>
</tr>
</tbody>
</table>
Review of the literature

A review of national and international literature was undertaken as a component of this project.

The literature review sought to describe a number of service delivery models and “best practice” examples purported to improve refugee access to specialist health care. The review aims to inform the development of evidenced based model options to effectively deliver specialist health care to refugees in Victoria.

Three main models of care were identified in the review, namely:

- Specialist Clinics – Hospital-based
- Shared/Collaborative care model – including “hub and spoke”
- Primary care - Visiting specialist model

These models are reviewed in detail in the attached literature review including a description of each model, national and international examples, associated benefits and challenges and critical success factors for implementation.

Of these three models, only two were selected following consultations with service providers and the advisory committee, while also taking into account the Victorian context, and the findings relating to the need for locally based, multidisciplinary, family centred models of care.

A copy of this literature review is provided as a supporting document to this project report (see Appendix 7).
Discussion

This section is a collation of the issues drawn from the relevant policy context, stakeholder consultations and review of the available literature. The following issues require consideration in the development of any service model option to improve refugee access to specialist services:

- Local accessibility of specialist services
- Service integration
- Service coordination
- Person and family centred care
- Building capacity of mainstream workforce to respond to refugee health issues
- Interpreter and translation services use
- Identification of mental health issues.

These issues will now be addressed in turn:

**Local accessibility of specialist services**

Currently the availability of specialist services for refugees varies significantly across key settlement areas within Victoria. While more comprehensive specialist service delivery models exist in areas where refugee settlement has a longer history, access to specialist services in some other settlement areas is limited. This is more of an issue in newer settlement areas such as outer metropolitan Melbourne and rural/regional areas of Victoria.

This is consistent with the literature which has found that specialist services tend to be largely concentrated in metropolitan areas and issues of accessibility to these services is a particular concern for rural/regional communities. Evidence further suggests that solutions to this problem lie in strategic partnerships across service sectors and flexible service models which consider local context, in order to improve service access.

The Victorian government has identified the issue of timely access to care in a number of key policy documents. The *Refugee health and well-being action plan 2008-2010*, highlights the need for timely and accessible service for refugee new arrivals. Similarly, *Care in Your Community: A planning framework for integrated ambulatory care (2006)* outlines the needs for services which are integrated and accessible in local communities.

*The Directions for your health system: Metropolitan Health Strategy (2003)* documents the critical role that community health services play in providing high quality, sustainable and accessible services to local communities.

Whilst consultations with stakeholders from key settlement sites did identify variances in current specialist service delivery for refugees, significant capacity was identified in many of these areas, from which a more coordinated response could develop. Stakeholders highlighted the need for further work to be done in local areas to identify clinical and leadership champions to drive the implementation of quality service delivery models. In
addition the stakeholders recognised the need for streamlined referral pathways and providing services closer to where people live as a means of improving service accessibility for refugee populations.

**Service coordination and integration**

The issue of service coordination and integration was highlighted through the findings. This included the need for enhanced integration with the broader health system in order to provide comprehensive services for refugees. The literature advocates for service designs which facilitate continuity of care throughout the whole patient journey, from primary care to specialist services.

The need for integrated services is explicitly highlighted within a number of key Victorian policy and planning documents including:

- *Rural Directions for a better state of health 2005*
- *Care in Your Community: A planning framework for integrated ambulatory care (2006), and*
- *Primary Care Partnerships Strategy (2006-2009)*

These documents articulate the need for health services which are planned, integrated and coordinated across the broader health system.

Stakeholder consultations identified the opportunity for further enhancing current refugee services through greater collaboration and integration between specialist and primary care services as well as between specialist services. Stakeholder feedback also suggested the need for capacity building resources to facilitate and establish protocol based partnerships and information systems which allow for exchange of client health information across sectors.

Significant service coordination work is already underway through the Health West Primary Care Partnership Refugee Service Coordination project by a number of Primary Care Partnerships (PCPs) where refugee health nurses have been recently employed. The aim of this work has been to reduce duplication, increase understanding of referral pathways and to improve service coordination between services to enhance service delivery for refugees. Stakeholder consultations identified this as a useful process, however recognised the need to build on this work particularly to address the primary care and specialist interface and response.

**Person and family centred care**

Findings suggest that the provision of person and family centred health care is an important consideration in the development of models of care for refugee background populations. Much of the literature presupposes person and family centred care as practice ideal. Literature further suggests that patient and family centred care increases patient satisfaction and engagement.

Stakeholder consultations identified the need to accommodate both adults and children together when providing specialist services. This was recognized as important in meeting the cultural needs of refugee families, while also working to minimise time, travel and resources spent in providing individual health care for each family member.

The Victorian government’s vision for integrated health services which are person and family centred is well articulated in its *Care in your community: a planning framework for integrated ambulatory care (2006)* which highlights the need to deliver person and family centred health care in community based settings, reducing the need for inpatient care and improving
health outcomes of Victorians. This vision is also similarly articulated in the *Health Independence Program Guidelines* (2008).

**Build capacity of mainstream health services to respond to refugee health needs**

Findings suggest that more work is needed to build the capacity of mainstream services to appropriately manage refugee health issues. The findings also acknowledged the need for more innovative use of workforce capabilities to improve access to comprehensive services by refugees. This includes up-skilling of GPs, refugee health nurses and other nursing and allied health staff to support delivery of specialist services for refugees.

*The Refugee health and well-being action plan 2008-2010* identifies a strategic priority to build capacity of mainstream and specialist services and health care practitioners in the area of refugee health care.

The literature provides strong support for workforce development strategies which seek to enhance mainstream service delivery to be inclusive and supportive for all people. It also highlights the role specialist refugee services can play in building the capacity of the wider health system to manage refugee health needs.

Stakeholder’s consultations identified the importance of developing competencies in the wider health system to appropriately manage refugee health needs. They also highlighted formalising the role of refugee specialist clinics in undertaking this work. Additionally stakeholders acknowledged the importance of up-skilling GPs and other primary care providers to enable appropriate assessment, care and referral to specialist services by refugees when required.

**Interpreter and translation service use**

Stakeholder consultations provided anecdotal information on the inconsistent use by the broader health system of professional interpreter and translating services for people who cannot speak English, including refugees. In addition stakeholders reported difficulties in accessing qualified interpreters onsite during consultations with refugees. This was particularly evident in discussion with rural/regional areas service providers.

The department’s *Language services policy* (2005) recognises the need for effective communication in the delivery of high quality health services. This policy outlines the requirements of all DHS funded programs and services to provide access to professional interpreting and translating services for people who cannot speak English well. In addition, the Commonwealth Government provides fee-free interpreting services for private GPs and specialists via the Translating and Interpreting Services for Medicare funded services (29).

The literature echoes Victorian government policy on this issue, highlighting the critical importance of providing people with access to appropriately qualified interpreting and translating services.

**Mental health issues**

The findings suggest that mental health is a significant issue for refugee populations. The literature highlights the particular nature of the refugee context (i.e. experiences of torture and trauma, grief and loss and resettlement) as significant determinants of poor mental health for refugees. This in turn leads to greater complexity of care issues and reduced health outcomes.

Stakeholder consultations identified mental health issues as an emerging consideration for refugee health service delivery. They also acknowledged the need for specialist mental
health programs to be provided in partnership with other specialist services to adequately meet the needs of this population group.

The Victorian Foundation for Survivors of Torture (Foundation House) provides a range of counselling and other services for refugee survivors of torture and trauma, including the refugee mental health clinics at Brunswick and Dandenong. People of a refugee background also require access to adult and child and adolescent mental health services when required. Like other specialist services, it is important that these services have access to training in working with refugee populations.

The *Refugee health and well-being action plan 2008-2010* has identified mental health as a priority issue within refugee communities.
Service model options

Following a review of the literature and consultations with service providers from nominated refugee settlement areas, the following service model options for increasing access to specialist services by refugees in Victoria are presented.

A number of overarching features have been identified as required in building an effective and sustainable model of care for refugee populations. In summary, the following elements are required:

- Refugee health model is integrated within the broader health system
- Services are easily accessible to key settlement areas
- Local context drives the application of regional service provision
- Services are affordable or free of charge for refugee families
- Adequate levels of administrative support available to coordinate service delivery
- Availability of qualified interpreters
- Primary care involvement (including GPs and refugee health nurses) is essential
- Clear pathways between specialist and primary care services established
- Clearly documented communication protocols between providers facilitate streamlined transition through the care continuum for refugees
- Care coordination for refugees with more complex health issues
- Service provision minimizes duplication and number of follow up appointments
- Consistency of screening / assessment processes
- Service models facilitate simultaneous care to both adults and children (i.e., family centered), and
- Clear pathways to culturally competent mainstream services are developed (e.g. mental health and maternity care).

The two state wide specialist refugee clinics, Royal Children’s Hospital Immigrant Health Service and the Royal Melbourne Hospital: Victorian Infectious Disease Service provides a range of capacity-building activities to support regional responses to refugee’s specialist health care (e.g. 24 hours phone consultation support, research, clinical guidelines and the refugee health fellows program). These existing systems and processes provide critical support to the success of both model options described below.

The following models provide options to guide and support decision-making by service providers in the development of specialist refugee health care. The application of these models requires consideration of the local planning context, including existing services and relationships, availability of specialists, resources and community need. One of these models or a combination of the two may be required to meet the health needs of refugees in a given area.
Model Option 1 – Visiting specialist to local community health service (Sentinel Site Model for Refugees)

Description

The sentinel site model for refugees proposes specialist care that is regularly hosted by community health services based in refugee settlement areas. This model involves visiting specialists (e.g., paediatrician and/or ID physicians) providing scheduled clinics for refugees identified as requiring specialist medical services. It suggests a network of GPs and other primary care staff with refugee expertise (e.g., refugee health nurses), work in partnership with visiting specialists to identify, assess and support those refugees requiring specialist intervention in the local area. This model requires the refugee health nurse (or other nursing or allied health role with expertise in refugee health, where RHN is not available) to provide care coordination support and liaise between networked GPs and visiting specialists.

Model Rationale

This model provides increased access to specialist services in localised settings with which refugees are potentially more familiar. CHSs are present in each of the nominated settlement areas across Victoria and provide established infrastructure from which to build specialist service provision, thereby minimising need for capital investment.

CHSs provide a focal point for a range of primary care services, including dental (not available in all CHSs), counselling and other allied health services of which refugees are identified for priority of access. In addition specialist services provided through CHS settings provide access to co-located refugee health nurses and to some extent GPs, both essential components of any model of care.

Application of this model

This model may integrate best with current service provision in settlement areas where there is:

- Limited capacity to establish hospital based specialist clinics
- A community health service with co-located GPs or with well-established links with private GPs with bulk billing capacity
- A refugee health nurse or community health nurse with developed expertise in refugee health to provide care coordination and GP/specialist liaison role, and
- Where there is availability of pathology, pharmacy and radiology services at no or minimal cost (or where there is a health service willing to provide support with these services).

### Components of care

The following components of care are included in this model, which may be available through existing agency and service provider resources or may require additional funding to support their implementation:

<table>
<thead>
<tr>
<th>Specialised component</th>
<th>Staffing</th>
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<tbody>
<tr>
<td><strong>Visiting specialist (Paediatrician and/or ID physician)</strong></td>
<td></td>
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<tr>
<td>- Providing clinical assessment and treatment through regular, scheduled clinics</td>
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<tr>
<td>- Potential to fulfil requirements for TB undertakings in nominated rural and outer metropolitan locations</td>
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<tr>
<td>- Provide pathways to other speciality services including mental health and maternity care.</td>
<td></td>
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<tr>
<td><strong>Refugee health nurse or existing nursing position with portfolio in refugee health</strong></td>
<td></td>
</tr>
<tr>
<td>- Providing essential care coordination</td>
<td></td>
</tr>
<tr>
<td>- Conduct initial needs identification of eligible refugees</td>
<td></td>
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<tr>
<td>- Providing updated information to DIAC funded IHSS settlement worker regarding experienced and trained GP providers</td>
<td></td>
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<tr>
<td>- Coordinating appropriate screening requirements</td>
<td></td>
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<tr>
<td>- Facilitating referral and support to attend specialist service appointments</td>
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<tr>
<td><strong>GPs with expertise in refugee health</strong></td>
<td></td>
</tr>
<tr>
<td>- Undertaking comprehensive health assessment (i.e., Refugee Health Assessment tool; GPDV, 2007) which may result in specialist referral</td>
<td></td>
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<tr>
<td>- Referral to specialist</td>
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<tr>
<td>- Providing monitoring and review between specialist visits</td>
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</table>

<table>
<thead>
<tr>
<th>Generalist components</th>
<th>Management and leadership support:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Build partnerships and collaborations at a regional level to enhance refugee health service delivery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Integrate specialist services with the wider community health service</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Identification of resources, including reorientation of existing resources to support refugee health service provision</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary care staff including:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allied health staff located at CHS as required and referral pathways that include these services</strong></td>
</tr>
<tr>
<td>Community support staff</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>• Identifying existing settlement workers and other community support workers who can link refugees into experienced network of GPs and facilitate their access into specialist services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Division of general practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Working with RHN to identify interested GPs to work with refugees</td>
</tr>
<tr>
<td>• Provision of support and professional development</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative and clinic coordination support providing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assistance with appointment making</td>
</tr>
<tr>
<td>• Interpreter booking</td>
</tr>
<tr>
<td>• Reception support</td>
</tr>
<tr>
<td>• Follow up and collation of client screening outcomes for pending specialist review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information management systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Availability of an integrated information management system which allows for the sharing of client information across specialist and primary care providers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pathology services which are accessible and have bulk-billing capacity</td>
</tr>
<tr>
<td>• Access to X-ray for children to support TB follow-up screening on mantoux tests</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Refugee specific components</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interpreting and translating services (including reminder calls using interpreters)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systems coordination to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify specialists to work within the model (e.g. locally or through existing specialist refugee clinics)</td>
</tr>
<tr>
<td>• Establish referral pathways between primary and specialist services (possible role for Primary Care Partnership – building on existing service coordination work)</td>
</tr>
<tr>
<td>• Document communication protocols</td>
</tr>
<tr>
<td>• Develop clinical guidelines to safely and appropriately manage refugee health issues</td>
</tr>
</tbody>
</table>

Complex health care coordination – provided by refugee health nurse and/or practice nurse.

Access to necessary medications and health screening tests which are common to refugee health issues. Available at no or minimal cost.

**Facilitators for implementation**

**Critical success factors for implementation of this model include:**

- Service delivery
  - A system of support is in place for client follow-up care in between specialist visits supported by clear clinical guidelines
  - Roles and scope of practice for all health workers are clearly defined
Challenges

- Funding
  - Access
    - Assessment
      - to specialist
      - and appropriately
      - with readily
      - required
      - refugee
      - billing
      - issues
    - Effective
      - Remuneration
      - Staffing
    - Funding
      - Access
      - Refugees
      - Integration
      - Staffing
      - Communication
      - Management
    - Funding
      - Services
      - strategic
      - implementation
    - Funding
      - such
      - as hospital
      - infrastructure
      - clients,
      - Availability
      - Clinics
      - funded
      - in appointment
      - settings.
    - Funding
      - within
      - CHS.
    - Funding
      - MSOAP
      - (MSOAP) – Appendix 6.
    - Funding
      - CHS
      - management
      - supportive
      - of the services
      - and incorporates
      - refugee
      - services
      - into strategic
      - and resource decision-making.

