

A Time for Change

Empowering First Nations Peoples' Health Care through
Shared Medical Appointments: A Proof-of-Concept
Project



ACKNOWLEDGEMENTS

ASLM and the Consulting Team wish to acknowledge the First Nations people of Australia, their Elders past, present and emerging not only for their custodianship of this country but also for their knowledge and science that was used to thrive for more than 60,000 years. We would also like to acknowledge the communities and Aboriginal Health Services who trusted us and invited us to undertake this Proof-of Concept project on Country. We hope this project honours that trust.

The Northern Territory Primary Health Network (NTPHN) and who provided the vision, the financial resources and ongoing support for this project.

PROJECT TEAM MEMBERS

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Professor Bob Morgan (ASLM)

Ms Kellie Kerin (AMSANT)

PARTNERING ORGANISATIONS

Central Australian Aboriginal Congress (Congress - <https://www.caac.org.au/>).

Danila Dilba Health Service Darwin (Danila Dilba - <https://ddhs.org.au/>).

Miwatj Aboriginal Health Corporation (Miwatj - <https://www.miwatj.com.au/>).

Aboriginal Medical Services Alliance (AMSANT – <http://www.amsant.org.au>)

Australasian Society of Lifestyle Medicine (ASLM – <http://www.lifestylemedicine.org.au>)

KEY STAKEHOLDERS

- The Northern Territory Primary Health Network (NTPHN): Funder of this Agreement (C1306), Contact Ms Dianne Bates
- Australasian Society of Lifestyle Medicine: Contractor for this Agreement (*ASLM- for a description Of ASLM see APPENDIX 1*). Contact Roni Beachamp CEO ASLM.
- Referred to in this report as the '*Project Team (PT)*' are 2 members of (ASLM) who were subcontracted for this project and also authored this report. 1) Professor Bob Morgan. Specialist in First Nations research evaluation, research impact, governance, cross---cultural studies, cultural affirmation and First Nations educational and health studies 2) Associate Professor John Stevens. Founder ASLM, Discipline Lead Lifestyle Medicine Southern Cross University, Registered Nurse, Medical Sociologist.

- Aboriginal Medical Services Alliance Northern Territory (AMSANT): AMSANT is the peak body for Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory (<https://www.amsant.org.au/>). AMSANT were engaged in this project oversee the cultural safety and responsiveness as well as to assist in the development of localised resources, materials and processes. And work closely and in collaboration with the Project Team. Ms Kellie Kerin, was employed by AMSANT with funding provided by the NTPHN to take on this role.

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1. EXECUTIVE SUMMARY

The Agreement

The NTPHN engaged ASLM to conduct a Proof-of Concept Project with the central objective of engaging Aboriginal communities through three of the largest Aboriginal Community Controlled Organisations in the Northern Territory, The Central Australian Aboriginal Congress (Congress), Danila Dilba Aboriginal Health Service Darwin (Danila Dilba) and Miwatj Aboriginal Health Corporation (Miwatj) to explore and test the potential use of Shared Medical Appointments. ASLM engaged Professors Bob Morgan and John Stevens to conduct the Proof-of-Concept study.

Since the initial signing of the contract Agreement (Contract 1306), the Project has evolved in to 2 discreet yet interconnected phases. This report focusses on activities and outcomes from Phase 1 (February 2023 to June 30th 2024).

Shared Medical Appointments defined

Shared Medical Appointments (SMAs) are also known in the medical literature as Group Consultations, Group Medical Appointments, and when applied to the care of Aboriginal and Torres Strait Islander people, Medical Yarn Ups. There are over 9000 peer reviewed articles showing improved outcomes when SMAs are used in specific circumstances, especially when managing the health of marginalised groups and those with chronic illness (see Appendix 3).

A typical SMA may take up to 90 minutes with 8-12 patients attending with similar health concerns, managed and supported by a trained facilitator, in which the General Practitioner, or other provider, consults with each patient individually and consecutively while the other patients observe and at times participate. Each individual consultation, within the group is performed according to the requirements of the provider's scope of practice and the Health Insurance Regulations (2021).

The SMA process is predicated on a personal attendance, involving a single medical practitioner, provided to a single patient, on a single occasion – this is an important consideration if an Australian provider is intending to claim Medical Benefit Scheme (MBS) item numbers and to distinguish it from group education.

The main difference that the SMA process offers is that other patients with similar concerns are listening and, when appropriate, are able to contribute their knowledge and lived experience to a conversation that might follow the consultation.

Project Team Activity

ASLM and the Project Team (PT) were tasked to meet 7 deliverables under the Agreement and these are described in the full report which follows this executive summary.

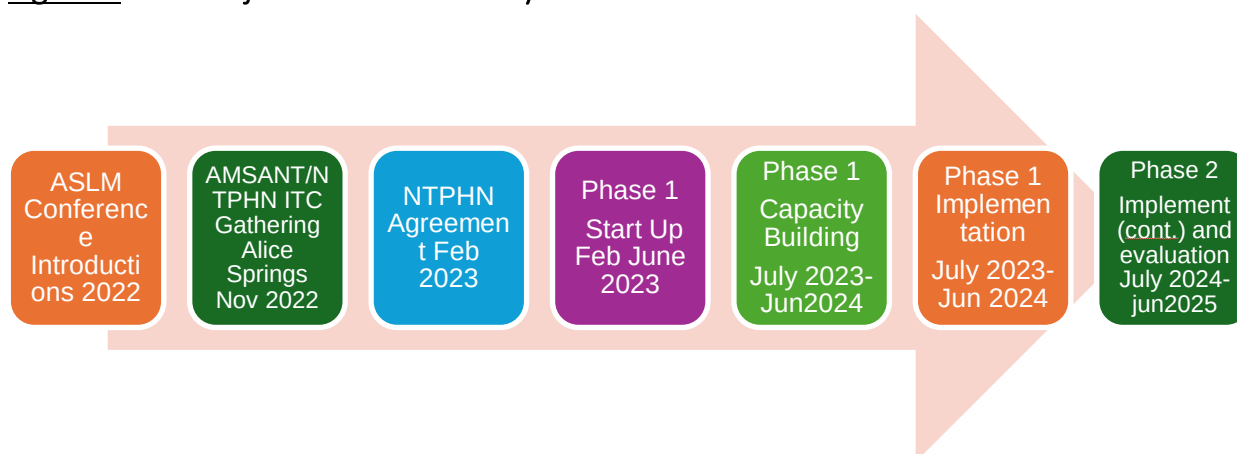
In brief: The Agreement requested PT services to assess, plan and implement SMAs with three collaborating ACCHOs: The Central Australian Aboriginal Congress (Congress), Danila Dilba Aboriginal Health Service Darwin (Danila Dilba) and Miwatj Aboriginal Health Corporation (Miwatj).

The Approach: The PT approach was to work in three stages within each participating ACCHO and with other stakeholders:

- 1) Start Up stage. (approx. February 2023-June 2023). During this stage the PT began to familiarise with context of the Services and communities they would be working with. Relationships were developed with stakeholders, assessments undertaken about the need for, and knowledge of, SMAs. This required many, mostly, face to face meetings (with a few online) with stakeholders and included presentations to and discussions with ACCHO leadership, services' workforce and Aboriginal communities.
- 2) The Development stage, (July 1st 2023 – June 30th 2024) During this stage, activity focussed on a) working with community members to obtain permission and support for the activity and then to co-design how SMAs might work in their specific context, b) orienting to understand SMAs as an Aboriginal model of care and c) developing operational knowledge and skills by training workforce to be able to design and deliver SMAs and This stage included assisting to develop the SMA local teams (SLTs) that were employed by each ACCHO to sustainably build capacity and integrate SMA into the services and communities.
- 3) The Implementation and Evaluation stage (July 1, 2023- June 30 2024), focussed on running SMAs in practice and measuring outcomes (this stage of the project continues in what is known as Phase 2 of the project 1 July 2024- 30th June 2025)

Figure 1 that follows shows the process pathway for this project

Figure 1. The Project Process Pathway



Project Team Aims

The specific aim of the PT has been to provide support and leadership for this project to ensure that SMAs (whatever their local name is adopted) are willingly adopted through co-design and co-construction with each community. That the SMA process is structured as an enduring Aboriginal model of care, led by Aboriginal people and communities and ideally operationalised by Aboriginal health practitioners or influential people. A key project aim was to privilege Aboriginal knowledge and science alongside mainstream health care practice currently provided by the services.

Our Phase 1 Activities Summary

At the completion of the Phase1 activities, completed by the Project team, there were:

- 75 Meetings with >1000 people
- 46 Formal Presentations given
- 738 People oriented to SMA
- 236 People Trained to Deliver SMA
- 61 Aboriginal Health Workers/Practitioners/RNs consulted/trained
- 22 Aboriginal Community Consultations
- 55+ SMA sessions delivered
- 270+ Aboriginal people who had attended an SMA for a health consultation
- (was) One National Conference Forum (ASLM Melb. 2023).

Project Learnings

Phase 2 of the project was intended to focus on collecting and analysing data to provide objective comment on the cultural responsiveness, satisfaction, outcomes and efficiencies of Shared Medical Appointments. However, there were also many learning's and insights gained from the activities from Phase 1. The more important of these learnings and insights include:

- That SMAs are not only a process for group consultations, but they are also an enduring Aboriginal model of care and are an example of how health business has always been done in many Aboriginal communities.
- That SMA are culturally responsive and safe, improving access to health services for Aboriginal people
- SMA can be adapted and localised as well as co-designed with communities and health service providers
- SMAs completed in Phase 1 resulted in:
 - increased attendance of Aboriginal participants compared to conventional 1 to 1 consultation method in some clinics.
 - being Aboriginal led (organised and codesigned by Aboriginal staff and their communities)
 - 100% patient satisfaction (from those whom attended and data collected by Aboriginal health workers)
 - 100% provider satisfaction
 - increased subsequent attendance at the clinic
 - privileging Aboriginal knowledge, experiences and science during medical consultations
 - a desire by communities to support the ongoing use of SMAs
 - increased participant trust in health providers and the services generally
 - understanding some of the barriers to integrating SMAs into service delivery beyond the life of this project.
 - the establishment of SMA local teams (SLTs) and growing their knowledge, skill base and ability to support ACCHOs to sustainably implement the SMA model of care and deliver the majority of the activities required for Phase 2 of the project.