Challenges for implementation

- Access to necessary medications and health screening tests that are affordable
  - Clinics provided outside hospital settings need to have access to publicly-funded pharmacy and pathology. This includes paediatric X-ray for TB follow-up. Currently these can be limited and expensive for clients outside hospital settings. The development of partnerships with hospitals may assist in resolving this issue.
- Staffing
  - Identifying specialist willing to travel to rural areas and provide bulk-billing medical services [See Medical Specialist Outreach Assistance Program (MSOAP) – Appendix 6].
- Refugees may still need access to tertiary health care services
  - In particularly complex cases referral to tertiary specialist.
- Funding
  - Availability of stable funding to establish and run the clinic. Missed appointment may impact on viability of clinic where funding is reliant on bulk billing.

Funding and strategic investment

Assessment of infrastructure support and required resources prior to implementing model, including:

- Effective administrative and medical clinical infrastructure (e.g. GP access, onsite or readily available pathology and X-rays) are in place and that specialist clinics are appropriately planned and coordinated
- Staffing resources are allocated to the specialist clinic, including component of refugee health nurse role, GP services and other allied health staff as required.
- Funding to employ specialists is allocated or partnership arrangement is established with hospital to outreach specialist staff. If the service is to be funded through bulk billing clients, consideration needs to be given to broader infrastructure costs, and issues such as missed appointments and their impact on clinic viability
- Remuneration to encourage specialists to travel to rural and regional areas where required (consider application to MSOAP).
This model is already in place to some extent in:

- Darebin LGA (GPs, Vitamin D and Paediatrics)
- Brimbank LGA (Paediatrics only)
- Maribyrnong LGA (GPs, Vitamin D, Paediatrics and mental health)

These visiting specialist services are funded jointly by the host community health services and MBS. The host community health service provides administrative support for the scheduled clinics and medication and clinical guidelines are provided by the Royal Children’s Hospital Immigrant Health Service.
Model Option 2 – Collaborative Care Model

Description

This model proposes a shared care arrangement for managing the health of refugees within regional catchments, based on a hub and spoke framework. This model is underpinned by a strong partnership approach between a network of local GPs with expertise in refugee health and regional specialist refugee health clinics. Comprehensive early health assessments and relevant screenings are provided for all refugees settling in a catchment area by a network of trained GPs. Network GPs are supported to manage appropriate cases in the community. Support is provided by a refugee health nurse or other appropriate nursing role with training in refugee health, who provides essential care coordination, and by regional specialist refugee health clinics. Regional specialist clinics support the network through a variety of activities such as providing cohesion and direction, managing complex cases and secondary consult support.

Figure 2: Diagrammatic representation of the Collaborative Care Model

Model Rationale

This model reduces fragmentation of care for refugees by strengthening links between primary care and specialist services, while also building local capacity to manage refugee health. Refugees are supported to access high quality care in their local area. Consistency of service is facilitated through comprehensive clinical guidelines and the support of specialist clinic hubs, thereby minimising duplication and the risk that critical issues remain undiagnosed or inappropriately treated. This model provides streamlined access to regional specialist clinics for complex cases through clear referral pathways. The model formalises the opportunity for specialist clinics to facilitate professional development, monitor trends, undertake research and, generally build the capacity of the broader health system to engage in issues of refugee health.

Application of this model

This model may integrate best with current service provision in settlement areas where:

- There is a well-functioning division of GPs to identify and support GPs involved in the model
- There are specialists locally or regionally able to be identified with expertise relevant to refugee health care, and
- Availability of refugee health nurse or other nursing roles to provide complex care coordination and GP/Specialist liaison.

**Components of care**

The following components of care are included in this model, which may be available through existing agency and service provider resources or may require additional funding to support their implementation:

<table>
<thead>
<tr>
<th>Specialised component</th>
<th>Staffing</th>
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<tbody>
<tr>
<td></td>
<td><em>Specialist (Paediatrician and/or ID physician) through specialist refugee clinics</em></td>
</tr>
<tr>
<td></td>
<td>• Providing clinical assessment and treatment through regular, scheduled clinics</td>
</tr>
<tr>
<td></td>
<td>• Provide secondary consultation, support and training to networked GPs</td>
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<tr>
<td></td>
<td>• Develop and regularly update clinical guidelines to support collaborative model</td>
</tr>
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<td></td>
<td>• Provide pathways to other speciality services including mental health and maternity care.</td>
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**Refugee health nurse**

- Providing essential care coordination
  - Co-ordinating initial identification of eligible persons
  - Linking refugees into preferred GPs for comprehensive health assessment
  - Assisting to coordinate screening appointments and follow up of results
  - Facilitating referral and support to attend specialist service appointments as required

**Network of preferred GPs**

- Participating in continuous professional development in areas of refugee health care
- Providing comprehensive health assessment for all refugee family members upon arrival
- Coordinating relevant screening requirements with support of refugee health nurse or practice nurse
- Managing appropriate cases in shared care consultation with specialists and documented clinical guidelines (e.g., Vitamin D deficiency or iron deficiency)
- Referring to specialist clinics for follow up assessment and treatment as required
- Ongoing monitoring of patient care

<table>
<thead>
<tr>
<th>Generalist component</th>
<th>Management and leadership support:</th>
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<tbody>
<tr>
<td></td>
<td>• Build partnerships and collaborations between specialist services and Divisions of GPs at a regional level to enhance refugee health service delivery</td>
</tr>
<tr>
<td></td>
<td>• Develop protocols and processes between partner services to facilitate refugee health service delivery across the care continuum</td>
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<tr>
<td>Settlement workers or other identified support worker</td>
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<td>------------------------------------------------------</td>
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<tr>
<td>- Identify existing community staff, including settlement workers and other community support workers, who can link refugees into preferred network of GPs and facilitate their access into specialist services (e.g. assistance with transport, reminder calls)</td>
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<tr>
<th>Division of GPs</th>
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<tbody>
<tr>
<td>- Local Division of GPs develops and manages a register of identified GPs and specialists interested in participating in the model as well as organising regular professional development sessions</td>
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<thead>
<tr>
<th>Information management systems</th>
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<tbody>
<tr>
<td>- Availability of integrated information management systems which allows for the sharing of client information across specialist and primary care providers.</td>
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<tr>
<th>Refugee specific components</th>
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<tr>
<td>Professional interpreting and translating services</td>
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*System coordination processes to assist in establishing:* |
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<tbody>
<tr>
<td>- Partnerships between specialist services and network of preferred GPs and specialists</td>
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<tr>
<td>- Referral pathways and communication protocols between primary and specialist services (possible role for Primary Care Partnership – building on existing service coordination work)</td>
</tr>
<tr>
<td>- Roles and responsibilities that are clearly defined</td>
</tr>
<tr>
<td>- Clinical guidelines to safely and appropriately manage refugee health issues</td>
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*(this could be undertaken by Division of GPs in partnership with specialist services and local PCP)*

A system to facilitate the exchange of client information between specialist clinics and providers

<table>
<thead>
<tr>
<th>Reminder calls using interpreters</th>
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<tbody>
<tr>
<td>Complex health care coordination – provided by refugee health nurse, and or practice/ clinic nurse.</td>
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| Access to necessary medications and health screening tests which are common to refugee health issues, available at no or minimal cost. |

<table>
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<tr>
<th>Facilitators for implementation</th>
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<tbody>
<tr>
<td>- Systems coordination</td>
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<tr>
<td>o Facilitate linkages within and between primary care and specialist clinics and other specialist services</td>
</tr>
<tr>
<td>o Define streamlined pathways from network of preferred GPs to specialist services</td>
</tr>
<tr>
<td>o Clearly define scope of practice for all providers in the shared care arrangement</td>
</tr>
<tr>
<td>o Development and regular updating of detailed clinical guidelines in consultation with all key providers to facilitate the consistent management of health issues.</td>
</tr>
<tr>
<td>- Commitment to regular, high quality communication and information exchange</td>
</tr>
<tr>
<td>o Documented communication protocols which include agreed timelines, responsibilities and referral information required</td>
</tr>
<tr>
<td>o System to support efficient and accurate exchange of client information</td>
</tr>
<tr>
<td>o Ready access to secondary consult support from specialists.</td>
</tr>
<tr>
<td>- Case coordination</td>
</tr>
</tbody>
</table>
o Availability of case coordination for complex cases to facilitate streamlined transition from primary to specialist services (e.g., refugee health nurse)

- Ongoing collaborative training and professional development.
  o Availability of regular collaborative training and professional development that increases shared understanding of refugee health issues (e.g., via refugee health fellow or GP rotation into specialist clinics).

- Collaborative care “lead”
  o This model requires a ‘leader’ to assume responsibility for the collaborative care arrangement. It is proposed that the specialist or specialist clinics would take this role.

Challenges for implementation

- Clarity regarding roles and responsibilities of key providers
  o This model requires close monitoring to ensure providers are aware of and adhere to, their roles and responsibilities to maintain consistency and management of care.

- Adequate support available to GPs
  o Health assessment of refugee adults and children have the potential to generate multiple referrals, requiring a lot of time in making referrals and following up results. Effective involvement of the refugee health nurse where available, or practice nurse or other suitably qualified provider can assist in managing the workload
  o Specialist services need to be readily available to provide support to GPs including secondary consultation and training – refugee health fellow role may help to facilitate this access.

- Access to necessary medications and health screening tests that are affordable
  o Currently, some medications and screening tests commonly used for refugees are limited and expensive outside hospital settings, while some require a specialist to prescribe. The involvement of specialist refugee clinics is vital in this model and assists in overcoming these issues.

- Complex cases may still require multiple appointments to resolve issues
  o Follow up appointments to other specialist services may still be needed for complex cases. By monitoring these trends, specialist clinics may be able to plan and coordinate flexible services to address these issues (e.g. specialist outreach).

- Turnover of professional staff
  o Need to manage succession planning for GPs. Necessity of documenting training programs and continuing to encourage expansion of the preferred GP and specialist network (Division of GPs to take a lead role on this work).

Costing and strategic considerations

- Availability of capacity building resources to identify network of GPs interested in refugee health, provide training, establish linkages between primary care and specialist services, and develop clinical guidelines and document referral pathways. This would require the endorsement of senior management and a competent systems thinker to drive necessary change.

This model is already in place to some extent in:

- Geelong (ID and paediatrics)
- Dandenong (ID, paediatrics and exploring mental health and pathways to maternity services).
References


Appendices

Appendix 1: Acronyms and definitions

Appendix 2: Top 10 reasons why people from refugee source countries presented to emergency departments in public hospitals across Victoria for period 2003-2008

Appendix 3: Top 20 reasons why people from non-refugee source countries presented to emergency departments in public hospitals across Victoria for period 2003-2008

Appendix 4: List of people consulted with during the review

Appendix 5: Service descriptions

Appendix 6: Medical Specialist Outreach Assistance Program (MSOAP) fact sheet

Appendix 7: Literature Review
Appendix 1: Acronyms and definitions

CHS       Community Health Service
DIAC      Department of Immigration and Citizenship
GPs       General Practitioners
PCPs      Primary Care Partnerships
RHN       Refugee Health Nurse
RHNPN      Refugee Health Nurse Program
VFST      Victorian Foundation for Survivors of Torture (Foundation House)
DHS       Department of Human Services
IHSS      Integrated Humanitarian Settlement Strategy
DIAC      Department of Immigration and Citizenship
RCH       Royal Children’s Hospital
RMH       Royal Melbourne Hospital
LGA       Local Government Area
MBS       Medical Benefits Scheme
RHA       Refugee Health Assessment
TB        Tuberculosis
TIS       Telephone Interpreter service
RHAT      Refugee health assessment tool
MSOAP     Medical Specialist Outreach Assistance Program
TBU       Tuberculosis Health Undertaking: The Department of Immigration and Citizenship outlines a range of health requirements for people who want to migrate to Australia permanently or stay in Australia temporarily. These requirements are outlined in the Migration Regulations. Specific TB health screenings are required for those applying for a visa. Where test show evidence of inactive TB the applicant may be asked to sign an undertaking. By signing an undertaking, the applicant agrees to contact the Health Undertaking Service on a free call number on arrival in Australia. The applicant also agrees to report follow up monitoring to a State or Territory health authority, as directed by the Health Undertaking Service \(^{(29)}\).
### Appendix 2: Top 10 reasons why people from refugee source countries presented to ED 2003/4-2007/8

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnoses</th>
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<th>Ethiopia</th>
<th>Thailand</th>
<th>Burma</th>
<th>Kenya</th>
<th>Iran</th>
<th>Nepal</th>
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<td>239</td>
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<td>162</td>
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<td>101</td>
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<td>176</td>
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<td>Nausea and vomiting</td>
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<td>Total admissions to ED (by source country)</td>
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<td>1673</td>
<td>1885</td>
<td>1734</td>
<td>1382</td>
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<tr>
<td>% of total ED admissions</td>
<td>29.8%</td>
<td>12.5%</td>
<td>14.1%</td>
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<td>10.4%</td>
<td>2.1%</td>
<td>6.8%</td>
<td>10.2%</td>
<td>1.1%</td>
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### Appendix 3: Top 20 reasons why people from non refugee source countries presented to ED 2003/4-2007/8

<table>
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<tr>
<th>Diag1</th>
<th>Diag1_Description</th>
<th>Frequency</th>
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<td>R074</td>
<td>Pain in throat and chest</td>
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</tr>
<tr>
<td>R104</td>
<td>Abdominal and pelvic pain</td>
<td>37698</td>
</tr>
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<td>B349</td>
<td>Viral infection of unspecified site</td>
<td>32585</td>
</tr>
<tr>
<td>Z099</td>
<td>F/U after Rx cond oth than malg neoplm</td>
<td>25585</td>
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<td>Diarrh &amp; gastroenteritis pres infectious</td>
<td>22991</td>
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<td>S619</td>
<td>Open wound of wrist and hand</td>
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</tr>
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<td>Acute URTI multiple &amp; unspecified sites</td>
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<tr>
<td>N390</td>
<td>Other disorders of urinary system</td>
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<tr>
<td>S628</td>
<td>Fracture at wrist and hand level</td>
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<td>Cellulitis</td>
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<td>R55</td>
<td>Syncope and collapse</td>
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</tr>
<tr>
<td>S0180</td>
<td>Open wound of head</td>
<td>14633</td>
</tr>
<tr>
<td>H578</td>
<td>Other disorders of eye and adnexa</td>
<td>12033</td>
</tr>
<tr>
<td>S9340</td>
<td>Disloc sprain strain jt ligmt ankle foot</td>
<td>11878</td>
</tr>
<tr>
<td>M7919</td>
<td>Other soft tissue disorders NEC</td>
<td>11430</td>
</tr>
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<td>R69</td>
<td>Unknown &amp; unsp causes of morbidity</td>
<td>11243</td>
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<tr>
<td>J181</td>
<td>Pneumonia organism unspecified</td>
<td>11194</td>
</tr>
<tr>
<td>K529</td>
<td>Oth noninfected gastroenteritis &amp; colitis</td>
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<td>R11</td>
<td>Nausea and vomiting</td>
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</tr>
<tr>
<td>J039</td>
<td>Acute tonsillitis</td>
<td>10410</td>
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## Appendix 4: List of people consulted with during the review

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<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Andrew Block</td>
<td>Southern Health (Dandenong hospital)</td>
<td>Medical Director, ID physician</td>
</tr>
<tr>
<td>Sue Willey</td>
<td>Greater Dandenong Community Health Service</td>
<td>Refugee Health Nurse</td>
</tr>
<tr>
<td>Dr I-Hao Cheng</td>
<td>Dandenong Casey General Practice Association</td>
<td>Refugee Health Program Coordinator</td>
</tr>
<tr>
<td>Dr Brian Cole</td>
<td>Latrobe Regional Hospital</td>
<td>Director of Medical Services</td>
</tr>
<tr>
<td>Rob Metcalfe</td>
<td>Latrobe Regional Hospital</td>
<td>Social Work Manager</td>
</tr>
<tr>
<td>Jo Anne Rash</td>
<td>Latrobe Regional Hospital</td>
<td>Acting Manager Clinical Governance, Community Engagement and Continuous Improvement - Acute</td>
</tr>
<tr>
<td>Claire Kent</td>
<td>Latrobe Regional Hospital</td>
<td>Manager Sub-Acute Care</td>
</tr>
<tr>
<td>Janine Silvester</td>
<td>Latrobe Regional Hospital</td>
<td>Manager Acute Care</td>
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<tr>
<td>Ms Sue Medson</td>
<td>Latrobe Community Health Service</td>
<td>Director of Clinical Services</td>
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<tr>
<td>Trevor Matheson</td>
<td>Ramsay Health Mildura</td>
<td>Director of Medical Services</td>
</tr>
<tr>
<td>David Kirby</td>
<td>Ramsay Health Mildura</td>
<td>Director of Mental Health</td>
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<tr>
<td>Stewart Lawrie</td>
<td>Ramsay Health Mildura</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Jo Marchingo</td>
<td>Ramsay Health Mildura</td>
<td>Midwife. Antenatal special needs</td>
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<tr>
<td>Barb Alexander</td>
<td>Ramsay Health Mildura</td>
<td>Pre-admissions coordinator</td>
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<tr>
<td>David Thompson</td>
<td>Northern Mallee Division of General Practice</td>
<td>Executive Officer</td>
</tr>
<tr>
<td>Rob McGlashan</td>
<td>Northern Mallee Primary Care Partnership</td>
<td>Coordinator</td>
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<tr>
<td>Greg Arthur</td>
<td>Sunraysia Tafe</td>
<td>Case Coordinator</td>
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<tr>
<td>Annette Whittaker</td>
<td>Sunraysia Tafe</td>
<td>Educational Business Manager</td>
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<tr>
<td>Dean Wickham</td>
<td>Sunraysia Mallee Ethnic Communities Council</td>
<td>Case Coordinator</td>
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<tr>
<td>Catina Eyres</td>
<td>Bendigo Health</td>
<td>Nurse Consultant infectious diseases</td>
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<tr>
<td>Brian Jenner</td>
<td>Bendigo Health</td>
<td>Business Director, medical services</td>
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<tr>
<td>Dr Jane Hellsten</td>
<td>Bendigo Health</td>
<td>Infection Control Consultant</td>
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<tr>
<td>Dr Mary Holland</td>
<td>Private GP</td>
<td>General Practitioner</td>
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<tr>
<td>Tracey Wilson</td>
<td>Ballarat Health Services</td>
<td>Manager population health and strategic planning</td>
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<tr>
<td>Dr James Hurly</td>
<td>Ballarat Health Services</td>
<td>ID physician</td>
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<tr>
<td>Leigh Rhode</td>
<td>Goulburn Valley Health</td>
<td>Director, Community &amp; Integrated Care</td>
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<tr>
<td>Dr Mark Harris</td>
<td>Goulburn Valley Health</td>
<td>physician</td>
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<tr>
<td>Faye Hosie</td>
<td>Goulburn Valley Division of general practice</td>
<td>Project worker – refugee health</td>
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<tr>
<td>Dr Dan Obrien</td>
<td>Barwon Health</td>
<td>ID physician</td>
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<td>Dr Eugene Athan</td>
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<td>Margaret Wardrop</td>
<td>Barwon Health</td>
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<tr>
<td>Heather McMinn</td>
<td>Eastern Access Community Health Service</td>
<td>Clinical Services Manager</td>
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<tr>
<td>Merilyn Spratling</td>
<td>Eastern Access Community Health Service</td>
<td>Refugee Health Nurse</td>
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<td>ED coordinators</td>
<td>Eastern Health – Maroondah hospital</td>
<td>ED coordinator</td>
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<td>Clare Douglas</td>
<td>Eastern Health</td>
<td>Acting Chief Executive Officer</td>
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<td>Dr Mary O’Riely</td>
<td>Eastern Health</td>
<td>ID physician</td>
</tr>
<tr>
<td>Dr Amelie Paull</td>
<td>Eastern Health</td>
<td>ID physician</td>
</tr>
<tr>
<td>Lindy Marlow</td>
<td>Western Region Community Health Centre</td>
<td>Refugee Health Nurse State-wide facilitator</td>
</tr>
<tr>
<td>Dr Georgia Paxton</td>
<td>Royal Children’s Hospital</td>
<td>Paediatrician</td>
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<tr>
<td>Dr Collette Reveley</td>
<td>Royal Children’s Hospital</td>
<td>Refugee Health Fellow</td>
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<tr>
<td>Dr Kate Thomson</td>
<td>Royal Children’s and Darebin CHS satellite clinic</td>
<td>Paediatrician</td>
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<tr>
<td>Dr Danni Bao</td>
<td>Ballarat Health and Dandenong Hospital</td>
<td>Paediatrician</td>
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<tr>
<td>Dr David Tickell</td>
<td>Ballarat Health, WRCHC satellite Clinic</td>
<td>Paediatrician</td>
</tr>
<tr>
<td>Name</td>
<td>Institution/Program</td>
<td>Role/Position</td>
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<td>----------------------------------------------------------</td>
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</tr>
<tr>
<td>Jason Cirone</td>
<td>ISIS Primary Care</td>
<td>Paediatric and Refugee health Program Coordinator</td>
</tr>
<tr>
<td>Dr Martin Wright</td>
<td>Western Hospital and ISIS satellite clinic</td>
<td>Paediatrician</td>
</tr>
<tr>
<td>Dr Beverley Ann Biggs</td>
<td>Royal Melbourne Hospital</td>
<td>ID physician Medical Director</td>
</tr>
<tr>
<td>Libby Matchett</td>
<td>Royal Melbourne Hospital</td>
<td>ID Clinic Nurse</td>
</tr>
<tr>
<td>Dr Chris Lemoh</td>
<td>Royal Melbourne Hospital</td>
<td>ID Physician</td>
</tr>
<tr>
<td>Dr Caroline Marshall</td>
<td>Royal Melbourne Hospital</td>
<td>ID Physician</td>
</tr>
<tr>
<td>Dr Karem Leader</td>
<td>Royal Melbourne Hospital</td>
<td>ID Physician</td>
</tr>
<tr>
<td>Dr Kathrine Gibney</td>
<td>Royal Melbourne Hospital</td>
<td>Refugee Health Fellow</td>
</tr>
<tr>
<td>Lee Kennedy</td>
<td>Health West Primary Care Partnership</td>
<td>PCP executive officer</td>
</tr>
<tr>
<td>Natalie Smith</td>
<td>Health West Primary Care Partnership</td>
<td>Refugee Health Project Officer</td>
</tr>
<tr>
<td>Roshan Hapuarachchi</td>
<td>Rural Workforce Agency</td>
<td>Medical Specialist Outreach Assistance Program Coordinator</td>
</tr>
<tr>
<td>Assoc Professor Paul Desmond</td>
<td>St Vincent’s Hospital Melbourne</td>
<td>Director Department of Gastroenterology</td>
</tr>
</tbody>
</table>
Appendix 5 –Service descriptions

Royal Melbourne Hospital: Victorian Infectious Disease Service (VIDS)

*Background to refugee access to specialist services*

The Refugee Health Service is integrated with the Victorian Infectious Diseases Service (VIDS) at the Royal Melbourne Hospital and was established in 2001. The service consists of a weekly refugee health clinic and state-wide referral service for immigrant (and other) patients providing specialist infectious diseases advice and inpatient and outpatient services. The service has a special focus on tropical infections, HIV/AIDS, hepatitis B and C and tuberculosis.

The clinic also provides secondary consultation and support to referring GP’s and specialists throughout Victoria. A 24 hours phone number is also available.

A part time Refugee Health Fellow (0.5EFT) has recently been appointed to the clinic for a 12 month period. This appointment is a part of the refugee health fellow project funded by the department. The fellow provides the clinic increased capacity for comprehensive, assessment and management of refugees, provides secondary consultation and provides professional development to outer metropolitan and rural services.

*Service type*

The RMH provides a weekly outpatients clinic for people of refugee background on a Tuesday afternoon.

*Location*

The clinic is based at Royal Melbourne Hospital (Melbourne).

*Client population*

The RMH immigrant clinic is available for adults from a refugee or immigrant background and refers children and young people to the Royal Children’s Immigration Health Service for follow up assessment and treatment.

*Client Numbers*

The clinic has between 42 and 115 clinic attendances per month.

*Model of Care*

The RMH clinic provides a state-wide specialist infectious diseases screening, assessment and treatment service for refugees or immigrants. Attendance to the clinic is via referral, typically from a GP or other service within RMH.

The service is provided at no cost to the client.

*Referral and management of care*

Referrals to the clinic are received for a variety of reasons including for initial assessment and specialist follow up of issues arising from assessment in primary care. The clinic provides direct treatment of infectious and nutritional diseases and coordinates patient care within the hospital, helping to integrate patients into mainstream services. The clinic nurse manages all referrals to the clinic and follows up with referring GPs and services as required.

Many patients require treatment for several conditions and may attend the clinic for a period of months, allowing medical, nursing and other health care professionals to provide a wide range of related services.
Following the completion of treatment within the clinic, detailed correspondence is sent to the referring GP to assist in assuming ongoing management and care.

**Interpreters**

Onsite interpreters from funded through the hospital are utilized during consultations where available. Where a suitably qualified interpreter is not available telephone interpreting is used. The clinic experiences some issues with access to interpreter’s onsite, particularly from newer and emerging language groups.

Currently no resources are available to provide a bilingual reminder system for appointments.

**Staffing**

The following RMH staff work through the clinic:

<table>
<thead>
<tr>
<th>Service</th>
<th>frequency</th>
<th>organisation</th>
<th>role</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID physicians x 4</td>
<td>weekly</td>
<td>Royal Melbourne Hospital</td>
<td>Screening treatment and management.</td>
</tr>
<tr>
<td>ID Registrar</td>
<td>weekly</td>
<td>Royal Melbourne Hospital</td>
<td>Screening, treatment and management</td>
</tr>
<tr>
<td>Clinic Nurse</td>
<td>weekly</td>
<td>Royal Melbourne Hospital</td>
<td>Coordinates appointments Reviews new referrals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Liaises with referring GPs and services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Referrals to other services as required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provides vaccines/medications as required</td>
</tr>
<tr>
<td>Refugee Health Fellow</td>
<td>weekly</td>
<td>Royal Melbourne Hospital</td>
<td>Screening, treatment, management Builds capacity of referring GP’s and specialist through secondary consultation support and professional development. Builds capacity of hospital departments to manage refugee health or refer to clinic where necessary.</td>
</tr>
<tr>
<td>Hospital Volunteers</td>
<td>weekly</td>
<td>Royal Melbourne Hospital</td>
<td>Assist s. patients to find their way to other departments and to interact with pharmacy</td>
</tr>
</tbody>
</table>

**Links with other services**

The clinic has established close working relationships with a small number of GPs and clinicians in the community, who have an interest and some expertise in refugee health. High levels of communication are in place between the clinic and this network. This includes detailed correspondence from the clinic to the referring GP as well as specialist being available to provide secondary consultation as required.

Beyond this small network of GPs and clinicians, communication channels are less well developed and the quality of referral information is inconsistent.

The refugee health fellow has provided a critical link between GPs and the clinic and is expected to have an impact on improving communication processes and capacity of these GPs to manage refugee health needs.

Refugee health care is currently not well integrated across other departments at RMH. The refugee health fellow is working with other departments to raise awareness of refugee health needs and improve communication and referral pathways.
Funding and Management
The clinic is funded through the infectious diseases clinic (VACS funding) and additional funding from the department. Limited funding was available to liaise and support GP’s until appointment of refugee health fellow position (this is currently a 12 month funded position).

Opportunities for enhances coordination
Some initial discussions have taken place with the Royal Children’s Hospital Immigration health service exploring the potential for running joint adult and paediatric clinics. A number of issue would need to be resolved to support this including; locating a suitable family friendly space to run the clinic and negotiating arrangements for pathology.

Currently exploring the possibility of a shared patient database with other refugee health clinics (RCH, DHRHC, BHRC) to assist with the management of the health care needs of refugees accessing specialist services.

Royal Children’s Hospital Immigration Health Service

Background to refugee access to specialist services
The RCH Immigrant Health Service was first established in 2001 as a comprehensive assessment and consultation service for refugee children and young people and their families. The clinic was developed to with the aim of streamlining specialist health care for this population group. The service has continued to develop and provides state-wide expertise in paediatric refugee issues through a focus on efficiency of clinical services, development of evidence based resources for clinical practice, provision of workforce development and through contributions to clinical research.

Service type
The RCH Immigrant Health Service runs a weekly outpatient clinic providing multifaceted assessment and consultation service. Immunisation, radiology, pharmacy and mantoux testing is all provided onsite. The clinic operates from a family centred care approach and runs concurrently with Infectious Diseases/Travel, Immunisation and Gastroenterology. The service also provides a combined clinic with hepatology. Appointments for other services are made were necessary (e.g. audiology and optometry).

Location
Royal Children’s Hospital (Melbourne).

Client population
The RCH Immigrant Health Service is available for children and young people from a refugee and or asylum seeker background. The service is accessed by referral. Adults are referred to other services for follow up assessment and treatment (i.e. Royal Melbourne Hospital).

Client Numbers
The clinic has 1100 attendances per year (representing 85% of bookings).

Model of Care
The RCH Immigrant Health Service provides a multi-disciplinary and family centred approach to the assessment and treatment of refugee children and young people with complex health issues. Families referred to the clinic are often large which increases the complexity of the healthcare visit. To minimise time and transport requirements for these families, RCH sees families simultaneously.
The service is provided at no cost to the client.

**Referral and management of care**

Referrals to the service are from GPs, including a network of GPs with expertise in refugee health, and also from other services from within RCH. Referrals are received for a variety of reasons including initial assessment, specialist follow up of issues arising from assessment in primary care, development and learning assessments, TB screening and assessment and treatment of Vitamin D. The majority of issues are resolved within the clinic, however where necessary referrals to other services within RCH are made. Following the completion of treatment within the clinic, families are provided with detailed correspondence and a clear plan for each member’s ongoing care. A copy of this information is forwarded to the referring GP for ongoing management and care.