Teaching 1. Lessons from the field

The following is just one (of many) stand-out and powerful teachings provided to the PT from an Aboriginal staff member who introduced the PT to some of the nuances of local Yolngu culture:

‘that Balunda build their world around the idea of time. For example, their health care system is based on busy activity and they measure their success by the clock – time... how many people get seen in what time frame, how many people turn up to appointments on time or get cured in a certain time frame, how much money was spent in financial year on services etc. This is how Balunda construct their world.

The world of Aboriginal people is built around relationships – not time. Our relationships with Country, our homelands, our families our community and our interactions with Balunda and their services are based on time or how long something takes.

You can see the disconnection when we come together because one works on time and one works on relationships.’ Medical Dhawu Dhawu (aka Shared Medical Appointments) offers a way that we might come together.

(Aboriginal Health Practitioner, Nhulunbuy October 2023 - (the accuracy of the author’s interpretation of the paraphrasing has been verified with the spokesperson who asked to remain anonymous)

2. FULL REPORT INTRODUCTION

The health and wellbeing status of Aboriginal peoples has been a site of conjecture and debate for decades and attempts to improve Aboriginal health conditions have been largely illusive and contested. Stemming from this background the Proof-of-Concept project evolved recognising an urgent need for new and innovative models of Aboriginal healthcare if sustainable change is to be achieved. Central to the need for new and innovative models of Aboriginal healthcare is community empowerment, a principle undergirding the need to empower Aboriginal people so that they are more than passive participants in the healthcare process.

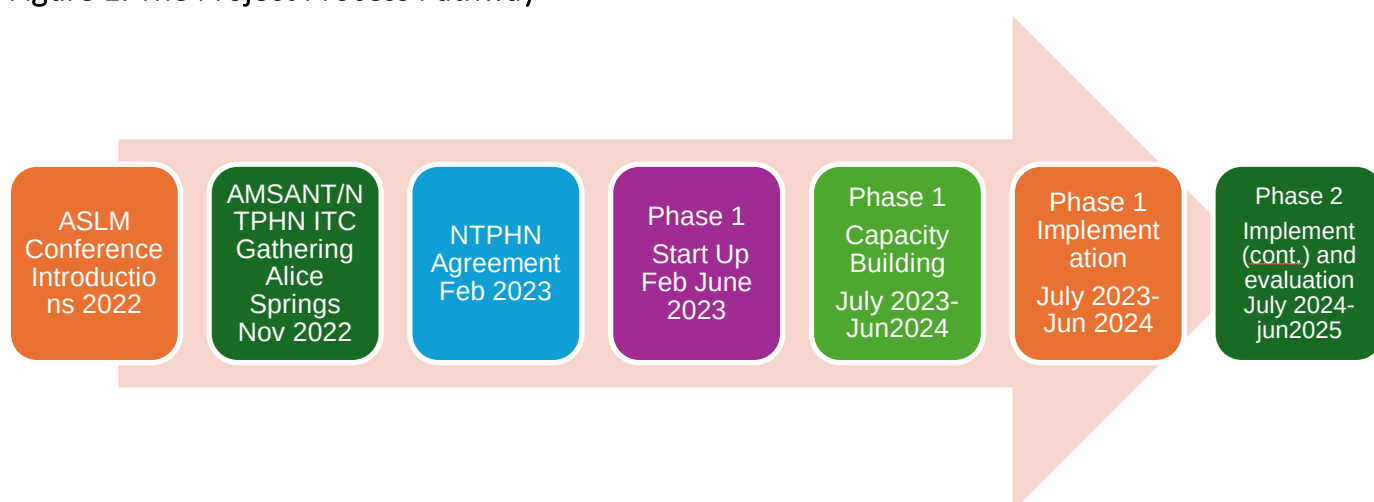
A new and innovative Aboriginal healthcare model incorporating improved access, cultural safety and responsiveness would also improve overall effectiveness and efficiencies. Innovative models also will need to be integrated into Aboriginal Health Services that allow for a co-designed, de-colonised approach to better understand, prevent and manage the growing burden of lifestyle-related chronic and other illness in Aboriginal communities.

The project evolved following the attendance and participation of a number of key stakeholders at the Cairns (July 2022) Australasian Society of Lifestyle Medicine (ASLM) Conference. Mr Alan Kennedy from NTPHN and Dr Monica Theron from Congress ACCHO observed a number of papers and workshops on shared medical appointments and could see the potential application for Aboriginal Health Services in the Northern Territory.

Subsequently, an invitation was issued to Profs Bob Morgan, John Stevens from ASLM and Willow Firth from the Waminda Aboriginal Women's South Coast (NSW) Health Service, to prepare and deliver a presentation on Shared Medical Appointments at an AMSANT professional development day (2nd November 2022) held in Alice Springs. A SMA workshop was also organised for the Central Australian Aboriginal Congress (Congress), in Alice Springs (5th November 2022). These events led to the NT Primary Health Network (NTPHN) agreeing to fund a Proof-of-Concept project to investigate the potential Use of SMA among a select number of NT ACCHOs. The NTPHN progressed an agreement with ASLM to conduct the SMA Proof of Concept project with an Agreement between NTPHN and ASLM, formalised and processed in February 2023.

The primary aim of the SMA proof of concept project was to identify 3 ACCHOs within the NTPHN footprint, at which Shared Medical Appointments/Medical Yarn Ups to be trialled and evaluated as a new and innovative model of Aboriginal healthcare.

Figure 1. The Project Process Pathway



Project Engagement throughout Phase 1 included:

- 75 Meetings with >1000 people
- 46 Formal Presentations given
- 738 People oriented to SMA
- 236 People were trained (face to face) to delivery SMA (additionally, 100+ of these people completed the 4 hours ASLM online training)
- 61 Aboriginal Health Workers/Practitioners/RNs consulted/trained
- 22 Aboriginal Community Consultations
- 55+ SMA sessions delivered
- 270+ Aboriginal people have attended SMA for a health consultation
- 1 National Conference Forum (ASLM Melbourne. 2023).

3. NOMENCLATURE

Note on Nomenclature.

Shared Medical Appointments (SMA) are also known in the medical literature as Group Consultations, Group Medical Appointments, and when applied to the care of Aboriginal and Torres Strait Islander people, it has also been referred to as Medical Yarn Ups. Indeed, the NTPHN contract refers to the project using the Medical Yarn Up terminology.

It is important to note that when localised to each ACCHO context, names that were more culturally relevant were adopted. Specific to Miwatj, SMA is known in Yolngu Martha as Medical Dhawu Dhawu. Specific to Congress SMA is known as 'Seeing the doctor together'. Specific to Danila Dilba SMAs are referred to as 'Medical Yarning'.

For the purpose of universal understanding, this report will use the nomenclature Shared Medical Appointment (SMA) unless otherwise clarified.

(See APPENDIX 2)

4. NT SMA – A 2-PHASE PROOF OF CONCEPT PILOT PROJECT

The SMAs Proof of Concept project was designed utilising 2 discreet yet interconnected phases. Phase 1 of the project was conducted between February 2023 and June 2024. Phase 1 comprised 3 discreet stages, the 1st involved start up activities, the 2nd refinement and development and the 3rd implementation and evaluation. This report focusses essentially on and deals with Phase 1 of the project.

Phase 1 of the project was completed on 30 June 2024. As indicated above, phase 1 involved the roll out of 3 stages that included:

- *Startup*, which focussed on developing relationships getting to know the stakeholders and the organisations, assessing enthusiasm for change and innovation, introducing the SMA concepts and the NTPHN project.
- *Development*, which focussed on workforce development to inform, orientate and train stakeholders in the SMA processes and model. This included training and developing the SMA Local Teams (SLTs)

- *Implementation and evaluation*, which focussed on running SMAs in practice and measuring outcomes (this stage of the project continues in what is known as Phase 2 of the project 1 July 2024- 30th June 2025)

Phase 2 of the project was conducted between July 1, 2024 and June 30, 2025. The primary focus of Phase 2 involved ongoing roll-out and implementation, health service integration and evaluation.

5. PROJECT DELIVERABLES

The following key project deliverables were identified and agreed as being:

1. Commence Service delivery no later than 1 December 2022 and continue Service delivery until 30 June 2024, (the Service Delivery Period), unless otherwise agreed in accordance with the terms of this Agreement.
2. Consult with Northern Territory PHN, Aboriginal Community Controlled Health Organisations (ACCHOs), other health services and communities that are interested in exploring Medical Yarn Ups (MYUs) and Shared Medical Appointments (SMAs). This will include consulting with ACCHO leadership groups, individual medical practices, patient advocacy groups and communities to orientate them to MYUs and assist them in their choice to adopt, or not, MYUs into their service and communities.
3. Deliver training for clinicians and other Aboriginal Health personnel and community leaders to be able to undertake, support and promote MYUs and SMAs.
4. Provide support and consultation to help services integrate and customise MYUs into practice to meet the needs of their clients and staff.
5. Provide Programmed Medical Yarn Ups (PMYUs) and ongoing codesign development support as well as client testing, and additional staff training to provide and/or develop (or support local staff to co-design) programs specifically.
6. Engage in research and evaluation, and continuous improvement of the MYUs in practice in Northern Territory related services and communities.
7. Provide continued support with ongoing staff training and continued professional development, quality improvement of resources and the codesign and development of new and innovative PMYUs designed to fit the MYU process and to bring about positive behavioural and health changes.

Progress against these key project deliverables will be discussed at appropriate stages of this report.

SERVICE AND DELIVERABLE ITEM 1.

Commence Service delivery no later than 1 December 2022 and continue Service delivery until 30 June 2024, (the Service Delivery Period), unless otherwise agreed in accordance with the terms of this Agreement.

SERVICE AND DELIVERABLE ITEM 2.

Consult with Northern Territory PHN, Aboriginal Community Controlled Health Organisations (ACCHOs), other health services and communities that are interested in exploring Medical Yarn Ups (MYUs) and Shared Medical Appointments (SMAs). This will include consulting with ACCHO leadership groups, individual medical practices, patient advocacy groups and communities to orientate them to MYUs and assist them in their choice to adopt, or not, MYUs into their service and communities.

COMMENT

During the start-up period of the agreement, between Feb 2023 and end of June 2023, the primary focus centred on raising awareness of SMA and sharing information about how effective SMAs had been in other contexts. This was accomplished by providing orientation presentations and workshops describing SMAs and their implementation in health services and communities to a range of stakeholder groups. During this period, continuous and ongoing consultations with NTPHN were conducted to refine the SMA model to ensure that the project fitted the NT ACCHO context and would grow the network and build relationships between the Project Team and potential stakeholders.