**Interpreter services**

RCH Immigrant Health Service aims to cluster clinics around language groups to assist with block booking of interpreters. Interpreter services are provided by onsite interpreters.

A reminder system is provided by a multi-lingual prior to notify them of their appointments.

**Staffing**

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric consultant and Clinic Head</td>
<td>Weekly</td>
<td>Royal Children’s Hospital</td>
<td>Provides liaison and support to GPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Strategic development and research</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatric consultant</td>
<td>Weekly</td>
<td>Royal Children’s Hospital</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatric registrar</td>
<td>Weekly</td>
<td>Royal Children’s Hospital</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Clinic Nurse Coordinator</td>
<td>Weekly</td>
<td>Royal Children’s Hospital</td>
<td>Manages bookings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coordinates the clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Liaison and referrals with GPs and other community workers</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>fortnightly</td>
<td>Royal Children’s Hospital</td>
<td>Dental assessment</td>
</tr>
<tr>
<td>Onsite interpreter</td>
<td>weekly</td>
<td>Royal Children’s Hospital</td>
<td>Interpreting during consultations</td>
</tr>
<tr>
<td>Volunteers x 2</td>
<td>weekly</td>
<td>Royal Children’s Hospital</td>
<td>Assist families to negotiate between departments within the hospital</td>
</tr>
</tbody>
</table>

**Links with other services**

RCH Immigrant Health Service has developed strong partnerships with a small network of GPs who have developed interest and expertise in refugee health. The service has developed strong partnerships with RMH and Dandenong specialist refugee services, as well as a network of paediatricians with expertise in refugee health.

**Funding and Management**

The clinic is funded through VACS funding and additional funding provided by the department. The service is managed through the Department of General Medicine at the Royal Children’s Hospital.
**Opportunities and potential for enhanced coordination**

Some initial discussions have taken place with the Royal Melbourne Hospital: Victorian Infectious Disease Service with regards to exploring the potential for running joint adult and paediatric clinics. A number of issue would need to be resolved to support this including; locating a suitable family friendly space to run the clinic and negotiating arrangements for pathology.

Currently exploring the possibility of a shared patient database with other refugee health clinics (RCH, DHRHC, BHRC) to assist with the management of the health care needs of refugees accessing specialist services.

**Barwon Health Refugee Health Clinic - Geelong**

**Settlement patterns of refugees in the Geelong region**

The Geelong region has long been a destination for direct settlement of new refugee arrivals. Approximately 250 humanitarian settlers moved to the area between 2002-2007, mostly from Africa. More recently newly arriving Karen families have begun settling in the Corio area. Geelong continues to be a significant settlement site for refugees, with 72 new arrivals reported in the period 2008-2009.

In 2005 the town of Colac supported the settlement of 60 Sudanese people, primarily to work in the local meat works. Settlement to this area has stabilized in recent years.

**Background to refugee access to specialist services in the Geelong area.**

The Barwon Health Refugee Clinic (BHRC) was initially established in 2007 as a part of the Infections Diseases Clinic. The clinic was set up with the goal of responding to the increasing numbers of refugees settling in the Geelong region, requiring specialist assessment and treatment.

In 2009 the clinic expanded to incorporate a satellite clinic in Colac to respond to the needs of refugees settling in this area.

**Service type**

Barwon Health operates a fortnightly outpatient’s clinic on a Tuesday morning from Geelong hospital.

The satellite clinic operating in Colac takes place on a Thursday afternoon once a month.

**Location**

The clinic is based at the Geelong Hospital.

The Colac satellite clinics run from Colac Hospital.

**Client population**

All persons with a refugee background are eligible to access the BHRC. The clinic has the capacity to see both children and adults. In 2008, the majority of refugees attending the BHRC were from Sudan and more recently Burma.

**Client Numbers**

The clinic sees approximately 60 new patients annually, occasioning around 420 episodes of care.
Model of Care

The BHRC clinic provides a multidisciplinary approach to the assessment and treatment of refugee people (both children and adults) with complex needs who require specialist intervention. The Geelong Hospital provides access to pathology testing, radiology and pharmacy through mainstream services.

Referral and management of care

Referrals to the clinic are from GPs, including a small network of GPs with an interest in refugee health and also from other services within Barwon Health. A GP referral pathway has been established between the Corio Community Health Service and the clinic.

The clinic nurse coordinates all referrals to the clinic, including follow up contact with the referring GP or service to ensure all the required information is included on the referral to prevent double up of screening investigations and timely management of health needs. On the completion of any assessment and treatment by specialists, the clinic nurse coordinates referral back to the initial referring GP or service. The discharge includes a letter detailing the treatment that has occurred and any requirements for ongoing management of care. The refugee client may returns to Geelong Hospital for periodical screening or treatment as required.

The Colac Satellite clinic operates as an outreach arrangement for clinical assessment and treatment. Complex issues are referred to Geelong Hospital where necessary.

Interpreter services

BHRC aims to organise onsite interpreting from TIS where possible. However, this is often not available and telephone interpreting is used. The clinic experiences ongoing difficulties in accessing appropriately qualified interpreters to be available onsite.

Staffing

The following Barwon health staff work through the BHRC:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID physician</td>
<td>Fortnightly</td>
<td>Barwon Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td></td>
<td>Runs the Colac Satellite clinic</td>
</tr>
<tr>
<td>ID Physician</td>
<td>Fortnightly</td>
<td>Barwon Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>ID registrar</td>
<td>fortnightly</td>
<td>Barwon Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatric consultant</td>
<td>fortnightly</td>
<td>Barwon Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatrics registrar</td>
<td>fortnightly</td>
<td>Barwon Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Clinic Nurse</td>
<td>Fortnightly</td>
<td>Barwon Health</td>
<td>Manages bookings</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td></td>
<td>Coordinates the clinic</td>
</tr>
<tr>
<td></td>
<td>Colac Satellite clinic</td>
<td></td>
<td>Follow up support to GPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coordinates referrals and discharges</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supports the Colac Satellite Clinic</td>
</tr>
</tbody>
</table>

Links with other services

BHRC has developed links with a small number of GPs who have developed an interest in refugee health issues. The clinic recognises the need to strengthen these links and broaden the network of GPs with specialist expertise in refugee health. Written communication is provided to the referring GP at the conclusion of treatment.
BHRC has strong links with the Barwon Health Community Health Service, in particular with the Corio site. A refugee health nurse has recently been appointed at the CHS and works collaboratively with the clinic to ensure people attend appointments and follow up on screening and treatment requirements. The RHN provides support to the clinic by following up on any additional social and primary care needs of refugees identified through the clinic including; dental, housing, dietetics and counselling where required.

**Funding and Management**

The clinic is funded primarily by VACS and Medicare funding. The clinic is managed through the Infectious Diseases unit.

**Opportunities and potential for enhanced coordination**

BHRC are interested in building the capacity of local GPs to develop expertise in managing refugee health needs in collaboration or shared care arrangement with the clinic. Staff see the role of the Division of GPs as critical in facilitating the identification and professional development for GPs.

BHRC have been involved in the early discussions between the department, RCH, RMH and DHRHC regarding the development of a shared patient data base to support the management and care of refugee patients.

**Southern Health - Dandenong Hospital Refugee Health Clinic and Asylum Seeker Medical Clinic**

**Settlement patterns of refugees in Dandenong**

The City of Greater Dandenong has a long history of refugee settlement and receives the largest proportion or newly arrived refugees in Victoria. In the period 2007 – 2008 the City of Greater Dandenong received 20% of all Victorian Humanitarian entrants.

**Background to refugee access to specialist services in Dandenong**

The Dandenong Hospital Refugee Health Clinic (DHRHC) was first established in 2006. This was in response to the increasing number of refugees settling locally and the number of refugee people presenting to the Emergency Department for conditions that could have been managed in the community. The clinic was set up as a specialist clinic with the goal of providing clinical assessment and treatment for a range of complex health issues experienced by refugees. The clinic has developed over the past three years continuing to offer a comprehensive range of specialist services.

Recently, the Asylum Seekers Medical Clinic (ASMC) moved from the Greater Dandenong Community Health Service (GDCHS) and now operates fortnightly from the DHRHC.

**Service type**

The DHRHC operates as a weekly outpatient’s clinic from the Dandenong Hospital on Mondays from 1.30-5.30pm.

The Asylum Seekers Medical Clinic operates on alternate Mondays from 1.30-5.30pm (this may be increased in future depending on patient numbers).

**Location**

Based at Dandenong Hospital in Dandenong.
**Client population**

DHRHC: All persons with a refugee background are eligible to access the DHRHC. The clinic sees both children and adults. Referrals are received from local GPs and the Refugee Health Nurse based at GDCHS.

ASMC: Medicare-ineligible asylum seekers or asylum seekers who have not yet received a Medicare card.

**Client Numbers**

The clinic sees approximately 200-250 new patients annually, occasioning around 600-700 episodes of care.

**Model of Care**

The DHRHC provides a multi-disciplinary approach to the assessment and treatment of refugees with complex health issues. In addition to hospital staff, a number of staff from external agencies provide services through the clinic. This is undertaken via a partnership arrangement whereby staff are supported by their own agencies to work through the clinic.

The service is provided at no cost to the client.

**Referral and management of care**

The DHRHC incorporates a shared care model involving a small number of local GPs with developed expertise in refugee health issues and the Dandenong Community Health Service Refugee Health Nurse. This involves refugee clients being initially assessed and screened by a GP using the Refugee Health Assessment Tool (developed by the Victorian Division of General Practice) and referred to DHRHS for specialist assessment and treatment of any complex health issue. Referrals are received using a common referral tool developed in consultation with referring GPs. Referrals are then reviewed by the Head of Clinic prior to acceptance. Following specialist assessment and treatment through DHRHC, the refugee client is then transited back to the referring GP for ongoing management and care. This transition includes a GP care plan and letter sent to the referring GP detailing the treatment that has occurred and requirements for ongoing care management. The refugee client returns to DHRHC for periodical screening or treatment as required. The Head of Clinic also provides phone support to referring GPs as required. High levels of communication between DHRHC clinicians and referring GPs are undertaken to manage the ongoing care of refugee clients.

**Support services**

The Refugee Health Nurse provides critical support throughout the complete care pathway including:

- Linking the refugee client to identified GPs
- Supporting GPs to gather information for initial health assessments
- Facilitating referrals to DHRHC specialists
- Assisting refugee clients to attend DHRHC (including physical support)
- Assisting with appointment follow ups.

A bi-lingual (Dari speaking) community worker supports refugees to attend DHRHC through the use of reminder calls, transport and organising interpreters. This worker also assists
refugees to navigate the hospital when required to attend other services such as pathology or pharmacy.

**Interpreter services**

DHRHC aims to cluster clinics around language groups to assist with block booking of interpreters. Interpreter services are provided by the hospital interpreting services including an onsite Dari speaking interpreter.

**Staffing**

The following external agencies and Southern Health staff work through the DHRHC:

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID physician and Head of Clinic</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Reviews all referrals to clinic Provides liaison and support to GPs Strategic development Clinical assessment and treatment</td>
</tr>
<tr>
<td>ID Physician</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>ID physician</td>
<td>weekly</td>
<td>Southern Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>ID registrar</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatric consultant</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>Paediatrics Fellow</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Clinical assessment and treatment</td>
</tr>
<tr>
<td>GP for asylum seekers</td>
<td>Fortnightly</td>
<td>Division of GPs</td>
<td>GP services for asylum seekers</td>
</tr>
<tr>
<td>Unit Manager</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Manages bookings Coordinates the clinic Assists administrative staff</td>
</tr>
<tr>
<td>2 x Administrative Staff</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Administrative support, Arranges appointments &amp; interpreter bookings</td>
</tr>
<tr>
<td>Dietician</td>
<td>Monthly</td>
<td>Greater Dandenong Community Health Service</td>
<td>Consultations and education. Sees children and adults</td>
</tr>
<tr>
<td>CAMHS consultant Liaison</td>
<td>Weekly</td>
<td>Children and Adolescent Mental Health Service</td>
<td>Consultation Facilitates referrals to other mental health services</td>
</tr>
<tr>
<td>Interpreters onsite – (Dari)</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Appointment making Interpreting during consultations</td>
</tr>
<tr>
<td>Refugee Health Nurse</td>
<td>Weekly</td>
<td>Greater Dandenong Community Health Service</td>
<td>Support to clinic staff and clients. Care coordination including follow up with primary care services &amp; other DH departments Immunizations</td>
</tr>
<tr>
<td>Community Development Worker (Dari speaking)</td>
<td>Weekly</td>
<td>Southern Health</td>
<td>Reminder phone calls to clients. Follow up with new clients to ensure they understand the referral and can attend scheduled appointments Assist RHN with follow up appointments Provides transport Assists clients to navigate the hospital</td>
</tr>
<tr>
<td>Centrelink Staff</td>
<td>Monthly</td>
<td>Centrelink</td>
<td>Available to assist patients with Centrelink queries</td>
</tr>
</tbody>
</table>
**Links with other services**

The clinic has comprehensive links with a small group of GPs and external agencies based in the local area. The main referral source for DHRHC comes from these GPs. Regular and timely written communication are provided from DHRHC to referring GPs and from the GPs back to the clinic. A GP care plan is developed in consultation with the referring GP. Specialists are available via phone consultations to assist referring GPs in the ongoing care and management of refugee patients.

The Head of Clinic participates in a local network of settlement, welfare and health agencies to monitor local refugee health needs. The Head of Clinic also regularly attends a practice meeting through the Division of General Practice for the small group of GPs with a special interest in refugee health. The Division of General Practice provides feedback to the Head of Clinic around emerging issues and challenges for these GPs.

**Funding and Management**

The clinic was initially established with surplus VACS funding. Following review of all outpatients services at Dandenong Hospital, a number of existing outpatient services were outsourced or shifted to bulk-billing arrangements. This created capacity to establish refugee specialist health services through existing VACS funding.

External agencies working through DHRHC are self funded and operate on partnership models.

**Opportunities and potential for enhanced coordination**

DHRHC are currently exploring potential to develop specialist mental health services for refugee people. It is anticipated that this service will be developed in consultation with primary care services with the potential of this being transferred to them in due course.

DHRHC are also interested in offering professional development opportunities for GP who are involved with refugees in the area, including opportunities to rotate through the clinic and other professional development areas.

Early discussions have taken place between the department, RCH, RMH and Barwon Health to look at developing a shared patient data base to support the management and care of refugee patients.

**Ballarat**

**Settlement patterns of refugees in Ballarat**

In May 2007, Ballarat was established as Victoria’s second Settlement Pilot site. The first Togolese families arrived in Ballarat in May 2007 and now 10 families are residing in the area.

Since that time, approximately 130 Sudanese have relocated to Ballarat. Numbers of refugees settling in the area are small and have stabilized over the last year.

**Background to refugee access to specialist services Ballarat**

A part time RHN was appointed to work closely with the first Togolese families to assist them in accessing necessary services. The RHN continues to play a central role in coordinating the care of all refugees settling in the area.

Two physicians located at Ballarat Health have the capacity to provide assessment and treatment of Infectious diseases. Access to this service for refugees is organised on a case by case basis.
Ballarat Health Service has a full range of paediatric services and provides assessment and treatment to refugees through mainstream services. A number of refugee children are referred to the RCH Immigrant Health Service for follow up specialist assessment and support for more complex health issues.

**Service type**

No specific service response has been established to support refugee access to specialist services. Services are organised on a case by case basis and facilitated by the RHN.

**Client population**

A small number of refugees (approximately 60 in the past year) have accessed a range of departments within Ballarat Health including the emergency department, antenatal and paediatric services.

**Current practice/Model of care**

The Central Highlands Regional Settlement Planning Committee was established prior to the first refugees settling to the area. The committee still provides a major role in the coordination of services to respond to the health needs of refugees. A health sub-committee, chaired by the CEO of Ballarat Community Health Service, has been established and any issues of access or service gaps are discussed at this forum and service system and workforce development activities organized to respond to these.

The RHN is informed by settlement services of any newly arrived refugees and coordinates initial access to GP services. There is reportedly variable consistency in GP knowledge and expertise in working with refugees and what to look for during initial screening. The RHN works closely with the GPs to follow up referrals and assists refugees to complete necessary screening and to attend specialist appointments where required. The RHN manages the refugee client throughout these episodes of care.

There is reportedly limited access to bulk-billing GP services locally and general lack of expertise regarding refugee health needs among these GP. Although the GP Division facilitated initial training for GPs prior to the arrival of the first Togolese families in 2007.

**Links with other services**

There are well-established links between locally based specialist services, RHN and GPs. The RHN plays a central role in ensuring managing referrals between these services, including communication and sharing of information.

The CEO of BH has been very supportive of ensuring access to services by refugees. Manager of population health has been active in building partnerships and networks with primary sector in relation to this population group.

**Potential for enhanced coordination**

Well-established links exist between services, although these rely somewhat on individuals rather than formalised processes. There is a need for these to be documented and formalised.

There are two locally based physicians who have the capacity to manage ID issues.
Extensive paediatric services available through Ballarat Health including; a paediatrician with an interest in refugee health who currently provides family centred clinics.

**Identified needs and opportunities**

- Potential for documenting referral pathways and communication protocols
- Need to identify and upskill local GPs in relation to refugee health issues and use of Refugee Health Screening (RHA) tool
- Build capacity of Ballarat Health staff in refugee health issues, use of interpreters and the role of RHN.

**Mildura**

**Settlement patterns of refugees in Mildura**

Refugee settlement has steadily slowed since the arrival of refugees from Afghanistan in 2005. The area has experienced approximately 85 refugees settling in the area during the period 2002-2007.

**Background to refugee access to specialist services in Mildura**

The Mildura Hospital has a good spread of specialist services available through mainstream services. They also have visiting specialist coordinated through the MSOAP program (see appendence for MSOAP guidelines). There is currently no coordinated response for refugees requiring specialist access. Reportedly refugees access mainstream services or are referred to Melbourne for specialist follow up if appropriate services are not available.

**Service type**

Currently there is no coordinated response for refugee requiring specialist services in Mildura. Where necessary refugees access mainstream services or are referred to Melbourne for specialist follow up (e.g. TBU’s).

**Client population**

Mildura Hospital currently do not have processes in place to monitor who is using their services and are unaware of any adverse issues or events in relation to refugees in the area. Refugees reportedly use mainstream care pathways to access specialist services.

Approximately 12 months ago there were some issues identified in antenatal services and the Emergency Department, however no issues have been reported over the past year. The issues reported were:

- Late presentation to emergency department for pregnancy
- Inappropriate presentations to ED (i.e. issue could have been addressed in primary care but no access to GP)
- No GP or GP shopping
- No record of previous health issues or treatment.
**Key aspects of current model of care**

A settlement planning committee was established to support the arrival of the first Afghan refugees in 2005. However, since this time the committee has met less frequently and now meet on an as needs basis. Currently there is not hospital representation on this committee.

Refugees are currently seen through mainstream specialist services and are referred by local GPs as required. Access to bulk-billing GP services has improved since the opening of a large extended hour’s clinic.

**Links with other services**

Well-developed networks exist between community agencies in relation to refugees in Mildura, however no formal links have been established between the health service and other agencies to assist in the coordination of care for refugee health issues. Some informal links are established but are based on individual knowledge.

**Potential for enhanced coordination**

Although there is no coordinated approach to refugee health through the hospital, there are examples of other good models of care in place for other vulnerable population groups, such as indigenous people. The indigenous health care model includes the following components:

- Established care pathways which are documented
- Specialist outreach clinics i.e.: paediatrics, Ante-natal services, mental health and ID
- Shared care arrangements with GPs
- Liaison workers to support follow up to appointments and case management
- Reminder system for appointments.

A general physician identified as having TB and other ID experience works through this clinic. There is some capacity to consider extending this clinic to include refugees if the need is identified.

**Identified needs and opportunities**

Hospital staff identified a number of issues in relation to provision of specialist services for refugees, including:

- Lack of availability of interpreters to be available onsite. Need to rely on phone and family
- Not linked into formal networks so are not aware of any issues relating to refugee health needs. Very limited knowledge about these communities. Need to link into existing networks
- Limited awareness of what is available in the community to support refugees. Based on informal networks
• Adhoc training currently provided to staff regarding cultural awareness. Need to increase availability of this training.

La Trobe Valley
Settlement patterns of refugees in the La Trobe Valley

Based on service provider reports, the La Trobe Valley have approximately 400 people of refugee background who have settled in the area, who are predominately Sudanese. Many people have moved from Dandenong to Morwell, Moe Traralgon and Churchill. One of the identified contributing factors has been the availability of public housing. It is expected that this trend will continue.

Background to refugee access to specialist services in La Trobe Valley

Currently there is no coordinated response for refugees requiring access to specialist services in the La Trobe Valley.

The La Trobe Regional Health Service (LRHS) receives limited outpatients funding, all of which are directed to the Emergency Department. There is limited capacity at this point to provide any additional outpatient services.

There is a range of locally based specialist (i.e. general physician, paediatrician) operating from private rooms who reportedly see people on a bulk-billing basis if required.

A part time Refugee Health Nurse was recently funded by the department and appointed by the La Trobe Community Health Service (LCHS) to work with refugees settling in the area.

Client population

In the past year, the LRHS has reportedly seen a small number of Sudanese people across various departments including: antenatal services and the Emergency department. No adverse events or issues have been reported.

The LRHS is not aware of any other refugees accessing the service. Data is not periodically run to identify these groups.

Key aspects of current model of care

There is no coordinated response for refugees requiring specialist support in the La Trobe Valley. It is assumed that refugees access mainstream services through existing care pathways.

Limited outpatient’s capacity is available via the LRHS and specialist services are typically provided through private specialist in their own rooms.

The LCHS and refugee health nurse provide support to refugees who need to access specialist services. If this is not available locally, refugees are referred to Melbourne to specialist clinics such as RCH and RMH.

Links with other services

The LRHS does not have any formal links with services in relation to refugee health issues. Staff from LRHS participates in the four surrounding Primary Care Partnerships.

The Refugee Health Nurse and other staff from the LCHS participate in formal networks in relation to refugee health issues.
**Potential for enhanced coordination**

The LRHS have a strong commitment to refugee health and have identified capacity to support a visiting specialist if required.

Good spread of specialists locally who could provide necessary specialist support in consultation with specialist clinics in Melbourne (RMH and RCH).

**Identified needs and opportunities**

LRHS staff identified the following issues:

- Need to link LRHS into existing refugee health networks to gain an understanding if emerging health issues for refugees locally. Noting La Trobe Valley PCP is currently undertaking service coordination work
- Additional funding would be required to set up an outpatient’s clinic for refugees if the need was established
- Need for workforce training regarding refugee health needs.

**Shepparton**

**Settlement patterns of refugees in the Shepparton area**

In 2004, the City of Greater Shepparton was identified as Victoria’s first Regional Humanitarian Settlement Pilot site for the direct settlement of people from the Democratic Republic of Congo. Prior to and since that time, there has been extensive secondary and internal migration has continued, particularly with people from Sudanese and Afghan backgrounds. In the period 2006 – 2009 Shepparton had more than 365 people from refugee backgrounds settling in the area (note: this is a conservative estimate as settlement data does not always include resettlement).

**Background to refugee access to specialist services in the Shepparton area**

Before its closure in October 2008 a bulk billing GP clinic was operated through the Goulburn Valley Community Health Centre (GVCHS). Previously all refugees settling in the area were seen through this clinic and referred on for specialist support where necessary. A Physician (providing TB screening and treatment) and a Paediatrician provided specialist assessment and treatment for these refugees through their own private clinics. This was provided at no cost to refugee patients. Since the closure of this clinic, these specialists have not received any new refugee referrals. It is currently unclear what is happening to refugees requiring specialist services.

A part-time refugee health nurse is employed through the GVCHS to support refugees to access primary care and specialist services.

**Service type**

Following the closure of the GVCHS GP clinic, the previous care pathways for refugees requiring access to specialist services are no longer in operation. Currently the GV Division of GPs are leading the work to re-establishing a GP clinic based at the GVCHS. This work is being supported by the Refugee health working group of the Regional Settlement Planning Committee. At the time of writing, it is envisaged that this clinic will provide comprehensive health assessments for refugees and referral to specialist services as required.
Location

It is envisaged that the GP clinic will operate from the GVCHS – due to commence in May 2009.

The physician and paediatric specialists provide clinical assessment and treatment through their private practices. Some consultations take place through the Goulbourn Valley Hospital.

Pathology screening, radiology and pharmacy are accessed through Goulbourn Valley Hospital.

Client population

All persons with a refugee background will be eligible to attend the re-established GP clinic. The clinic will have the capacity to see both children and adults in family groups.

The Physician and paediatric specialist will see all persons from a refugee background requiring specialist support.

Key aspects of current model of care

Currently settlement services refer refugees to the refugee health nurse who assists them to link with a GP in the community (bulk-billing). However, these services have very limited capacity to take on new patients and it is unclear what is happening with refugee patients beyond this point.

Current issues:

- Limited capacity of the refugee health nurse to support all arriving refugees to attend GP’s and ensures follow up to specialists. Difficulties transitioning refugees onto mainstream care and therefore reducing RHN capacity to take on new clients.
- Lack of integrated response to refugee health needs following the closure of the GP clinic at the community health service. Concern refugees are falling through the gaps.
- No clearly documented care pathways. Old model was reliant on informal networks.

Proposed Model of Care

The Goulbourn Valley Division of General Practice are currently taking the lead on work to re-establish a GP clinic based at the GV community health centre providing services for refugees along with a number of other disadvantaged population groups.

Referral and management of care

This proposed model would include; 2-3 GPs with expertise in refugee health needs working through the GVCHS GP clinic, to undertake the refugee health assessment, providing treatment where required. Clearly documented referral pathways to the Physician and paediatric specialists would support GPs to make referrals to specialist services.

It is envisaged that the RHN would provide a key role in identifying refugees who would need to attend the GVCHS GP clinic. Using the PCP complexity screening tool, it is proposed that the RHN identify those at high and low risk and coordinate their access to GP services as required. Those assessed as High risk would be seen by the GVCHS GP clinic for initial health
assessment, catch up health care and immunisations. Where required this will involve specialist support and be managed through a shared care approach.

Those assessed as low risk would be linked directly into a mainstream GP for ongoing management of care. The same referral pathways to specialist services would be utilised.

*Interpreters and support services*

The community health services have existing capacity to provide administrative support, interpreter access and a reminder system for refugees accessing the GP clinic.

*Links with other services*

At this stage the GVCHS GP clinic is expected to work in partnership with other GPs locally who are already seeing refugee patients. This clinic does not propose becoming the sole provider of refugee health assessments and treatments, but be available as an additional resource for more complex cases.

The links with specialist services will need to be re-established once the clinic is operational.

*Potential for enhanced coordination*

- A good network of specialist, hospital services (including radiology, pharmacy and pathology) and primary care service exists in Shepparton; however, work is required to strengthen these links and enhance coordination.

- The opening of the Melbourne Uni school of rural health refugee health clinic (due to be established in late 2009) Not clear how this will collaborate with current services.

*Identified needs and opportunities*

- Need for local level planning and system development. Funding required to employ a project worker (more than 12 months) to continue to build the pathways, bring people together, define roles and responsibilities, document care pathways and protocols and monitor the implementation of these processes

- Develop a demand management framework for RHN role to support transitioning of refugee clients into mainstream services, thereby enhancing capacity to take on new refugees

- Need to improve availability of onsite interpreters who are suitably qualified.

- Need to re-establish refugee health network meeting involving all levels of the health system to enhance coordination

- Re-establish referral pathways to specialists and other primary care services

- Enhance communication and sharing of information between specialist and primary care services.
Bendigo

Settlement refugees in Bendigo

In 2005 the Bendigo Karen Refugee Project was developed to support the establishment of a Karen refugee community in Bendigo. Since then Bendigo has experienced significant increase in refugee settlement. Local service providers report that there are now over 120 people of a refugee background now settled in Bendigo, including direct settlement and those who have moved to Bendigo after initial settlement elsewhere.

Background to access to specialist services by refugees in Bendigo

A range of specialists are available through Bendigo Health including paediatrics, antenatal support and specialist mental health services. At this stage an ID specialist from the Austin hospital visits on a monthly basis to run the ID clinic. 2 physicians are based at BH in the Infection Control Unit; however see Hep C patients only. Currently there is no capacity for these physicians to take on a broader ID role. The visiting ID specialist from the Austin also has very limited capacity to attend more frequently.

A settlement planning committee has since been established, involving a wide range of service providers, with steps taken to establish a health sub-committee or similar to look at the specific health needs of refugees settling in the area. Services involved include the Division of General Practice and Bendigo Health, Bendigo Community Health Service. It is anticipated the PCP will coordinate these meetings.

Although some informal links exist between a number of key agencies, currently there is no coordinated response for refugees requiring specialist support in the Bendigo area.

Service type

Refugees are referred to mainstream services for specialist assessment and treatment as required using existing referral pathways.

An Infectious Diseases Clinic operates 1 x monthly by a Visiting Medical Specialist from the Austin Hospital.

Key aspects of current model of care

Referral and Management of care

- Settlement agency links refugees into GP services to undertake Refugee Health Assessment (RHA)

- Karen community is supported by a local GP, via the Division of GPs, to access a small group of GPs who have an interest in refugee health issues. No specific training has occurred for these GPs

- Referrals are made by the GP to Bendigo Health Services for specialist follow up as required. This is usually in the form of written correspondence. No common referral tool is used at this stage

- Refugees are currently seen through mainstream specialist services using existing pathways. Limited integration occurs across departments for this population group.

- Onsite specialists provide clinical assessment and treatment for Hepatitis C
• The ID clinic has the capacity to see adults and children, but more complicated cases are sent to the RCH for further assessment and management

• The infectious Disease Clinical Nurse Consultant provides a booking and reminder service for all clients accessing the ID clinic (no interpreter used). This role also provides a link between referring GPs and the specialists and provides follow up support and advice to these GPs as required

• A discharge letter is sent to the referring GP once the ID clinic has assessed and treated the refugee client.