The list of organisations engaged and to which various presentations were presented (most on more than one occasion) included: NTPHN, AMSANT, Congress, Danila Dilba, Miwatj, NTG, NT Health, Menzies Institute, Catherine West, Sunrise, Purple House. Flinders University and Charles Darwin University.

Total formal presentations during this time = > 30 (plus about 10 other presentations, on Country to patient and community groups in and around the communities that are serviced by the three ACCHOs, Danila Dilba, Congress and Miwatj.

6. AMSANT PARTNERSHIP

From the early stages of the project, it became abundantly clear that the project would not be supported by the clients and communities if it was seen as another research project that involved clients and community members simply as subjects. Just another extractive project conducted by ‘*balunda*’ (Yolngu Martha meaning coloniser, outsider, foreigner). This dictated that the project would not be known nor defined as a research project. The Project was subsequently referred to and spoken about with Yolngu community and colleagues as, ‘*an exploratory and implementation proof-of-concept project*’.

An analysis of data also concluded that the SMAs process and model of care would need to be culturally contextual, customised and localised so that it is culturally responsive and integrated into practice. For this to occur, required the development of ‘SMA local teams (SLTs)’ in each participating ACCHO and for each of these SLT teams to be trained so that they could confidently support staff and clients to customise SMA at each specific location or for specific programs.

AMSANT was contracted by NTPHN to provide overarching and linking support for the project across the participating ACCHOs and to contribute, as necessary, to cultural quality assurance, training and resource development. The Project Team members have worked closely and in partnership with AMSANT employee, Ms Kellie Kerin during all stages of the project. To help orientate Ms Kerin for the role that she played in the project it was arranged for her to participate in intensive initial SMA training to develop knowledge, skills and practice of SMAs and to offer a culturally responsive lens and advice on ways SMAs might be best adapted among each of the ACCHOs.

The Project Team worked with the participating ACCHOs to help develop job descriptions for SMA local teams that would lead and sustained the SMA project within each organisation. As well, the Project Team continued to engage with the ACCHO workforce and community to develop SMA presentations and training. See [TABLE 1](#) for a summary of these activities.

7. PROJECT TEAM ACTIVITIES

Engagement

Engagement throughout Phase 1 included:

- 75 Meetings with >1000 people
- 46 Formal Presentations given
- 738 People oriented to SMA
- 236 People were trained (face to face) to delivery SMA (additionally, 100+ of these people completed the 4 hours ASLM online training)

- 61 Aboriginal Health Workers/Practitioners/RNs consulted/trained
- 22 Aboriginal Community Consultations
- 55+ SMA sessions delivered
- 270+ Aboriginal people have attended SMA for a health consultation
- 1 National Conference Forum (ASLM Melb. 2023).

Data Collection Methods

Surveys, focus groups (yarning groups), field notes and direct observation were utilised to collect and analyse data for evaluation rather than research purposes. Overall, approximately 1000 people contributed to the data collection process through these evaluation methods.

The Data Analysis

The data from ACCHO's leadership groups, staff and client groups established a common, clear and overwhelming theme, 'the need for change.'

The data established the perception that existing models of care were ineffective, inefficient and not culturally safe or responsive enough for use among First Nations clients in many circumstances. The Health Services, staff and communities which they serve, were frustrated that the health gap was not closing despite the huge effort of personnel and investment in resource development and application.

Additionally *the ACCHOs* reported:

- high levels of non-participation with services. Some reported 'no show' rates for primary care appointments as high as 80%. That is, of clinical appointments booked and scheduled, 80% of clients did not attend nor communicate to cancel or postpone.
- concern over the high costs of providing care to Aboriginal communities
- high levels of burnout and turnover especially of clinical staff.
- community needs for services and expenses were consistently out-growing funding income

Clinicians invariably reported that they were frustrated with:

- the apparent lack of impact their work was having overall;
- the often perceived, unachievable workloads/client loads;
- having to work with models of care that clearly are ineffective;
- the frustration and inability to affect change higher upstream among policy makers and funders;
- working with large number of 'fly in fly' out colleagues;
- the repetition of, often unheeded, treatment and messaging to clients about preventing and managing illness;

- the issues with language and interpreting;
- their limited understanding of the cultural barriers to providing care;
- the often lack of engagement by clients in their own health and wellbeing, as indicated by the high 'no show' rates.

The client groups reported that they:

- wanted the services to be '*more Aboriginal*';
- did not feel culturally safe. The physical locations and architectural design of many of the clinics made the Aboriginal client group feel unsafe. As one older client told us, '*the clinic is where all the bad stuff happened*';
- perceived that the services and many clinicians often did not understand nor appreciate their cultural/social environments, including determinants and the commitments that had to be prioritised before attending to their own health and engagement of the clinics;
- did not understand the Clinicians' language, especially the medical language;
- rarely experienced an exchange of information with the services. They were '*just told what to do*' by the clinicians;
- rarely had their own knowledge and experiences acknowledged by the clinicians;
- did not want to be part of another research project where, '*settlers did research on them and go away never to be heard from again*'. They indicated that they would, however, participate in trying a new way of doing health through the project if it wasn't a research project.

The Project Team also deduced from the analysis that:

- there is a large hardworking workforce dedicated to improving the health and wellbeing of First Nations people and their communities who are frustrated with the lack of momentum on closing the gap locally and more globally. Clinicians especially, were looking for innovative ways of practicing that could be more effective;
- the models of care observed are still largely based in a 'Colonial paradigm', where well-meaning and knowledgeable 'settlers' are telling first nation's people how to care for themselves and the community;
- many of the clinics' physical locations and lay outs were barriers to Aboriginal participation;
- there was a surprising shallow understanding and appreciation of the narrative of trauma, dispossession and oppression as determinants of health and wellbeing (there were exceptions to this observation as well);
- over 90% of clinicians and clients had not heard of, or experienced Shared Medical Appointments before delivery of our presentations and conversations.

- Services, clinicians and clients and their communities appeared to embrace the concept of SMAs once it was explained and were keen to participate in the proof-of-concept project.

Over the course of at least 75 meetings, approximately 1000 stakeholders were communicated with during Phase 1 of the project, there was not one sustained objection to proceeding with a proof-of-concept project as a means to explore the SMA process and model of care and its effect on patient engagement, effectiveness and efficiency.

8. ACCHO STAFF ORIENTATION & TRAINING

The SMA Orientation Training Development and Consultation activity Feb 2023 – June 30th, 2024 is detailed at Table 1 below.

A standard orientation session of approximately 45 minutes was provided to leadership teams, non-participating clinicians and other staff as face to face and ZOOM PowerPoint presentations aimed at providing relevant information and raising overall awareness of SMAs and the intended objectives of the proof-of-concept project.

During Phase 1 of the project, between July 2023 and July 2024, at least 46 sessions were provided involving more than 700 ACCHO staff members. ACCHO staff report that local SMA teams have now embedded SMA orientation into staff induction programs.

STAFF TRAINING

The standard SMA training normally included a 2-hour face to face introductory workshop followed by enrolment into a pre-existing ASLM, online SMA facilitator training program. Successful completion of this training leads to an ASLM endorsed, statement of attainment (approx. 4 hours learning). The SMA training aims to develop the knowledge skills and practice of clinicians, other health workers and relevant community members to design, plan and deliver SMAs.

[Of the 236 clinicians who participated in the face-to-face SMA training more than 100 have also enrolled in the SMA online program.](#)

SMA LOCAL PROJECT TEAM TRAINING AND DEVELOPMENT

The Project Team also provided intensive, customised and focussed training with SMA local teams at the 3 participating ACCHOs namely, Congress, Danila Dilba, Miwatj. (This included the broad training described above, as well as workshops designed to customise SMA for local delivery.

ASLM CONFERENCE 2023 (MELBOURNE)

A select number of SMA local teams were sponsored to attend the 2023, ASLM conference held in Melbourne during (August 2023) as part of their overall SMA development. The teams were engaged in a pre-conference First Nations Forum that focussed on Aboriginal health and the use of SMAs in local communities. Relevant SMA and other related research was presented during this forum providing opportunities for plenary discussion and networking among attending ACCHOs and Aboriginal Medical Services. The ASLM conference more specifically emersed ACCHO attendees with colleagues using SMAs and other Lifestyle Medicine knowledge and skills in practice.

Table 1. Phase 1 Orientation Training Development and Consultation (Feb 2023-June 30th, 2024)

Provider/stakeholder	Formal Presentation	People Oriented to SMA	Clinicians Trained to deliver SMA	Aboriginal Staff consulted and or trained	Aboriginal community consultations
Congress	9 (+SLT Dev)	200 +	79	14	10
Danila Dilba	9 (+ SLT Dev)	250+	90	12	8
Miwatj	6 (+ SLT Dev)	50	42	2	1
NT Health	2	40+	0	n/a	0
NTPHN	4	30+	4	2	0
AMSANT	1	18	1	1	0
Other	15	150	20	30	3
Total	46	738	236	61	22

Table 2. Phase 1 SMAs Completed (as of June 2024)

Provider	SMAs Attempted	Number of People Attended
Congress	25	~150
Danila Dilba	10	n/a
Miwatj	20	120

SMA LOCAL TEAM TRAINING

The SMA local teams (SLT) have been trained and developed by the Project Team and resourced by NTPHN and their respective ACCHOs so that they can implement SMAs consultations, as well as coordinate SMA activity within each ACCHO. This includes delivering

the orientation and training required for other ACCHO staff, clients and communities. The Project Team also provided the SLTs with training program materials and resources for face to face and online training sessions.

KEY TRAINING AND ORIENTATION OUTCOMES

Training Satisfaction

The orientation and training sessions were well received and evaluated highly with consistent ratings on a 5-point Likert scale of 4 and above for usefulness, delivery standard, engagement and skills fit for practice (see APPENDIX 4 for the evaluation template). Though not every person at every session provided feedback, of the 100+ that were collected there were no negative comments. There was a clear and consistent suggestion that the resources could be improved for Aboriginal and Torres Strait Islander people's context. (This has informed the development of resources)

As a result of the training, and with some ongoing support, clinicians were mostly confident that they could design and run a SMA for their clients (and indeed, some did, as reported on in succeeding sections of this report)

THE NEED FOR FIRST NATIONS RESPONSIVE RESOURCES AND MATERIALS

It was determined that the existing online facilitator training, whilst adequate, required refinement for it to be more responsive to the learning needs of many First Nations health workers or community members. This resulted in planning by each Project team for the development of locally responsive resources for Aboriginal Health staff, clients and communities.