Interpreters

• Telephone interpreting is used where necessary during consultation

• Appointments are made via phone, however no interpreter is used.

Client profile

• Bendigo health has experienced a steady increase in the number of refugees they are seeing through their departments, in particular infection control unit and antenatal services

• The monthly ID clinic is seeing 2-3 new refugee patients each month and currently has 5 on the waiting list. These patients are the main source of ID, Hep B, Hep C, TB and malaria.

Links with other services

• Informal links exist between primary care and BH in relation to refugees; however, this is based on individual interest and is not documented

• These links vary significantly across departments and is developed on an as needs basis

• A recently appointed GP liaison role based at the hospital has commenced work on enhancing communication and coordination of care between GPs and specialists.

Potential for enhanced coordination

• Significant amount of interest from Infection control unit and Division of GPs for developing a more coordinated response to refugees requiring specialist support.

• Initial discussions have taken place regarding organising joint training, streamlining referral process and establishing communication protocols.

• Expressed interested in pursuing a more formalised shared care model for complex health issues requiring ongoing support.

Identified needs and opportunities

• Increased onsite ID specialist support required (ID registrar) to meet increasing demand for service
• Division of GPs to play a key role in Identify, training and supporting GPs locally to work with refugees. Enhance role of GP to manage complex needs in the community through specialist support

• Need to bring key services and specialist around the table to develop referral pathways and protocols in relation to refugee health issues.

• Enhance capacity for the exchange of knowledge experience and ideas. Including regular seminars and professional development involving relevant staff across sectors involved in refugee health care

• Need for streamlined referral process and sharing of client information.

**Outer Eastern Metropolitan area**

*Settlement patterns of refugees in the outer eastern metropolitan area*

The outer eastern metropolitan area of Melbourne includes the municipalities of Knox, Maroondah and Yarra Ranges. The outer east metropolitan area has experienced increasing refugee settlement over the past few years. From the period 2005-2009, saw approximately 815 refugees have settled directly to the area. These have included people from Burma and Sudan. This trend looks likely to continue.

*Background to refugee access to specialist services in outer eastern metropolitan area*

• Although some informal links exist between local primary care agencies, currently there is no coordinated response for refugees requiring specialist support in the Outer Eastern metropolitan area.

• A refugee health nurse was recently appointed through Eastern Access Community Health Service (EACH) and is currently working to establish links with specialist and primary care services in the area. The refugee health nurse provides support to refugees who need to access specialist services.

*Key aspects of current model of care*

• Eastern Health currently runs weekly outpatients clinics for Infectious Diseases assessment and treatment at both Maroondah and Box Hill Campuses. These clinics are not refugee specific, but interpreters are used when required.

• These clinics are predominately adult focused; however some children are seen if they have been previously seen as inpatient. Children are seen in consultation with a paediatrician. Complex cases are sent to the Royal Children’s Hospital for follow up.

• Eastern Health provides a comprehensive mix of specialist services and outpatient’s services (including paediatric, antenatal and mental health services) through its various campuses.

*Links with other services*

• Eastern Health infectious diseases department report good links with a small number of local GPs who refer to their clinics. This is supported by clear referral pathways into the clinic, responsiveness of specialists to GP referrals and written communication.
**Potential for enhanced coordination**

- Eastern Health recognised the need to link more with community based migrant services as well as the refugee health nurse. Some work has already been undertaken in this area, but a need for greater coordination and referral pathways was identified.

**Identified needs and opportunities**

- Specialist services to be linked into existing networks to identify emerging unmet refugee health needs.
- Identified need for workforce training regarding local refugee health needs.
Appendix 6: Medical Specialist Outreach Assistance Program Guidelines

What is MSOAP

MSOAP is a national program funded by the Australian Government’s Rural Health Strategy under the Rural Specialist Support Program. The aim of the program is to:

- Increase access of regional, rural and remote communities to medical specialist services, and
- Increase and maintain the skills of rural doctors in these areas.

RWAV administers MSOAP in Victoria across all five Department of Human Services (DHS) rural regions:

- Loddon Mallee
- Grampians
- Barwon South West
- Hume
- Gippsland

The Victorian Advisory Group (VAG) provides the broad strategic direction and monitoring of the program in Victoria and is chaired by the Victorian Office of the Australian Government, Department of Health and Aging (DoHA). It includes representatives from the Rural Health Sub-Committee of the Presidents of Medical Colleges, Victorian Department of Human Services, Health Consumers of Rural and Remote Australia, Rural Doctors Association Victoria, General Practice Victoria, Victorian Aboriginal Community Controlled Health Organisations and RWAV.

Further consultative and planning mechanism is provided through a Regional Steering Group (RSG) established in each region to provide input into decision-making about funding allocation and service planning in the region. Membership of the RSGs includes resident medical specialists, hospital CEOs, Divisions of General Practice, University schools of rural health, Department of Human Services, Primary Care Partnerships and GPs. Each RSG is represented on the VAG.

MSOAP Target Areas

Areas of need have been determined using the Accessibility/Remoteness Index of Australia (ARIA) and Socio-Economic Indexes for Areas (SEIFA) as a guide.
### Role of RWAV in MSOAP

RWAV is responsible for the administration and management of MSOAP in Victoria. This includes facilitating/contributing to the needs assessment process, assisting prospective specialists with the development of service proposals, establishing contracts with service providers, monitoring service provision, administering payments to participating specialists and fulfilling reporting and contractual requirements with the DoHA.

### MSOAP Funding Support

Outreach specialists eligible for MSOAP can be supported for the following:

- Travel Expenses
- Travel time
- Meals
- Accommodation
- Facility Fees
- Administration support

### Application for Funding Process
medical specialist service can put forward a proposal to RWAV. Eligible proposals will then be considered in consultation with the relevant RSG according to the priority needs of the area and agreed funding criteria. Service priority needs have been identified through regional and local consultations undertaken with health service providers, including GPs and resident specialists.
Appendix 7: Literature Review

Introduction

This literature review describes a number of service delivery models and “best practice” examples purported to improve refugee access to specialist health care. The review examined evidence both within Australia and internationally, and focused on models of care in rural and regional areas where possible.

This review aims to inform future departmental and service provider planning decisions in developing service models which will most effectively deliver appropriate and quality specialist health care to refugees in Victoria. It also sought to contribute to the evidence base in relation to “best practice” for refugee health care. This review was used to support the development of the Access to Specialist Services by Refugees in Victoria report (2009).

In 2002, the UN High Commissioner for Refugees identified essential health promoting features of health services provided to resettled refugees. It was identified such services “would:

1. Be voluntary and confidential;
2. Be free of charge or affordable;
3. Offer new arrivals choice of gender of treating practitioner;
4. Offer extended consultation time, multiple consultations (where required) and relevant extra-consultation follow-up;
5. Use accredited interpreters;
6. Be delivered by or involve input from a multidisciplinary team involving expertise in mental health, communicable disease, allied health and general medical care;
7. Be delivered by health care professionals with expertise in responding to the special health care needs of resettled. Including those determined by cultural difference;
8. Have well developed links with other health care services involved in refugee health care as well as with services, networks and resources required by new arrivals in the integration process (e.g., employment and housing services);
9. Provide debriefing and professional support to health care providers, particularly those caring for many refugee patients” (1).

With these features in mind, and given the policy context outlined above, a review of the literature was undertaken to identify models of care that meet the specific needs of refugee populations.
Method

This review has drawn on publically available information published in academic databases (including MEDLINE®, EBSCOhost®, informit®, Web of Science® and Expanded Academic ASAP®) and in documents published by national, state and local governments. Literature published by professional and community based organisations was also sourced.

The search protocol involved searches incorporating specific terms delineating three separate areas of focus: (i) Client group focus, (ii) health care focus and (iii) focus on systems / models. Specifically these terms were:

i. Client group focus: “refugee”, “immigrant”, “asylum seeker”, “rural” and/or “regional”

ii. Health care focus: “health care”, “specialist care”, “primary care”, “multidisciplinary care” and/or “integrated care”, and

iii. Focus on models: “models”, “systems” or “frameworks”

Published literature regarding ‘what works and why’ in health systems research has been identified as largely fragmented, often highly contextualised and typically poorly evaluated (2). Much of the literature identified by this review reported on the delivery of primary care for refugees, but fell short of examining comprehensive models of specialist medical care for this resettled population. Similarly, a dearth of evidence was identified for research that clearly documented robust evaluation processes for interventions with refugees. Future research would be well served to continue undertaking comprehensive analyses and evaluation of the issues surrounding the implementation of health systems, specialist care and models of care for refugees.

Models of Care

This review considered health care models designed specifically for refugees as well as drawing on lessons from health service models for other marginalised groups with similar needs (i.e., isolated and under-resourced client groups including rural and regional persons).

Numerous authors have highlighted the variable and confusing taxonomy of health care models that exist in the literature (3) (4) (5) (6) (7). Whilst documented models may use the same language (e.g., ‘shared care’, ‘collaborative care’, ‘shifted outpatients’, ‘specialist clinic’, ‘outreach’, ‘care planning’, ‘case management’, etc.), there exists a large discrepancy in the focus, client profile, care needs addressed, common interventions, provider skills or service responses of specific models (8).

Utilising these variables as a review framework, this report identified three models of care worthy of exploration regarding the development of a specialist model of care for refugees in Victoria: Namely these were:

- Specialist clinic – Hospital based model
- Shared / Collaborative care model – including “Hub and spoke”
- Primary care, Visiting specialist (sentinel site) model
The review evaluates each model in turn. Each model is described; documented benefits and challenges are outlined, before key factors for successful implementation are discussed. In efforts to identify services evidencing “best practice”, a number of specialists service examples for refugee populations were identified and are outlined below. Where possible, efforts have been made to highlight how these particular examples of care fit within the conceptual framework.

Specialist Clinics – Hospital Based Model

Specialist health services are part of the Victorian public health system continuum of care providing an important interface between acute inpatient and primary care (9). Specialist clinics provide “planned non-admitted services that require the focus of an acute setting to ensure the best outcome for a patient” (p. 1). Evidence suggests specialist clinics typically operated as out-patient clinics from within either tertiary or regional hospitals. These two models are presented separately with shared benefits and challenges highlighted. The term ‘specialist clinic’ in this review refers to clinics specialising in assessing and managing complex issues of refugee health.

Tertiary Hospital Model:

Description

A tertiary hospital is typically a major hospital centrally located in a metropolitan area with a large compliment of specialist services available to provide tertiary level health care (e.g., paediatrics, general medicine, various branches of surgery, oncology and / or psychiatry). Although staffing arrangements vary markedly between specialist refugee clinics, this model typically included a range of specialist physicians and medical staff practiced in refugee health issues, who would operate regularly from the clinic. Specialist clinics within tertiary hospitals were typically responsible for providing state-wide service provision, secondary consultation, monitoring and research opportunities (9) (10). Patient referrals are received from GPs, specialists and emergency department clinicians, inpatient units or other areas of the hospital. Following treatment, patients were discharged, discharged to their referring GP or provider or admitted for inpatient treatment.

Tertiary Hospital Model: Examples

In Victoria there are currently two specialist refugee clinics based at tertiary hospitals:

- Royal Children’s Hospital: Immigrant Health Service
- Royal Melbourne Hospital, Victorian Infectious Diseases Service: Immigrant and Refugee Clinic

These specialist clinics are reviewed in Appendix 5 of the attached report. It worth noting that both of these clinics recently received DHS funding to employ Refugee Health Fellows to increase each clinics capacity for comprehensive assessment and management, secondary consultation and professional development. An important capacity building part of the Refugee Health Fellow’s role will be to provide education and support to GPs and specialists who see refugees in mainstream services.

Centralised specialist refugee clinics operating from tertiary hospitals were also identified in a number of other Australian states. Of note were:

- Sydney Children’s Hospital: Refugee Clinic (NSW),
  (see: http://www.sch.edu.au/services/services.asp?id=34)
- Royal Hobart Hospital: Refugee and Humanitarian Arrival Clinic (RAHAC; Tasmania)

- Princess Margaret Hospital for Children: Paediatric Refugee Health Clinic (Western Australia) (see: http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=153)

Internationally, one particular specialist refugee clinics was identified:

- San Francisco General Hospital and Trauma Center: Family Health Center – Refugee Medical Clinic

The Refugee Medical Clinic, a primary care clinic at San Francisco General Hospital, specialises in providing culturally appropriate health care services to refugees, asylum seekers, victims of trafficking and other immigrant communities. This model is primary care led, however incorporates specialist assessment and management through scheduled clinics.

The Refugee Medical Clinic collaborates to navigate newly arriving clients through a full physical health exam, extensive medical history, mental health evaluation, health education, dental screening, referrals and follow-up for all identified health conditions. Special care has been taken to create partnerships between specialist providers and interpreters/health educators to serve as brokers between the cultural practices and health beliefs of these communities, as well as to bridge linguistic gaps. Services are delivered within a ‘primary care continuity provider model’, designed to maximize health care resources. Primary care referrals and support (e.g., patient education, counseling, and the selective use of diagnostic, screening and therapeutic services) are all incorporated in a coordinated and comprehensive fashion to facilitate early diagnosis, treatment of illness health and ongoing maintenance.

(see: http://www.sfdph.org/dph/comupg/oprograms/CHPP/Newcomers/default.asp)

**Regional Hospital Model:**

**Description**

Specialist refugee clinics based in regional hospitals are similar in structure to specialist clinics provided through tertiary hospitals; however, these clinics are based in areas of the state with high refugee settlement and have a regional catchment.\(^{(10)}\)

**Regional Hospital Model: Examples**

In Victoria there are two specialist clinics based in regional hospitals

- Dandenong Hospital Refugee Health Clinic

- Barwon Health Refugee Clinic
  (See: http://www.baronhealth.org.au/App_CmsLib/Media/Lib/0803/M2184_v1_633422340976483750.pdf)

Other regional based hospitals running specialist clinics include:
**Coffs Harbour Base Hospital – Refugee Health Clinic:**

This clinic runs four hours weekly, takes community referrals and has been operating since 2006. The clinic was established after staff identified increasing demand regarding infectious diseases and became aware that the needs of refugee clients were not being adequately addressed through mainstream or community-based services. A single ID nurse undertakes initial client assessment and arranges pathology screenings for comprehensive health assessments by one of several GPs running from the clinic. Clinic GPs complete health assessments and make specialist referrals as required utilising internal referral processes through the hospital. Non-referred clients are managed through the clinic until a community based GP can be sourced who agrees to undertake ongoing management of the client. Difficulties are reported in securing community based GPs prepared to take on refugee clients (Michelle Greenwood, personal communication, 2009).


**Benefits for specialist refugee health clinics based in hospitals (both tertiary and regional)**

The literature identified a number of benefits for hospital based specialist refugee health clinics. These included:

- **Service delivery – Access**
  - Improved access to a range of health specialists due to their co-location \(^9,11\).
  - Improved access and affordability to on-site pathology, pharmacy and radiology \(^12\).