The establishment of SLTs at each ACCHO was essential as a hub from where training and development, planning and implementation as well as cultural safety could be identified and sustained. Once SMAs are embedded in the operations of ACCHOs the SLTs would become the 'go-to places' for all things SMA in the ACCHO which would in turn help to develop standards and quality within each organisation.

Once this occurred, the focus of the Project Team would move to supporting the SLTs so that they are the change agents rather than the Project Team who would work with individual clinical teams and disciplines.

9. FIRST NATIONS EVALUATION TOOL

The Project Team found that existing tools used to evaluate services and programs were generic in nature and therefore limited for specific use to confidently evaluate SMAs and

provide impactful and culturally responsive feedback to ACCHOs and funding authorities. Consequently, it was agreed that a new evaluation tool/s would need to be developed to evaluate the SMA project.

An SMA (and for other programs as well) evaluation tool responsive to First Nations health and other circumstances will be developed and tested. (This will be achieved by a co-design process led by NTPHN and described at APPENDIX 5)

The Project Team in collaboration with AMSANT and the SLTs will continue to develop and improve orientation, training and promotional resources for SMA development that respond to local needs of communities, clients, leadership teams, and clinicians.

10. PROGRESS AGAINST PROJECT DELIVERABLES ITEMS 5 - 7

Project deliverable item 5, is structured to: *Provide Programmed Medical Yarn Ups (PMYUs) and ongoing codesign development support as well as client testing, and additional staff training to provide and/or develop (or support local staff to co-design) programs specifically.* Likewise, **deliverable item 7** is aimed to: *Provide continued support with ongoing staff training and continued professional development, quality improvement of resources and the codesign and development of new and innovative PMYUs designed to fit the MYU process and to bring about positive behavioural and health changes.*

COMMENT

Programmed Shared Medical Appointments (PMYUs) have been shown to be effective in Aboriginal Health Services and their communities (Egger et al 2016, Stevens et al. 2016, Stevens et al. 2022, unpublished paper 2024). The concept of Programmed Shared Medical Appointments (PSMA/PMYUs) were first described by Egger, Morgan and Stevens et al. (2016). PSMA/PMYUs are described as consecutive SMAs that use the SMA process to deliver a specific curriculum of knowledge, skills and behavioural change over a limited number of sessions. For example, the Project Team have developed, implemented and evaluated PSMA/PMYUs in the past, for weight management, T2DM prevention, chronic pain management, smoking cessation.

Occasionally existing health programs within ACCHOs fit the SMA process but usually they need to be specifically designed and written.

The Project team outlined and promoted the concept of PSMA/PMYUs during the orientation and training programs. The development and implementation of PSMA/PMYUs would need to be staged. The generic SMA process first needed to be well understood and integrated into practice. With SMA knowledge, experience and skills developed from this activity, ACCHO health teams using SMA would also be able to more easily identify needs that could be met by utilising a PSMA/PMYUs.

Further specific training leading to the development of PSMA's to meet local needs, has been planned for Phase 2 of the project post July 2024.

In the short term, the SMA local teams have been invited to use and adapt existing programs developed by ASLM if the opportunity arises for their use. On request, the SMA local teams can access PSMA/PMYUs in Weight Management, Type 2 Diabetes Prevention and Fighting and Resisting Nicotine Addiction in First Nations People & Others.

OUTCOME

The Project Team found there is scope for programs in many of the chronic conditions experienced by the clients of the participating ACCHOs. Working with clinicians and client groups there emerged a seemingly urgent need for specifically tailored programs, in language where possible, for metabolic health and managing disorders.

FURTHER ACTION

As Phase 2 of the project is rolled out and the SMA local teams become firmly established and feel confident in their roles, the design and delivery of PSMA/PMYUs will become their responsibility. The SMA local teams have been asked to identify local needs and priorities where PSMA/PMYUs could be developed and implemented. The Project Team will meet with the SLTs early in August 2024, (Phase 2) to further investigate, and where appropriate, decide the development and delivery of PSMA/PMYUs for each organisation.

Service and Deliverable Item 6 established that the project team would: *Engage in research and evaluation, and continuous improvement of the SMAs in practice in Northern Territory related services and communities.*

COMMENT

For ACCHOs to make informed decisions about the integration of SMAs beyond the life of the current project and for the SLTs to continually improve their training and resource development, reliable evidence is required. This includes identifying or developing evaluation tools and outcome measures.

The Project Team understood that the project would evolve in stages. **The start-up stage** focussed on developing relationships and explaining SMA concepts. **The development stage** focussed on developing stakeholder knowledge and skills in the delivery of SMA in local community contexts. This included developing the SMA local teams to become the hub for ongoing training and support for the delivery and integration of SMAs into and across ACCHO services. In addition, it was anticipated that the SMA local teams would identify meaningful local ways to measure and collect data among stakeholders.

The implementation and evaluation stages commenced just prior to the end of June 2024 and will continue through Phase 2 of the project till June 30, 2025.

CULTURALLY RESPONSIVE OUTCOME MEASURES

It became clear as the SMA local teams were developing that there was need for culturally and locally relevant measuring and evaluation strategies that could better account for the unique cultures and people that the ACCHOs service. After considerable research, the Project Team was unable to find existing tools that were fit for purpose in the Northern Territory Aboriginal and Torres Strait Island context.

The Project Team held discussions with NTPHN and AMSANT about the lack of culturally responsive measuring and evaluation tools that could gather evidence about the introduction of innovative clinical models. The PHN agreed to lead a series of co-design workshops to develop a fit-for-purpose framework and tool (with the potential use beyond this project). Details of the framework and tool are described at [APPENDIX 5](#).

FURTHER DEVELOPMENT

Phase 2 of the proof-of-concept project (running between July 1, 2024, and June 30, 2025) will focus on implementing and evaluating SMA in practice. The SMA local teams have commenced running SMA sessions and Programmed SMAs (PSMA) and this work will continue throughout Phase 2 of the project.

The Project Team will continue to support the development, roll out and training as required as well as using the NTPHN evaluation framework to gather the evidence required to measure the effectiveness, efficiency and cultural responsiveness of SMAs. This will include evaluating and improving SMA quality processes and training resources.

11. SPECIFIC ACCHO BASED ACTIVITIES AND DEVELOPMENTS

The following is a summation of the activities and developments specific to each of the 3 participating ACCHOs, namely Congress, Danila Dilba and Miwatj. Summaries of each ACCHO are provided sequentially.

CONGRESS ‘SEEING THE DOCTOR TOGETHER’ PROJECT RELATED ACTIVITIES

Congress clients and staff came to refer to the SMA process as, ‘*Seeing the Doctor Together*’. The Central Australian Aboriginal Congress (Congress) has provided support and advocacy for Aboriginal people in their struggle for health equality, justice and equity since 1974.

Since its inception, Congress has expanded to become the largest Aboriginal community-controlled health organisation in the Northern Territory, providing comprehensive, holistic and culturally-responsive primary healthcare services to Aboriginal people living in and around Alice Springs, including the remote communities of; Amoonguna, Ntaria (and Wallace Rockhole),

Ltyentye Apurte (Santa Teresa), Utju (Areyonga), Imanpa, Yulara and Mutitjulu. The more remote communities of Ampilatwatja, Urapuntja and Pintupi Homelands were also part of the SMA project rollout.

Congress' Health Services Division is responsible for delivering all client services; offering a comprehensive range of culturally responsive services targeting the social, emotional, cultural, and physical health and wellbeing of Aboriginal people in Central Australia. Congress employs more than 500 employees across its operational footprint.

THE THREE STAGES OF CONGRESS SMA PROOF OF CONCEPT PROJECT

There were 3 stages to the Congress SMA Proof of Concept project:

Stage 1, essentially focussed on orientating the Project Team to the scope of Congress services and the clients they served. Additionally, the Project Team engaged in building relationships with the workforce, and where possible, the community.

Key activities of stage 1 included planning and communicating the SMA model and concept and the aims and intentions of the project. The PT collaborated closely with Kellie Kerin (AMSANT) to explore and define how SMAs might best work in the Central Australian Aboriginal community context.

This required delivering numerous presentations to, and networking with, Congress leadership groups, clinicians, clients and community. This included Bob Morgan and Kellie Kerin holding a specific Congress presentation to an exclusive Indigenous workforce group in order to provide information and receive unbiased feedback on elements of the project.

An interim report from July 2023 to Dec 2023 (See APPENDIX 7), explains the activities and interactions of this early stage of the project. Congress's first SMA was conducted on Country at Walkabout Bore, led by Kellie Kerin – (See Kellie Kerrin's report on the first Congress SMA delivery at APPENDIX 8 September 13, 2023).

Stage 2 focussed on employing and developing the Congress SMA local team whose major task would be to drive the project at the local level. Teddy McDiarmid and Michael Ahmat (Michael is a local Arrernte man) were employed in November 2023 and began intensive training in SMAs with the PT and Kellie Kerin (AMSANT).

Under the guidance of the PT team and Kellie Kerin the SLT members began their experience with SMAs and the facilitation process in practice. As the SMA local team became skilled and confident and independent of the PT, the PT was able to decrease their involvement. The SLTs continued to develop and support Congress staff so that they are able to promote and run SMAs with minimal support from the PT and AMSANT.

Stage 3 focussed on the SLTs developing their own SMA knowledge, skill and experience base, and that of the Congress staff, so that SMAs could be utilised to engage communities more effectively in medical consultations.

Table 3 below shows outcomes from Congress activity up and until end of June 2024.

TABLE 3. A SUMMARY OF SMA ACTIVITY AS OF JUNE 2024: CONGRESS

Activity	Outcome
Number of visits with Congress health teams and communities by Project Team	9
Presentations	20+
Est. number of staff oriented to SMA	250+
Dedicated Clinical Training sessions	4
Number of Congress staff trained as (facilitators)	90
Number of Congress staff who also completed online SMA course	30
Community consultations/yarning with TOs and other leaders (before SMA Local Team was employed)	6
<i>As of June 2024,</i>	
Number of 'Seeing the Dr together' sessions (data provided by Congress SMA Local Team)	~25
Total Number of Participants	N/A
male	N/A
female	N/A
average participant numbers per session	N/A

Table 3 depicts the various activities and their numerical occurrences as the Congress 'Seeing the Doctor Together' model of client engagement was developed, refined and implemented. This element of the project included the delivery of more than 20 SMA sessions in a variety of Urban and remote healthcare settings.