- **Service delivery – Staffing**
  - Access to staff with specialist skills in responding to refugee health needs \(^13,14\).
  - Access to (often onsite) interpreting services \(^13,15\).

- **Service delivery – Assessment, care management and referral**
  - Enhances streamlining and efficiency of the clients care journey by provision of a range of specialists and services on one site. Also enables improved capacity to more fully document client’s care journey \(^10,13,12\).
  - Provides simplified access to specialist advice for more complicated cases \(^17,18\).
  - Ability to focus explicitly on delivering culturally competent services \(^1\).

- **Program management – Building expertise**
  - Consolidation of knowledge of refugee health needs \(^10,19\). This consolidation facilitates clinics to play an important role in:
    - Informing government policy to ensure health service delivery remains responsive to refugees \(^1\)
    - Providing research, teaching opportunities, professional development, support and secondary consultation to the wider health system \(^9\).
• Documenting emerging issues and trends in relation to refugee health needs \(^{10}\)

• Advocating for refugee health \(^{20}\).

**Specific benefits of specialist clinic based in regional hospitals**

- **Service delivery – Access**
  - Provides decentralised specialist health services closer to where communities live thereby reducing travel requirements \(^{21}\), \(^{22}\), \(^{23}\).
  - Increased potential to combine paediatrics and adult services on single site \(^{22}\).

- **Program management – Building expertise**
  - Consolidates and builds local expertise to see refugees \(^{13}\), \(^{23}\).

**Identified challenges for hospital based specialist clinics (both tertiary and regional)**

The literature also identified a number of challenges for hospital based specialist refugee health clinics. These included:

- **Service delivery – Access**
  - Risk of stigmatising refugees by separation from mainstream services \(^{23}\), \(^{24}\).

- **Program management – Building expertise**
  - May reduce development of capacity in the wider health system in supporting refugees and assuming responsibility for their health care \(^{13}\), \(^{1}\), \(^{2}\).

**Specific challenges for tertiary based specialist clinics**

- **Service delivery – Access**
  - Location of specialist clinics and distance to where refugee people are settling. Particularly an issue for outer metropolitan and rural/ regional areas \(^{21}\), \(^{1}\).

- **Service delivery – Links with other services**
  - If specialist clinics are not located locally to where refugees are settling, specialist clinics may struggle to build partnerships with, and link new arrivals to, resources and services in those areas \(^{4}\), \(^{23}\), \(^{22}\).

**Specific challenges: for regional hospital based specialist clinics**

- **Service delivery – Access**
  - May still require referral to tertiary hospitals for complicated health issues \(^{9}\).
  - The lack of critical mass and / or transience of refugees in newer settlement areas, may mean specialised refugee clinics are not utilised regularly \(^{13}\), \(^{22}\).
• Service delivery – Staffing
  o May not have the necessary specialist expertise based locally \(^{21},\ 23\).

• Corporate services – Funding
  o Additional resource and infrastructure costs required to establish and run specialist refugee clinics need to be viable for regional hospitals \(^{13},\ 25,\ 26\).

Discussion

The model of specialist refugee health clinics based in public tertiary and/or regional hospitals provides a number of considerable opportunities for maximising health outcomes for refugees. International and local precedence exists for this type of model, with a number of Victorian clinics currently operating in this manner. Reviewing the literature, a number of issues appear significant for the successful implementation of this model. These include:

• Forecast assessment of infrastructure resources and support,
• Availability of necessary expertise,
• Management support, and
• Integration within the wider health system.

**Forecast assessment of infrastructure resources and support**

Specialist service delivery typically requires resources and protocols that are not readily available in mainstream health settings \(^9\). In the context of refugee health care this includes access and funding for qualified interpreting and translating services, the opportunity for more flexible consultation times to ensure refugee clients’ cultural needs are being addressed, opportunity for family-centred practices and complex mental health issues are adequately assessed. Sufficient assessment of the infrastructure and resources required in each setting is critical to ensure specialist service delivery needs can be accommodated and sustained \(^{10},\ 25,\ 27\).

**Availability of necessary expertise**

At present, providing specialist health care for refugees involves expertise not typical within mainstream services (e.g., expertise in rare infectious diseases, mental health issues precipitated by torture and trauma and specific paediatric developmental issues; \(^{13}\)). Literature suggests a multi-disciplinary team approach to delivery of specialist services for refugees \(^{26},\ 2\), as well as extensive support and specific training to service delivery personnel including debriefing \(^1\). Whilst a number of governmental strategies have been implemented to improve the sustainability of the public health workforce (e.g., Victorian Government *Better Skills, Best Care* – Workforce design strategy, *continuing professional development for rural General Practitioners subsidy* program, Australian Government *Workforce support for rural General Practitioners* program and *More Doctors for outer metropolitan areas relocation incentive grants*), there continues to be ongoing workforce issues, including the availability of specialist practitioners prepared to engage in rural and regional service provision.

**Management Support**

Leadership and governance issues are essential in building and maintaining any effective health system \(^1\). Support from management for refugee specialist clinics is critical as there is often
increased volume of service activity associated with these clients which may impact on the wider health service such as requirements for diagnostic testing and pharmacy, as well as interpreting services and the appropriateness of developing creative and innovative treatment strategies\(^{(13)}\)\(^{(16)}\)\(^{(29)}\).

Integration within the wider health system

Successful models appear to be well imbedded within existing service systems (i.e., they do not operate as isolated units);\(^{(4)}\) They have developed strong links with a variety of primary care services that facilitate effective transmission of data and information, standardised practice in management of the client and clear decision points throughout the patient’s journey\(^{(30)}\). The literature suggests specialist clinics should consistently work to integrate refugees into other refugee specific services (e.g., accommodation services, alcohol and drug services, family and social services) and mainstream services generally\(^{(1)}\)\(^{(10)}\)\(^{(13)}\).

Role of specialist clinics in the care continuum

Clearly, the nature of acute health care settings demand they be available in circumstances of complicated health which require highly specialised interventions. The literature highlighted specialist clinics need be an ancillary to other service models, rather than a substitute\(^{(1)}\)\(^{(9)}\)\(^{(13)}\).
Shared / Collaborative Model of Care – Hub and Spoke model

Although not all are specific to refugees, numerous studies, protocols and programs were identified in the literature that made reference to models of care implying shared or collaborative care (e.g., “Bury Primary Care Trust, 2008” [31]; “partnership model”, Queensland Health, [32]; “community acute / post acute care” [33]; “integrated health system”, [34]). Many of these models compared favorably to those that explicitly identified themselves as “shared care” or “collaborative care”, incorporating features of close inter-service co-operation, documented protocols for referral, data management, and case co-ordination, shared understanding for client treatment goals and appropriate interventions. The models differed markedly however, in their identification of “lead” agency and / or the levels of communication co-ordination prescribed (4). It is hypothesised that this diversity of practice within the shared / collaborative care model, underpins the varied evaluation outcomes available.

A number of studies highlighted the positive outcomes shared / collaborative models can provide to disadvantaged groups in various aspects of health (e.g., [35] [36] [37] [38]) on the other hand, some conflicting evidence suggested that shared care in disease management resulted in minimal client benefits. Their meta-analyses reviewed twenty studies, 19 of which were randomized control trials. The studies were typically complex, multi-faceted and of short duration. The outcomes however, suggested no significant evidence justifying shared care Improved physical or mental health outcomes, psychosocial outcomes, hospital admissions, default or participation rates, recording of risk factors or satisfaction with treatment. The only significant outcome identified was an improvement in prescribing for those studies that included it. The authors reiterate the difficulties in controlling for the complexities of such interventions and the need for longer studies to test the effectiveness and sustainability of shared care over time.

Shared / Collaborative Care model: Description

The predominant feature of the shared / collaborative care model identified in the literature was the prioritisation of effective and efficient communication across the primary-specialist interface in the interests of optimum client care (3) (35) (36). In this manner, the shared / collaborative model of care does not specify a required level of service model complexity other than to highlight it is more comprehensive than standard discharge / referral notices (40). Nor does it specify the formal service structure required, that is the components of the model, service locations, who “leads” and how clinical governance is managed.

Shared / Collaborative Care model: Example

- Collaborative Care Model for Newly Arrived Refugee Families (Sydney, NSW)

The model was initially developed in collaboration between Sydney’s Children’s Hospital (SCH), The Wollongong Hospital (TWH), South Eastern Sydney Illawarra Area Health Service (SESIH) Multicultural Health Service (MHS) and the Illawarra Division of General Practice (IDGP) to provide routine comprehensive health assessment and specialist follow up to all newly arrived refugees (41). Prior to the implementation of this model, no specialised refugee health care services or system ensuring routine comprehensive assessment for refugees existed in SESIH region.

The ‘GP-Hospital collaborative care model’ is underpinned by a strong partnership between SESIH and IDGP. Thorough early health assessment and relevant screenings are provided for each refugee family settling in the area by a network of trained community based GP’s who are aided by a refugee health nurse and supported by hospital based specialists. The model consists of the following components:
• IDGP develops and manages a register of identified GPs interested in participating in the model as well as hosting regular training sessions.

• Department of Immigration and Citizenship (DIAC) contracted settlement agencies notify SESIH of new refugee arrivals

• Settlement worker and refugee nurse based in SESIH link families with identified GPs and support families to attend appointments (both specialist and GP appointments) as needed.

• GPs provide comprehensive health assessment for all family members on arrival as well as ongoing care

• Specialists (Paediatrician and ID physician) at SCH and TWH offer support to GPs through education, training forums, regularly updated screening and management guidelines, easy access to consultation and clinical referral pathways

• Refugee health nurse facilitates communication between GPs and specialist services, supports GPs in managing complex cases and in providing immunisation

• A regular refugee health clinic operates from SCH offering paediatric access to tertiary services (i.e., paediatric infectious diseases assessment), and

• TWH run regular infectious diseases clinics for those requiring tertiary intervention.

The collaborative care model was developed using small capacity building project grants to identify and train GPs, develop clinical guidelines and referral pathways. In the models first year, 100% of children (n = 64) and 95% of adults (n = 56) who settled in the SESIH area received a comprehensive health assessment, recommended screening test and catch up immunisation and vaccinations. Of the 64 children, 28% required follow up tertiary assessment. It was noted that the refugee health nurse and SESIH MHS provide essential coordination and sustainability for this model, with a newly created Refugee Health portfolio at SESIH MHS charged with maintaining the collaborations.

**Benefits for Shared / Collaborative care models**

• Service delivery – Access
  
  o Provides decentralised specialist health services closer to where communities live thereby reducing travel requirements  

  (21)(22)(23)

  o Increased client access to the appropriate screening and level of care in a timely manner  

  (35)(39).

• Service delivery – Assessment, care management and referral

  o Improved care consistency and cohesion across the care continuum  

  (4)(35)(42)

  o Improved provider and client satisfaction through opportunity to provide culturally sensitive, family-centred care  

  (1)(43)(10).

• Service delivery – Links with other services

  o Strengthened linkages between primary secondary and tertiary providers  

  (2)(3).
• Program management – Building expertise
  o Improved capacity building and service integration throughout the region (44),(45)
  o Empowering GPs (36),(44)
  o Greater efficiency of resources through shared protocols and assessment tools (30), (41).

**Challenges for Shared / Collaborative care models**

• Service delivery – Staffing
  o Identifying time and personnel to implement and manage the shared care (46)
  o May not have the necessary specialist expertise based locally (21) (23).

• Program management – Building expertise
  o Limited capacity to effectively evaluate the model (38).

• Service delivery – Links with other services
  o Power and status differences between health providers (e.g., between nurses and GP’s or GP’s and medical specialists; (47)
  o Professional territorialism and perceived threat to professional autonomy and scope of practice (47).

• Corporate services – Funding
  o Inadequate or unsustainable funding arrangements that do not adequately renumerate the logistical difficulties (41),(41)

Regarding shared / collaborative care for refugees, a number of other service models were also identified. Whilst these models all fit within the shared / collaborative care model, they all appeared to possess a central organisation or network that lead the model: a “hub”. This lead organisation had developed strong protocols with a variety of other providers (e.g., Divisions of General Practice, preferred GP’s, primary care agencies), with whom they liaised readily and frequently: the ‘spokes’. This formalised “hub and spoke” network of the shared / collaborative care model was found to provide numerous benefits and minimise a number of challenges typically faced by shared / collaborative care arrangements.

**Shared / Collaborative Care model – Hub and Spoke: Description**

This particular form of shared / collaborative care utilises a formalised network of providers (i.e., ‘spokes’) lead by a single service entity (i.e., the ‘hub’). The ‘Hub’ performs a state-wide support and coordination function as well as a clinical service function for a metropolitan area. It provides specialist expertise, planning, coordination, education and quality monitoring. It also provides a function of monitoring trends, disseminating research and networking the ‘spokes’, facilitating consistent and standardised best practice care approaches.

The ‘spokes’ are autonomous refugee health services or GP services located in regional areas. The spokes provide comprehensive initial health screening, medical assessment and review (in consultation with specialists) and referral to specialist services where required.
Shared / Collaborative Care – Hub and Spoke model: Examples

Three such models were identified and selected for presentation in the review, one in Queensland, one in Massachusetts, USA, and one in British Columbia,

- Queensland Refugee Health Service (QRHS) Hub and Spoke model

Queensland Refugee Health Service uses a hub and spoke model to provide health care to refugees throughout Queensland. Based on a partnership model, the model involves a ‘hub’ based in Brisbane and ‘spokes’ based in significant regional settlement areas in Queensland (i.e., North Brisbane, Logan, Toowoomba, Cairns, Townsville). This model provides a coordinated state wide health service for refugees. The Hub comprises both state-wide and clinical functions, and was planned to be co-located with the Queensland Integrated Refugee Community Health Clinic providing complex health care coordination. The hub reportedly has a small statewide team to undertake planning, coordination, education, support and quality monitoring, as well as conduct the Brisbane South Refugee Health Clinic. The ‘spoke’ services provide direct clinical care services to the client group in the local area and are supported by the hub.


- Refugee Health Assessment Program – (Massachusetts, United States).

[This program] developed a network of private GPs and physicians to provide public health screening and specialised medical services for newly resettled refugees. This arrangement was based on a small network of preferred providers who had enhanced knowledge of refugee health issues. The network of preferred providers was known as the Refugee Health Assessment Program (RHAP) which was networked to the Massachusetts Department of Public Health. Evaluation suggested the program facilitated a decrease in the time refugees waited to be screened and improved the consistency and quality of referral to specialist services through the implementation of clinical protocols. The contractual preferred provider system also reportedly led to improvements in the consistency and quality of care, and facilitated improved transition to primary and specialist services for newly arrived refugees. The model highlighted the necessity of secured funding arrangements, the opportunity a limited network provided to undertake research, program evaluation and monitoring for the changing health needs of refugees, as well as the critical role of the department in co-ordinating this model.