A number of Congress professional and clinical staff attended and participated the SMA training and development sessions including Podiatrists, Registered Nurses, Midwives, Doctors, Specialists, Aboriginal Health Practitioners, Clinic Drivers, Clinic Cleaners, Clinic administration, Clinic Managers, Public Health Team, Mental Health Practitioners, Primary Care Services, Managers, Dieticians, Public Health Nutritionists, Congress Research staff.

CONGRESS - THE PATIENT CONTEXT.

The clients who access Congress services come from many remote and urban communities as well as diverse, tribal, family and language groups.

CONGRESS – ONGOING SMA PROJECT MANAGEMENT

Congress's Allied Health Services team led the management of the SMA Project at Congress. Andrew Jolly and Laura Stuart, who report directly to Dr Sam Heard, Congress's Medical Director. Andrew and Laura provided excellent corporate leadership and cultural sensitivity when

GOING FORWARD

It is anticipated that Phase 2 of the project (July 1, 2024 – June 30, 2025) will continue the development and evaluation of SMAs, revisiting staff training and community consultations and further developing training and promotional materials.

During Phase 2 the Project Team will work closely with all ACCHO stakeholders to integrate SMAs into their services, with the expectation that SMAs will become a regular and embedded activity beyond the life of the proof-of-concept trial.

A key development arising from Phase 1 of the project are plans to run regular SMAs during Phase 2, in Diabetes for Parents, Diabetes for youth, Bush Mobile, Keeping Men Strong, Town Camp regular SMAs, other specific Men's and Women's clinics for Contraception, Respiratory disorders, PCOS and foot health.

CONGRESS TRAINING AND RESOURCE MATERIALS DEVELOPMENT

The Congress SMA local team in consultation with the PT and AMSANT, have been developing a SMA tool kit that includes:

Presentation and materials specifically for:

- Leadership groups
- Community groups,
- SMA attendees
- Aboriginal health workers
- Clinical staff general orientation and induction
- Clinical staff SMA and facilitator training.

These resources will be used and evaluated during Phase 2 of the project and will be adapted and refined where necessary and appropriate.

The Congress SMA local team is also developing their medical records inserts, to record SMA interactions for both billing and evaluation purposes so that outcomes data can be readily measured.

PROJECT TEAM'S GENERAL OBSERVATIONS OF CONGRESS SMA ACTIVITY CONGRESS SMA PROJECT STRENGTHS

From the outset, the Congress leadership and clinical staff were enthusiastic about the SMA project as there was an appetite for innovation and change in Aboriginal healthcare within the organisation.

The General practitioners who provided clinical services during Congress SMAs endorsed the model as a positive and meaningful change that is both client-centred and culturally responsive. One of these GPs, Dr Monica Theron, was responsible for the early conversations that led to the entire project being supported by NTPHN and embraced by Congress.

Congress was able to recruit an exceptional leader of the SMA trial in Teddy McDiarmid. Teddy McDiarmid is passionate and extremely capable, possessing skills and knowledge developed over many years of experience in the sector where he was able to establish local community and professional networks in the region. This experience and networking are considered vital to effectively coordinating the activities of the Congress SMA project.

The following anecdote (see Figure 2 below) is from the Congress activity involving an outstanding experience that demonstrated how SMAs can be an effective and culturally responsive Aboriginal health model of care with the potential to improve Aboriginal healthcare management, efficiency and outcomes.

CONGRESS LOCAL BARRIERS TO SUCCESS.

Clearly the Congress SMA local team is playing an important role in developing the culture of SMAs at Congress and within the community. If the team is disrupted, then SMA activity could become chaotic.

Ongoing team stability and support from senior leadership will be required to progress and sustain the project.

Clinical staff turnover slows progress. With so much staff turnover within the organisation at times, keeping SMA skills and knowledge current will be an ongoing challenge.

If the Proof-of-Concept trial proves to be successful, Congress Governance and Senior Leadership will need to strategize how to resource SMA as a feature of their service and integrate sustainable methods going forward—this cannot be done at the local clinical level.

DANILA DILBA HEALTH SERVICE'S 'MEDICAL YARNING' ACTIVITY

Danila Dilba Health Service (DDHS) is an Aboriginal community-controlled organisation providing a comprehensive and culturally responsive primary healthcare and community services to Biluru (Aboriginal and Torres Strait Islander) people in the Yilli Rreung (greater Darwin) region of the Northern Territory.

DDHS is Darwin's only Aboriginal community-controlled health service, with seven clinics in the region catering to the Aboriginal and Torres Strait Islander population. Healthcare services provided by DDHS are focused on acute care, immunisation, chronic disease management, women's health, men's health, child and maternal health, sexual health and social emotional wellbeing. DDHS also provides a range of community programs in areas including health promotion, mental health/social and emotional wellbeing, and alcohol, tobacco and other drugs. Currently, DDHS delivers services and programs that are designed to improve health outcomes to almost 80% of the Greater Darwin Aboriginal and Torres Strait Islander population.

THE THREE STAGES OF THE DANILA DILBA SMA PROOF OF CONCEPT PROJECT

There were three stages to the Danila Dilba SMA Project in Phase 1:

The first stage of Danila Dilba's SMA project focussed on planning and communicating the SMA concept and the objectives of the project to explore how SMAs might work in the DD context. This required numerous presentations to and networking with DD leadership groups, clinicians, clients and community. An interim report detailing project activities from July 2023 to Dec 2023 (See APPENDIX 7), explains the activities and interactions of this stage of the project.

The second stage focussed on employing and developing the SMA local team. The employment of Olivia Bowden and Tegan Djanghara-Cooper, both of whom are Aboriginal and trained Allied health assistants (AHAs) were to become the core of the SMA local team. The SMA local team participated in presentations and one to one learning and support opportunities provided by the Project Team and Kellie Kerin with the view of developing an understanding of SMAs and the knowledge and skills necessary for SMAs to be successfully implemented.

Under the guidance of the Project Team, the local SMA team members began exploring the potential opportunities for SMAs within the DD services. The first SMAs were delivered within the context of the existing weekly DD exercise and fitness group at the Darwin clinic. A key outcome of this training, as the SLT Team developed SMA understandings and proficiencies, was the expectation that the SLT Team would be able to orientate and train other DD staff particularly in the role of SMA facilitator.

The third stage focussed on continuing to develop The SMA local team’s knowledge, skills and experience and that of the health centre staff and communities so they could engage in SMAs. This stage also aimed to design, conduct and evaluate SMAs on a regular basis to develop the skills of health service staff and familiarise the communities with this process.

TABLE 4. SUMMARY OF SMA RELATED ACTIVITIE: DANILA DILBA.

Activity	Outcome
Number of visits with DD health teams and communities by Consulting Team	6
Presentations	6
Est. number of staff oriented to SMA	~ 50
Dedicated Clinical Training sessions	4
Number of Congress staff trained as (facilitators)	42
Number of Congress staff who also completed online SMA course	18
Community consultations/yarning with TOs and other leaders (before SMA Local Team was employed)	1
<i>As of June 2024,</i>	
Number of ‘Medical Yarning’ sessions (<i>data provided by DD SMA Local Team</i>)	~10
Total Number of Participants	N/A
male	N/A
female	N/A
average participant numbers per session	N/A

Table 4 depicts the various activities and their numerical occurrences as the Danila Dilba, Medical Yarn Up (MYU) was developed, refined and implemented. This element of the project included the delivery of more than 10 MYU sessions in an urban healthcare setting.

A number of Danila Dilba professional and clinical staff attended and participated the SMA training and development sessions including Physiotherapists, Aboriginal Allied Health Assistants, Podiatrists, Doctors, Clinic administration, Clinic Managers, Dieticians.

PATIENT CONTEXT.

Because of the cosmopolitan and multicultural nature of Darwin, the Client group serviced by DD include people from many different cultures and language groups including from the local Larrakia people and Aboriginal and Torres Strait Islander people from many other nations, tribes and family groups across the NT.

SMA PROJECT LEADERSHIP

The Danila Dilba SMA project is led and managed by the Allied Health team and led by Kate Finegan and Phillipa Cotter.

TRAINING AND RESOURCE MATERIAL

The DD SMA local team, in consultation with the PT and AMSANT, is planning the development of a SMA tool kit. The SMA tool kit will include:

Training and Resource Materials specifically for:

- DD senior leadership groups
- Darwin community groups,
- SMA attendees
- Aboriginal health workers
- Clinical staff general orientation and induction
- Clinical staff SMA and facilitator training.

These training resources will be used and evaluated during Phase 2 of the project and continually revised where considered necessary.

GOING FORWARD

Phase 2 of the project (July 1, 2024 – June 30, 2025) aims to continue the development and evaluation of SMAs, staff training and community consultation and continually improving training and promotional materials.

Phase 2 also aims to work closely with all stakeholders to integrate SMAs into the service, so it becomes a regular activity of DD beyond the life of this proof concept trial.

Unfortunately, both Aboriginal AHAs moved on from DD mid-2024 and the service is currently recruiting to replace them at the time of writing this report. The PT and Kellie Kerin will be available to help develop the knowledge and skill of new staff when they are employed.

PROJECT TEAM OBSERVATIONS OF DANILA DILBA PROJECT ACTIVITY

Perceived Strengths of SMAs

There was a high level of enthusiasm about the SMA project across the three ACCHOs and the DD leadership and clinical staff exhibited an appetite for innovation and change within the organisation. A number of workforce issues restricted the planned activity. The late recruitment of the 2 AHA positions slowed the commencement of activity at DD and their subsequent and unforeseen departure interrupted developments and restricted the implementation of SMAs throughout DD.

The General practitioners at DD who were familiar with and who had experienced SMAs endorsed the model as a positive and meaningful change that was client centred and culturally responsive.

Anecdotally, the SMAs that have been conducted have resulted in great success as reported by clients and staff.

Conducting primary care consultations in a group, away from the clinic, at the Gym, was seen as a preferred consultation model by those attending the SMAs.

Local barriers to success.

The dependence on the SMA local team and its stability, coupled with the support of senior leadership will be required to progress the project.

The First Nations healthcare environment is generally a site of struggle for the recruitment and retainment of suitably qualified and experienced clinical and other staff. Compounding matters is that when ACCHOs are able to employ staff there is an unfortunate level of staff turnover, the combination of these factors threaten effective service delivery and progress. Considering this, keeping SMA skills and knowledge current will be an ongoing challenge to ensure that SMAs are sustainably embedded in DD services.

Leadership stewardship. Senior Leadership will need to strategize how to integrate and resource SMA in their service – this can only be done at this senior management and operational level.

As noted in the context of other participating ACCHOs, the support of Danila Dilba's governance and senior leadership will be critical to strategize, resource and integrate SMAs into the respective operations of the participating ACCHOs.

MIWATJ 'MEDICAL DHAWU DHAWU' PROJECT RELATED ACTIVITIES

Miwatj Health Aboriginal Corporation (Miwatj) is one of the largest Aboriginal Community Controlled Health Organisations in Australia providing primary health care services to about 8000 people in some of the most remote communities in the country. There are seven local health centres who deliver the majority of health services to the communities. These local health centres are located in Nhulunbuy, Gunyangara, Yirrkala (all within 20mins drive of Gove District Hospital), and the more remote communities of Galiwin'ku, Milingimbi, Ramingining and Gapuwiyak

THE THREE STAGES OF THE MIWATJ SMA PROOF OF CONCEPT PROJECT

There were three stages to the Phase 1 Miwatj SMA Project:

The first stage of the Miwatj SMA project focussed on planning and communicating the SMA concept, the aims and intentions of the project and beginning the 2-way process of learning how SMA would work in the Yolngu and Miwatj contexts. This required numerous presentations to, and networking with, Miwatj leadership groups, clinicians, clients and community. An interim report from July 2023 to Dec 2023 (See APPENDIX 7), explains the activities and interactions of this early stage of the project. With the help of Aboriginal Health Practitioners Nathan Garrawurra and Gwen Dhumarrandji the team explored the concept of SMA and how it could be interpreted with Yolngu communities and where possible using Yolngu Martha. Further conversation with the AHPs in Gapuwiyak (Damien and Amanda) established the Yolngu Martha name for Shared Medical Appointments: Medical Dhawu Dhawu.

The second stage focussed on employing and developing the SMA local team employed by Miwatj to drive the project at the local level. The employment of Dr Sharon Atkinson-Briggs RN PhD (as SLT Coordinator), Stuart McGrath RN and Matthew Dowling MSC, provided the core of the Miwatj, SMA local team. Sharon Atkinson-Briggs is a Yorta Yorta Aboriginal woman. Stuart McGrath identifies as Yolngu man.

The team was provided presentations and intensive in one-to-one learning and support environments by the Project Team to engender greater understanding SMAs. Dr Lou Sanderson familiarised the SLT with the communities and the culture they would be working with (though Stuart McGrath was a local Yolngu man who added greatly to the context of the communities and culture).

Under the guidance of the Project Team the SMA local team members began experiencing SMAs and the facilitation process on Country and in practice. The first SMAs was conducted on Country at Yirrkala and Gapuwiyak in November 2023. As the SMA local team became skilled

and confident and independent of the Project Team (PT), the PT was able to decrease their direct involvement but was on hand to provide advice as required and requested.

Initially under the guidance of the PT, the SMA local team also developed relationships with Health Centre staff at each location, including the Yolngu health workers and support staff. The SMA Local teams developed, and continue to and support, health centre staff so that they are better able to promote and run SMAs with minimal support from the SLT.

The third stage focussed on continuing to develop the SLT's own knowledge, skill and experience and that of the health centre staff and communities generally. The Third Stage also aimed to design a SMA tool kit of resources for developing SMA in the health service.

Phase 2 of the Miwatj based project (July 1, 2024 – June 30, 2025) aims to continue the development and evaluation of SMAs, staff training and community consultation and continually improving training and promotional materials.

Phase 2 also aims to work closely with all stakeholders to integrate SMAs into the service, so it becomes a regular activity of Miwatj beyond the life of this proof-of-concept trial.

TABLE 5. A SUMMARY OF SMA ACTIVITY SUMMARY AS OF JUNE 2024: MIWATJ

Activity	Outcome
Number of visits with Miwatj health centres and communities by Consulting Team	9
Presentations	20+
Est. number of staff oriented to SMA	200+
Dedicated Clinical Training sessions	4
Number of Miwatj staff trained as (facilitators)	79
Number of Miwatj staff who also completed online SMA course	49
Community consultations/yarning with TOs and other leaders (before SMA Local Team employed)	6
Professions Trained/	Nurses, Midwives, Doctors, Specialists, Aboriginal Health Practitioners, Clinic Drivers, Clinic Cleaners, Clinic administration, Clinic Managers, Public Health Team, Mental Health Practitioners, Primary Care Services Managers, Dieticians, Public Health Nutritionists.
<i>As of June 2024,</i>	
Number of Medical Dhawu Dhawu sessions (<i>data provided by Miwatj SMA Local Team</i>)	20
Total Number of Participants	120
male	47
female	73
average participant numbers per session	6
Number of Miwatj team members and miwatj contractors briefed by SMA Local Team (approx..)	125
Number of external (outside Miwatj) community stakeholder consultation sessions by SMA LT (approx.)	30

Table 5 depicts the various activities and their numerical occurrences as the Miwatj ‘Medical Dhawu Dhawu’ was developed, refined and implemented. This element of the project included the delivery of more than 20 SMA sessions in a variety of remote healthcare settings.

A number of Miwatj professional and clinical staff attended and participated the SMA training and development sessions including Podiatrists, Registered Nurses, Midwives, Doctors, Specialists, Aboriginal Health Practitioners, Clinic Drivers, Clinic Cleaners, Clinic administration,

Clinic Managers, Public Health Team, Mental Health Practitioners, Primary Care Services, Managers, Dieticians, Public Health Nutritionists, Charles Darwin and Flinders Universities.

MIWATJ PATIENT CONTEXT.

The client group serviced by Miwatj are mostly Yolngu from Eastern Arnhem Land. The client group mostly share a rich and sustained Yolngu culture. The core language is Yolngu Matha, though there are a number of local dialects.

MIWATJ - SMA PROJECT MANAGEMENT AND LEADERSHIP

Under the leadership of Dr Lou Sanderson (Miwatj Medical Director) the program evolved as 3 iterative stages (see APPENDIX 6, Dr Sanderson's December report).

MIWATJ - TRAINING AND RESOURCE MATERIALS DEVELOPMENT

The Miwatj SMA local team, in consultation with the PT and AMSANT have progressively developed a SMA specific tool kit. The tool kit includes presentation and materials specifically for:

- Miwatj senior leadership groups
- Yolngu community groups,
- SMA attendees
- Yolngu health workers
- Clinical staff general orientation and induction
- Clinical staff SMA and facilitator training.

These resources will be used and evaluated during Phase 2 of the project and where appropriate refined and enhanced.

PROJECT TEAM'S GENERAL OBSERVATIONS OF MIWATJ ACTIVITIES

Strengths of SMAs

Miwatj leadership and clinical staff were enthusiastic about the SMA project as there was a pre-existing appetite for innovation and change within the organisation.

The General Practitioners who utilised SMAs endorsed the model as a positive and meaningful change because SMAs are client centred and culturally responsive. One GP stated that it has saved her career as she was on the point of resigning, frustrated at not making a difference working from the clinic. SMAs showed that an Indigenous led and culturally responsive model can make a difference to health and communities.

'I would not be here if not for MDD. I had grown sick of sitting in my clinic knowing I was not making a difference.'

When the SMA process was explained, Yolngu people and community members understood the concept of SMAs as 'Medical Dhawu Dhawu'. They were comfortable with the SMA process, because they aligned with Yarning Circles which have always been a way of communicating in Aboriginal contexts. As one Traditional Owner commented:

'This is the way we have always done our business.'

And

'... so your job is to teach the service how to do this? Because you are not teaching us anything new. This is how we have always done our business. ... we'll help you teach the service because this is the best way to do it. Many more will come if this is how it is done from now on.'

Showing Respect for Traditional Owners and Community

Seeking permission of traditional owners and keeping them informed of the SMAs project resulted in SMAs being enthusiastically embraced by the community.

Conducting primary healthcare consultations outside of the clinic is seen by Aboriginal clients as the preferred model of consultation by those attending SMAs.

The local team made sure that SMAs were adaptable and responsive to community events. Particularly when sorry business, weather events, power failure and even the presence of a rogue water buffalo prevented attendance. The SMA local team was able to adapt, postpone and reschedule to fit community availability in these types of circumstances.

Local Barriers to Success.

A stable and effective SMA local team was viewed as a major enabler for the potential success of SMAs. Ongoing team stability and support from senior leadership will be required to ensure the success of the project. Unfortunately, the departure of Sharon Atkinson-Briggs and Stuart McGrath from the Miwatj SMA team means that Matthew Dowling is the sole remaining SMA team member.

Clinical and Yolngu staff turnover invariably threatens progress. With so much staff turnover within the organisation, keeping SMA skills and knowledge current will be an ongoing challenge.

Governance and senior leadership and stewardship will be critical to strategize, resource and integrate SMAs into the respective operations of the participating ACCHOs. Of course, there is already existing leadership of this nature from each of the ACCHOs and this level of commitment can be expected post project.

(See APPENDIX 8- 9 for extended narrative reports on visits to Gapuwiyak and Milingimbi)

A MIWATJ ANECDOTE

The Exchange.

The shop could be difficult to access. The Bodiya camp for example, was approximately 4.5 km away. Roads were often impassable during wet season to people on foot or in vehicles. Indeed, the day we visited Bodiya camp the shop was shut the entire day for stocktake.

The men explained how they used hunting to help them stay healthy, as it gave them bush food, exercise and kept the young engaged in culture. They were keen to tell us about some of their bush medicines.

The men were also keen to explore the MDD concept and said clearly, that they wanted to exchange knowledge not just receive it and this might be a way to do it. They shared stories with us of ill health from diabetes and kidney disease that they believed were healed by hunting.

One older man told us (through Tristan, the Yolngu trainee Aboriginal Health Practitioner and interpreter) that he had some time ago been diagnosed with severe diabetes and renal failure and that he had felt unwell for a long time. He had recently seen a Dr at the clinic and was told he no longer had diabetes or renal failure.