(see: http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Consumer&L2=Multicultural%26Specific+Populations&L3=Refugees+and+Asylees&L4=Refugee+Health&sid=Eeohhs2)

- The Bridge Community Health Clinic – Vancouver, Canada

The program was established in 1994, via a collaboration of a major hospital, a new immigrant resettlement agency, a health promotion service, Vancouver’s health authority and other agencies providing mental health, family and housing support to refugees. The clinic offers a health assessment service with access to on-site interpreters and at no cost to clients. Whilst screening for communicable diseases and addressing other physical health concerns (e.g., dental care), clients are introduced to a wide variety of primary health care options (e.g., immunisation, cervical screening), resettlement or mental health services as required. The clinic prioritises the need to connect refugees into their local communities, dedicating itself to the building and maintenance of collaborative arrangements with a wide variety of localised services allowing successful referral. The
Additional benefits for Shared / Collaborative care model – Hub and Spoke model

- Service delivery – Access
  - Care is provided in regional locations closer to where people are living, through services and providers people are familiar with (1) (10)(34).

- Service delivery – Assessment, care management and referral
  - Providers are empowered to manage refugee health issues through the support and coordination of the Hub services as well as clear protocols for specialist referral where necessary (17)(23)(48).
  - Provides complex health case coordination to refugees with complex health issues requiring multiple referral (32)(35).
  - Consolidation of knowledge to a network of providers increases quality and consistency of care provided to refugees (4)(23)(48).

- Service delivery – Links with other services
  - Clearly delineated roles and responsibilities improve capacity for service cohesion and security, thereby limiting professional territorialism and / or power imbalances (9).

- Program management – Building expertise
  - Access to professional development for networked providers via specialist expertise located within the hub (17)(32).
  - Network of providers have the opportunity to develop enhanced clinical expertise in refugee health issues (10), (32).
  - Combined clinical experience of the providers allows for the development of clinical research and professional development for the wider medical community (9).

- Program management – Mapping and research
  - The use of a limited network of providers facilitates program evaluation and monitoring for the changing needs of refugees (48).

Additional challenges for Shared / Collaborative care – Hub and Spoke model

- Service delivery – Access
  - Complex patients may still need to be referred to specialist clinics either for further investigation or management (32).

- Service delivery – Links with other services
- Support needed from specialised refugee services (23).

- Service delivery - Model documentation
  - Roles and responsibilities need to be clearly defined (9) (32).

- Program management – Communication
  - High levels of communication and coordination are required to ensure consistency and quality of refugee health care (23)(38)(48).

Discussion

The generic model of shared / collaborative care and its more structured variant the ‘hub and spoke’ model, both provide opportunities to assist refugees navigate their journey through the continuum of care. It is noteworthy that specialist clinics that build effective linkages with a provider and referral network could be considered hub and spoke variants. It is also noteworthy that the network of providers through the South Eastern Sydney Illawarra Area Health Service model appeared to have evolved to identify a ‘hub’ service that would engage in effective co-ordination and monitoring of the system.

Whilst the literature on these models does not provide clear direction for implementing this model, a couple of key factors for its successful establishment were highlighted. These included:

- Good governance and organisational structure to manage network of providers
- Need for ongoing management support
- Funding issues

**Good governance and organisational structure to manage network of providers**

This model requires clear protocols, lines of communication and accountability. The less structured the model (i.e., a loose network of equivalent partners), the greater the need for communication and discussion regarding the model, its management and maintenance. The more structured the model (i.e., clearly delineated scopes of practice and lines of accountability), the less negotiation is required. Clearly, the need for a single, unified system of communication suggests a central repository for information and or dissemination may be useful (2)(10).

**Need for ongoing management support**

The model requires strong leadership, coordination, planning and monitoring to support the network of providers. Each service is required to be accountable for its individual role within the model and continue to consider the model within its own strategic planning processes (29). Regional services need to be considered and telemedicine may be a useful consideration (22).

**Funding issues**

The interdependence of the model means flexible funding structures which can accommodate a partnership style of service provision are necessary (32)
Primary Care, Visiting specialist (sentinel site) model

The Victorian Government’s strategic document Care in your community: A planning framework for integrated ambulatory care (2006), highlights the vision of increasingly delivering “person and family centred health care in community-based settings, reducing the need for inpatient care and improving the health outcomes of Victorians” (p. 5). The third model regarding refugee health to be described then, involves specialist outreach to primary care settings: Primary care, visiting specialist (Sentinel site) model.

The Cochrane Collaboration undertook a review examining the effectiveness of specialist outreach in a range of health areas and a variety of settings (49). Although this review was not specific to refugee populations, a number of key issues can be drawn to inform the viability of this type of care model and how it may relate to refugee populations.

The review found that simple “shifted outpatients” styles of specialist outreach did improve access; however, no evidence of improved health outcomes was identified. Where specialist outreach was provided as a part of a more complex multi-faceted intervention involving primary care collaborations, education and other services, significant positive outcomes were noted including improved health outcomes, more efficient and guideline consistent care, and reduced use of inpatient services. This review also identified a need for more evidence evaluating specialist outreach within disadvantage population groups (49).

The Australian Government’s recent Rural Health Strategy has noted that medical specialists tend to be heavily concentrated in major metropolitan and urban areas (50). Under the Rural Specialist Support Program, the government developed the Medical Specialist Outreach Program (MSOAP; see Appendix 6 - for a description of MSOAP program and application process). This program aims to improve access for regional, rural and remote communities to medical specialist services. The specific objectives of the program are:

- To increase visiting specialist services in areas of identified need
- To facilitate visiting specialists and local health professional relationships and communication about patient are, and
- To increase and maintain the skills of regional, rural and remote general practitioners and specialists.

This commitment by the Australian Government highlights the desirability and perceived utility for this model of care.

Primary Care, Visiting specialist (sentinel site) model: Description

The primary care, visiting specialist (sentinel site) model for refugees proposes specialist care that is regularly hosted in local, primary care settings. The model involves a network of specifically trained GPs undertaking initial screening and assessment tasks for new arrivals, typically with the support of refugee specific staff (e.g., refugee health nurse, interpreters, etc.). Referral for further medical assessment and treatment is made to specialists (e.g., paediatrician and/or ID physicians) who provide regular scheduled clinics for refugees onsite (i.e., at the assessing primary health care site). Specialists may typically be based in a dedicated refugee health clinic, or operate from private rooms either metropolitan or locally based. The ‘partnership’ arrangement between health practitioners and associated allied health staff is facilitated by shared administrative procedures, opportunities for both direct (i.e., GP-specialist-GP) and indirect (i.e., GP-refugee health nurse-specialist-refugee
health nurse-GP) communication regarding health management. The model presupposes case coordination within the primary health care setting to assist refugee clients navigate their journey.

**Primary care, visiting specialist (sentinel site) model: Examples**

Three examples of this model were identified: two Victorian and one in Canada:

- **Vitamin D Clinic at Western Regional Health Centre (WRHC; Footscray)**

In 2005 the Western regional Health Clinic (WRHC) in partnership with the RCH Immigration Health Service commenced a Vitamin D Clinic to help relieve unnecessary pressure on the regional hospital. WRHC employs a paediatrician from the RCH Immigration Health Service and the RCH supplies the high dose Vitamin D medication used in treatment. This clinic operates as a component of the primary care Refugee Health Program provided through WRHC, with the Refugee Health Nurse taking on a key healthcare coordination role to support specialist referral and care. Close working relationships have been established with GPs at WRHC. More recently a visiting psychiatrist is providing specialist services in conjunction with GP services. The Vitamin D Clinic at WRHC is currently attempting to broaden its focus to include other refugee and immigrant health issues beyond Vitamin D (42).


- **ISIS Primary Care (Werribee)**

This program includes a Refugee Health Nurse, GP’s and visiting Western Health paediatrician all based on the one site. It also includes referral to a range of allied health services and to RCH and RMH refugee clinics as required. Increasingly referrals are being received from local community GPs who have completed refugee Health assessment and identified the need for specialist consultation and assessment (10).


- **North Hamilton Community Health Centre Immigrant/Refugee Program (Ontario, Canada)**

The Immigrant / Refugee Health Program (IRHP) attached to the North Hamilton Community Health Centre commenced in 1989 and has since adopted an integrated primary-specialist model of care. The main goal of the IRHP is to assist refugees and new immigrants. A comprehensive range of primary care services are provided at a regional site with visiting specialist/consultant care (including antenatal, gynaecology, TB/respiratory and paediatric) provided intermittently. Where additional specialist services are required these services are accessed through local hospital outpatient clinics or private rooms. The IRHP collaborates with a wide range of local services including refugee support services, culture specific community groups, family violence networks, housing / resettlement programs, employment services and churches. Mental health services are also provided by a Spanish speaking psychologist and utilisation of interpreters where possible. Initially established in response to the large Central American population, the centre’s target population has shifted as demographic patterns have changed. It is noteworthy that the centre has now developed into a regional resource for the broader Hamilton region (1)(51).

[http://www.northhamiltonchc.org/program.asp?program=6](http://www.northhamiltonchc.org/program.asp?program=6)
Benefits for Primary care, visiting specialist (sentinel site) model

- **Service delivery – Access**
  - Local provision of specialist medical services in settings clients are familiar with. This may be particularly important for managing mental health issues \(^{(34),(36),(42)}\)
  - Increased opportunities for family-centred practice to be enacted \(^{(10),(34),(51)}\)
  - Minimisation of travel time, distance and cost for refugee clients and their families compared to attending appointments in urban centres \(^{(49),(52)}\).

- **Service delivery – Staffing**
  - Assists in addressing workforce shortages in regional and remote areas \(^{(53)}\).

- **Service delivery – Assessment, care management and referral**
  - Provides continuity of care and opportunity for service flexibility \(^{(34),(51),(49)}\)
  - Availability of local follow up support for refugees accessing specialist services (i.e., allied health, Refugee health Nurse; \(^{(42),(51)}\).

- **Service delivery – Links with other services**
  - Provides excellent opportunity for family engagement with a variety of primary care services (i.e., all those programs run from the primary care site; \(^{(1),(10),(34)}\).
  - These settings provide a local / regional focus for refugee health care \(^{(1),(51)}\).
  - Facilitates ongoing communication between specialist and other health professionals involved in a refugee’s care \(^{(4),(42),(52)}\).

- **Program management – Building expertise**
  - Build local capacity for delivering refugee health \(^{(10),(53)}\).

Challenges for Primary care, visiting specialist (sentinel site) model

- **Service delivery – Access**
  - Clinics provided outside hospital settings require access to publically funded pharmacy, pathology and radiology which can be difficult \(^{(21),(42)}\)
  - Refugees may still need access to tertiary health care services \(^{(9),(21)}\).

- **Service delivery – Staffing**
  - Identifying specialists willing to travel to rural areas and provide bulk-billing medical services \(^{(21)}\).
Clearly, Forecast issues particularly difficult health primary projected. The Discussion suggests refugees. fit localised well skilling interventions model • • • • • • • • • • • • • • • • Access are care. In significant to care process. Ideally, this process addresses service needs of the population, actual and projected demographics, assessment of risk and comprehensive consultation with all sectors, particularly allied health care services (21,49).

**Discussion**

The model of primary care, visiting specialist (sentinel site), proposes a large number of benefits that fit well within a number of overarching policy and principle documents (e.g.,(1), (10), (34)). Evaluation suggests it can improve health outcomes when appropriately integrated into multi-faceted primary care interventions (49). Despite these positive indications, evidence suggests this model can be difficult to sustain long-term with a number of logistical challenges evident. Although many of these issues are not specific to refugee populations, the literature highlights certain factors which may be instrumental in successful implementation of a primary-care, visiting specialist model of care for refugees. These are:

- Forecast assessment of infrastructure support and resources
- Service delivery – Model documentation
- Integration within the wider health system
- Corporate services – Resources

**Forecast assessment of infrastructure resources and support**

Clearly, significant resources are required to introduce, establish and maintain specialist visiting into primary care sites. In the context of this model and refugee health care this includes identification of localised at-risk refugee populations, funding for qualified interpreting and translating services, and up skilling for primary care staff to better facilitate family-centred practices and complex mental health care. Planning for sentinel site services should involve a catchment based comprehensive planning process. Ideally, this process addresses service needs of the population, actual and projected demographics, assessment of risk and comprehensive consultation with all sectors, particularly allied health care services (21,49)
Service delivery – Model documentation

Similar to all the models presented do far, the critical role of developing robust and clear protocols for care management of refugees is noted. In this way individual practitioner roles and responsibilities are clearly defined, a system of support is in place for follow up care for clients in between specialist visits, and appropriate up skilling of primary health care staff in undertaken. Effective administrative and clinical support structures are in place and that specialist clinics are appropriately planned and coordinated (16), (29).

Integration within the wider health system

Given that specialists are effectively ‘hosted’ in primary care settings, hosting agencies are required to respect their commitment to these visitors in all strategic and logistical planning (i.e., specialist service delivery is viewed as a core component of service delivery, not just an add on). Similarly, ongoing corporate / management support is important else primary care-specialist relationships will falter and specialists may be lost. All practitioners are equally responsible for supporting each other with refugee health nurses and / or other dedicated primary care staff perhaps critical in consolidating and maintaining these relationships (10).

Corporate services – Resources

Evidence suggests this model may suffer in its heavy demand on both financial and human resources (21), (49). Adequate investment in building sustainable funding and staffing arrangements appears critical. In particular, creative remuneration needs to entice and secure specialists with necessary refugee health expertise to travel to regional and rural areas (53). Finally, services needs to build upon local capacity thereby creating sustainability through effective succession planning and opportunity to accept refugee clients into up skilled ‘mainstream’ services.

Conclusion

This literature review sought to describe a number of service delivery models purported to improve refugee access to specialist health care. In doing so, the review aimed to inform the development of evidenced based models of care to support departmental and service provider decision making.

Following review of the international and national literature, a number of relevant models of care were identified. These included:

- Specialist clinics - hospital based,
- Shared/collaborative care (Hub and spoke), and
- Primary care, visiting specialist

Current practice examples for each of these models were described and evaluative information was provided where available. Each model identified specific benefits and challenges as well as key features required for their successful implementation and sustainability.

The literature review considered health care models designed specifically for refugees, and also drew on lessons from those models targeted toward other relevant marginalised groups. It was noted that much of the literature failed to undertake comprehensive evaluation of models of specialist medical care for refugees, with even fewer examining multi-specialist interventions. Future research would be well served to continue undertaking comprehensive analyses and evaluation of the issues surrounding the implementation of health systems, and in particular, models of specialist service delivery for refugees.
A number of common features warrant consideration in decisions regarding future planning and service model development for refugee populations. These include the need for models of care to:

- Incorporate flexibility and decentralised service provision which serve to improve access to high quality care closer to refugee settlement sites
- Build relationships between specialists and primary care providers, emphasising the need for partnerships across the care continuum which are supported through robust referral and communication protocols
- Facilitate innovative service delivery, including opportunities for family centred practices
- Integrate with, and build capacity of, the broader health system to respond to specific refugee health needs
- Accommodate the range of specialist services relevant to refugee needs, including paediatrics, infectious disease management, maternity and mental health treatment.

In conclusion, numerous policy and research documents outline essential features in comprehensive and appropriate models of care for refugee populations. This review has identified a number of health service models that effectively incorporate many of these features. The task remains in selecting appropriate models and tailoring them to effectively address challenges and issues of implementation relevant to the local context.
References