...Yeh Doc (referring to Dr Steve) you told me my diabetes had got so bad that my kidneys were sick and I might need to have dialysis ... I felt crook too for too long. I went – over there – (pointing out to sea towards an uninhabited island a few kilometres away) by myself. I stayed for three months, may be more. I only ate what I hunted. I lived outside. I lost weight. I felt good and strong again. When I came back just the other day the other Dr at the clinic said I didn't have diabetes anymore and my kidneys weren't sick anymore – he was surprised.

The Traditional Owner interjected and said: ...

That's what we did here for 1000s of years. That's our medicine.

The men then wanted to hear stories from us about our personal issues, had we engaged behaviours that were unhealthy? Dr Steve and John both provided stories of our past that recalled unhealthy eating, drinking and smoking behaviours which led to a clear and honest discussion about these issues amongst them.

Before we left, the TO told us that no Dr had sat with them like this in the past, from his memory. The men, he said, were looking forward to developing this method of consulting.

(As interpreted by Tristan Baker, trainee AHP and paraphrased by author John Stevens, May 2024)

FINAL COMMENT

Positive, constructive and sustainable change and transformation in any context is always difficult to achieve but especially so when issues of resources, the lack of local involvement and agency, misinformed government policy and programming (See CTG results), the relative absence of decision-making power of community and a myriad other factor shape and influence the glacial pace of change for Indigenous people's social justice aspirations.

A key research finding of the Harvard Kennedy School's Project on Indigenous Governance and Development established that: "When Native nations make their own decisions about what development approaches to take, they consistently out-perform external decision makers—on matters as diverse as governmental form, natural resource management, economic development, health care and social service provision."

This transformative principle sits at the heart of the Time for Change - Empowering First Nations Peoples' Care Through Shared Medical Appointments Proof-of-Concept Project and all available evidence indicate that all project objectives are being met.

The Shared Medical Appointment, proof-of-concept project remains on track.



11. APPENDICES

APPENDIX 1

A description OF ASLM

ASLM is a leading health promotion charity that supports practitioners to implement Lifestyle Medicine into practice for the prevention, management and often reversal of chronic disease. We support an interdisciplinary approach to health and healthcare; shifting away from siloed practice to create a genuinely collaborative means through which complex problems can be solved. We advocate for health and wellbeing, which includes the absence of disease, but also health equity, social justice, corporate responsibility, and environmental sustainability.

Our vision: Complete health and wellbeing for Australians and New Zealanders, which includes but is not limited to the absence of chronic disease.

Our mission: To establish Lifestyle Medicine as central to health and wellbeing, medicine, healthcare and health policy.

Core values:

- AUTHENTIC: We act with integrity, openness and honesty.
- RESPECTFUL: We are committed to equality and diversity.
- DISRUPTIVE: We are innovative and bold change-makers.
- CARING: We are warm, compassionate and supportive.
- FUN: We are creative, friendly and positive.

The ASLM Annual report can be found at [Publications - Australasian Society of Lifestyle Medicine](#)

APPENDIX 2

A DESCRIPTION OF SMA NOMENCLATURE AND PROCESS

Shared Medical Appointments (SMA) are also known in the medical literature as Group Consultations, Group Medical Appointments, and when applied to the care of Aboriginal and Torres Strait Islander people, Medical Yarn Ups. Indeed, the NTPHN contract refers to project using the Medical Yarn Up.

Specific to Miwatj, SMA is known in Yolngu Martha as Medical Dhawu Dhawu. Specific to Congress SMA is known as 'Seeing the doctor together'. Specific to Danila Dilba SMAs are referred to as 'Group medicine visits.'

For the purpose of a more universal understanding, this report will use the nomenclature Shared Medical Appointment (SMA) unless otherwise clarified.

A typical SMA may take up to 90 minutes with 8-12 patients attending with similar concerns, managed and supported by a trained facilitator, in which the General Practitioner (GP) consults with each patient individually and consecutively, according to the requirements of their scope of practice and the Health Insurance Regulations (2021).

The SMA process is predicated on a personal attendance, by a single medical practitioner, being provided to a single patient, on a single occasion – this is an important consideration if an Australian provider is intending to claim MBS item numbers.

The requirements of a consultation are met in a SMA as the Provider, (eg a GP) evaluates the patient's health-related issue/s; formulates a management plan in relation to the health issues; provides advice to the patient and/or their relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient.

The main difference that the SMA process offers is that other patients with similar concerns are listening and, when appropriate, are asked to contribute their knowledge and lived experience to a conversation that might follow the consultation.

The literature shows (see APPENDIX 3 Evidence for SMAs) that using SMAs as a model of care results in improved patient outcomes and satisfaction reports, reduced presentation to emergency departments and hospital admission rates while improving patients' knowledge and self-management competency. Participant interaction, sharing of experiences and peer support rate highly as is the clinician experience.

SMAs are a rare example of a model meeting healthcare's quintuple aim of better cost-effective care and outcomes, better education, high patient and clinician satisfaction. It is also a

model of care, using processes that are appealing to many Aboriginal and Torres Strait Islander people.

There are over 9000 peer reviewed articles in the last 5 years (see APPENDIX 1 for a review of the literature on SMAs) showing the positive outcomes and efficiencies that SMAs can bring to practice with very few negative outcomes reported on.

Repeated, reported outcomes show that compared to 1:1 consulting SMAs:

1) *from the health system (and health service) perspective*, save money, are more efficient, reduce presentations to hospitals and emergency services, reduce waiting lists, improve patient's activation and satisfaction;

2) *from the patients' perspective*, provide a safe group environment where they learn from health professionals and peers. Patients report: improved retention of information and higher success rates of self-managed behavioural change; having others empathise with them; having others ask questions they forget; seeing their health professional for longer and in a more relaxed state. And from an Aboriginal patient's perspective, SMA offer improved cultural safety, responsiveness and accessibility. One Aboriginal community who renamed Shared Medical Appointments as Medical Yarn Ups said that '*this is the way Aboriginal people have always done health care.*'

3) *from the providers perspective*, improve outcomes and efficiencies and work satisfaction as they perfect a process to help them better manage lifestyle-related chronic disease with lifestyle related interventions and see their patients for longer. Providers report: not having to repeat the same messages over and over; they are not as isolated as they work with small team and have a facilitator and sometimes a note taker; they get to know their patients better and generally have more fun at work.

In Australia and New Zealand, the Australasian Society of Lifestyle Medicine (ASLM) has been pioneering the use of SMAs in practice through the work of Profs Garry Egger, Bob Morgan, Andrew Binns and John Stevens. In particular ASLM has been collaborating with Aboriginal health services, mostly in NSW, to integrate SMAs into practice.

SMAs are being used by a growing number of ASLM practitioner members. In addition to the above-mentioned advantages, the ALSM team have been able to show that SMAs can also provide opportunities in Aboriginal health services for culturally safe and responsive health

care to occur which appears to improve access as well as patient outcomes and satisfaction. A number of AMSs have integrated SMAs into practice and delivered lifestyle-related health programs (pSMAs) successfully through the process.

APPENDIX 3

A Brief Review of The Evidence for Shared Medical Appointments/Medical Yarn Ups. (V43 090224)

By John Stevens RN PhD FCN FASLM.

Email. John.Stevens@scu.edu.au

SMA Nomenclature and Process

Shared Medical Appointments are also known in the medical literature as Group Consultations, Group Medical Appointments, and when applied to the care of Aboriginal and Torres Strait Islander people, Medical Yarn Ups.

A typical SMA may take up to 90 minutes with 8-12 patients attending with similar health concerns, managed and supported by a trained facilitator, in which the General Practitioner (GP) consults with each patient individually and consecutively, according to the requirements of their scope of practice and the Health Insurance Regulations (2021).

The SMA process is predicated on a personal attendance, involving a single medical practitioner, provided to a single patient, on a single occasion – this is an important consideration if an Australian provider is intending to claim MBS item numbers.

The requirements of a consultation are met in a SMA setting as the GP evaluates the patient's health-related issue/s; formulates a management plan in relation to the health issues; provides advice to the patient and/or their relatives (if authorised by the patient); provides appropriate preventive health care advice; and records the clinical detail of the service(s) provided to the patient.

The main difference that the SMA process offers is that other patients with similar concerns are listening and, when appropriate, are able to contribute their knowledge and lived experience to a conversation that might follow the consultation.

Evidence for SMAs

There is a large and growing body of evidence showing that this difference in the consultation process is making significant improvements to: patient outcomes, practice efficiencies and cost effectiveness ^{1 2 3 4 5 6 7}; reduced waiting times ^{5 7 8}; reduced presentations to emergency departments and hospital admission rates. ^{2 8 9 10} The literature also strongly and consistently

reports that SMAs improve patients' knowledge and self-management competency^{3 11 12}. SMA consultations are a rare example of a model that meets healthcare's quintuple aim of better cost-effective care and outcomes, better education, high patient, and clinician satisfaction.^{6 13 14 15} There is also a recent study showing its use in Naturopathic consultations.¹⁶

SMAs and T2DM.

There is also a growing body of evidence about the utility of SMAs, specifically, in the overall improved management of patients with type 2 diabetes mellitus as well as specific measures in knowledge and self-management skill development and overall provider and patients satisfaction.^{12 17-27}

A few recent studies have emerged showing patients using SMAs having equal and or improved management of specific determinants of t2dm such as blood glucose measurements (HbA1c)^{28 29} and weight.^{3 30 31 32 33}

SMAs as a Strategy for First Nations people relative to the Closing The Gap Objectives

Shared Medical Appointments provide a model of care that is of great interest amongst Aboriginal Controlled Community Health Organisations (ACCHO's) as it also offers improved accessibility while being culturally safe and responsive.^{3 33 34} The model has been named Medical Yarn Up by ACCHOs who have trialled it and by their clients who have participated in these trials. Medical Yarn Ups have been reported in the literature and through roundtable discussions facilitated by ASLM, as being an important strategy in Closing the Gap.^{33 34} Studies with First nations people continue to demonstrate positive engagement and outcomes when using SMAs.^{35 36 37 38 39}

SMAs, Current Practice, And Collaborations with Primary Health Networks

ASLM is currently working with a number of PHNS to develop SMAs as an adjunct to General Practice. The PHNs are engaging SMAs as a strategy to enhance primary care's capacity to manage the rise in lifestyle-related chronic disease presentations and workforce issues.

ASLM has trained over 1400 clinicians in the last 5 years in the SMA process and conducted a number of trials showing its effectiveness and acceptance by patients and providers in practice³. ASLM has worked with UK and NZ Health Services to help develop equivalent SMA processes that are now being integrated into services in those countries⁵. The UK is routinely using Group Consultation (SMAS) in over 1000 medical centres. Group Consultations, as SMAs are referred to in the UK, have been identified by the NHS as the most important strategy for reducing ~8 million patient waiting list, an aftermath of the COVID 19 pandemic.^{40 41}

THE EVIDENCE FOR SHARED MEDICAL APPOINTMENTS/MEDICAL YARN UPS



WHAT ARE SHARED MEDICAL APPOINTMENTS/ MEDICAL YARN UPS?

SMA/MYU are medical consultations that normally include groups of 6-15 people with similar concerns, managed and supported by a trained facilitator, in which their General Practitioner consults with each patient individually, in person or as telehealth as per the Health Insurance Regulations, with other patients listening, contributing and supporting.



SMA/MYU IMPROVE EFFECTIVENESS AND EFFICIENCY

There is a large and growing body of evidence showing improvements in patient outcomes, practice efficiencies and cost.

First Nations people report feeling safer, and services are more responsive and accessible



SMA REDUCE WAITING TIMES, PRESENTATIONS TO EMERGENCY AND HOSPITAL ADMISSIONS

There is a growing body of evidence showing that SMAs reduce waiting times, reduce presentations to emergency departments and hospital admission rates



SMAS/MYUS IMPROVE PATIENTS' SELF-MANAGEMENT COMPETENCIES

The evidence is strong showing that SMAs and MYUs can improve patient's knowledge and self management competencies, especially in relation to chronic and lifestyle related disorders



PATIENT AND PROVIDER SATISFACTION IS EXTREMELY HIGH

There are over 9000 published articles that describe extremely high rates of satisfaction for Patients and Providers in using SMAs.

No articles have been found showing negative outcomes or poor satisfaction



SMA/MYUS CAN BE USED TO MANAGE T2DM

There are a growing number of publication including systematic reviews showing SMA/MYU improving HbA1c and other determinants vs standard care

A S L M

<https://lifestylmedicine.org.au>

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41. Lawson R 2023 Letter to Australasian Society of Lifestyle Medicine - Un published.

APPENDIX 4

SMA Training Program Evaluation Template

SMA or PSMA (Office Use only)

ID: _____

Location: _____

Date: _____

A. GENERAL INFORMATION

Name: _____

Phone: _____ Email: _____

COURSE EVALUATION

B1. On a scale of 1-5, how do you rate the SMA training you attended here? (circle choice)

1	2	3	4	5
Poor	Fair	OK	Good	Great

B2. How useful has the program been for you?

1	2	3	4	5
Useless	Not very useful	OK	Useful	Very useful

B3. did the program provide you with technics you could use in practice immediately? Yes No Maybe

B5. What did you not enjoy about the program you attended? (Please write in)

B6. Would you recommend this training to others? Yes No Maybe

B7. Did this training give you confidence to undertake SMA? Yes No Maybe

B8. Would you run an SMA practice if you had the opportunity? Yes No Maybe

B.9 Would you like to do the online version of this program? Yes No

B.9 What, if anything, would you change to make the program better?

APPENDIX 5

The NTPHN Evaluation Framework

First Final Draft completed June 2024. Available on request.

APPENDIX 6

Shared Medical Appointments/Medical Yarn Ups project at Miwatj Health Progress report

Lou Sanderson, Sharon Atkinson Briggs, Bob Morgan, John Stevens

31/10/2023

Terms:

Miwatj Health Aboriginal Corporation (MHAC)

Medical Yarn Ups (MYU) are also known in mainstream as Share Medical Appointments (SMA)

Australasian Society of Lifestyle Medicine (ASLM)

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

Northern Territory Primary Health Network (NTPHN)

Aboriginal Health Practitioners (AHP)

Aboriginal Health Worker (AWP)

Aboriginal Community Worker (ACW)

Proof of Concept (POC)

Consultants:

Bob Morgan (ASLM and Gumilaroi Dhalli)

John Stevens (ASLM, Southern Cross University)

Kellie Kerin (AMSANT Central Arrernte, prior Miwatj staff)

Project oversight: Lou Sanderson

MYU Co ordinator: Sharon Atkinson Briggs

Miwatj Health Aboriginal Corporation have secured funding from NTPHN to do a proof of concept for delivering Medical Yarn Ups in a remote Aboriginal, bilingual setting. This is from July 2023 to June 2024. Yolngu, community, elders and MHAC staff are critical to the 'proof of concept' and will be consulted and negotiated with during all stages of the development of ideas and plans in relation to the POC.

Medical Yarn ups are Shared medical appointments where a group of clients with similar needs e.g., diabetes, are brought together in a group of 8-10 with a trained facilitator, a Yolngu interpreter/cultural adviser and a clinician. The facilitator ensures that privacy and confidentiality are understood, invites each member of the group to talk about what they hope to get out of their "appointment" with the clinician; following the group discussions, the facilitator welcomes the clinician into the group and facilitates the conversation between client and clinician, ensuring that the needs of each individual are met and enabling a group conversation about shared experiences. Consultations requiring detailed assessments or assessments and/or questions of a more personal nature are deferred to a 1:1 session with the clinician.

MYU participant groups can be constructed to be gender specific and/or include family and carer observers. Any health professional may fulfill the “clinician/provider” role within the MYU team, however some clinicians e.g., GPs, Diabetes educators, dietitians can, if they meet their profession’s legislative requirements, access Medicare billing for their services.

The following table extracted from Sharon’s GANT chart.

Initial planning and consultation	Lou, Alan, Michelle ER	1/7/2023	
Visit to Gapuwiyak, Bob, John, Kellie, Lou. Community and health service engagement	Lou	31/07/2023	3/08/2023
Prepare JD for Project officer and Yolngu project worker, advertise, interview and appoint	Lou / Alan	7/08/2023	15/09/2023
ASLM conference in Melbourne Lou, Nathan, Gwen, Leonie, Amanda, Alan, Eileen	Lou	7/09/2023	10/09/2023
Planning for Nhulunbuy visit (Oct) and Gapuwiyak visit (Nov)	Lou	10/09/2023	
Sharon Atkinson Briggs appointed to MYU Co-ordinator position at Miwatj		9/10/2023	9/10/2023
Finalise Yolngu Project Worker JD, advertise (PCCC), interview and appoint	Sharon/Lou	11/10/2023	12/11/2023
Travel to Nhulunbuy and MYUs Training Provided SMA facilitator training to 24 Miwatj staff Undertook first formal MYU	Sharon/Lou/John/Bob Gwen/Nathan/Eileen	19/10/2023	25/10/2023
Plan Gapuwiyak visit 13-16 Nov, John, Kellie, Sharon. Accom sorted	Sharon/Lou	18/10/2023	25/10/2023

The project started with a focus on Gapuwiyak but it rapidly became clear we should spread it out on realising limitations in scheduling our consultants and clinic commitments (and housing and flights). So, our second trip to Nhulunbuy, provides an opportunity to engage with Head office and the Nhulunbuy, Yirrkala and Gunyangara clinics.

The initial goals are:

- Appointment of MYU Co-ordinator (Sharon Atkinson Briggs - confirmed) and Yolngu Project worker (in progress)
- To engage with Yolngu communities and elders and Miwatj Health Centres to introduce awareness of Medical Yarn Ups so that the project is Yolngu driven
- Bob, Sharon, Kellie and Yolngu staff/community members to ensure continuous cultural safety and respect and that the POC is community responsive and driven.
- To decide on a name for MYU and clarify if this is the right name in a Yolngu environment
- To develop a logo for promotional material
- To engage with staff and provide introductory information and training
- To engage with the MYU (or Shared medical appointment) networks and the Australasian Society of Lifestyle Medicine
- To inform the wider Miwatj staff and programs about MYUs through promotional material, meetings, participation in reference groups etc.

At this stage we are still at the introductory engagement level although some significant work has been conducted in relation to community engagement, introducing staff to MYU concepts and practices and the actual conduct of MYU trials.

Gapuwiyak

We have engaged with community and health centre in Gapuwiyak and have another trip planned there 13-16 Nov with the plan to further engage with community and run some MYU sessions involving Sharon AB, John S, Kellie K, AHP/W Amanda Dhagapan, Leonie Wunungmurra, Terese Nhurruwuthun, Damien Guyula, Dr Penny Ramsay and manager. Dr Jenny Jobst has been engaged and supportive since the inception of the planning for Medical Yarn Ups and had run her own version of group education prior to learning about MYU.

Nhulunbuy and Gunyangara

Members of the MYU team visited both clinics and chatted to staff in general about the concept of MYUs and looking at the physical environment in the clinics for such meetings.

An information meeting was held on 20 Oct in the Nhulunbuy Head office with 24 health centre staff attending an introductory meeting. A list of centre staff who may be interested in doing the online MYU facilitator training was collected. Further discussions were held with the visiting Diabetes Educator and Cardiac Educator to discuss the challenges in their roles and the place of MYUs going forward.

On Friday (27/10) Sharon was able to chat with two staff members from the Rapiirri-rom team, Kane Baker, support worker and Velda Winnungu, Team Leader. Both are interested in hearing more about MYUs and how the team can assist. Kane suggested that it would be a good idea if Sharon could attend (when next in Nhulunbuy) one of the team meetings. Sharon will email both Kane and Velda to lock in a date.

Yirrkala

An initial visit to Yirrkala to inform staff about our visit, see the Health Centre and plan for further meetings. Yirrkala staff organised a small group (men and women invited) to come to a discussion about Diabetes and MYUs which was held on 24 Oct. This was attended by three Yolgnu women and one child and was held under the tree and shade shelter next to the Aged care facility. Two Yirrkala staff attended, along with Sharon AB (facilitator), Gwen Dhamarrandji (AHP/interpreting) Dr Eileen Gourley, Dr Lou, Dr Charlie Bligh (observing).

This was a great location and we had a relaxed talk about diabetes, medicines, challenges, symptoms. We introduced MYUs and as a result of the discussions other activities that could come from a group. For example, walking, games, cooking and food preparation. We snacked on fruit, veg and biscuits and dips and had cold water available. Mat and deck chairs provided by staff and MYU team.

Learnings:

Early planning with health centre staff vital
Lists for staff to select participants
Invitations to be circulated prior to MYU
Male or female groups requiring MYU team of same gender
Interpreting essential

There is widespread knowledge of and excitement for MYUs being introduced within Miwatj services

There is a need to create the correct messaging about MYUs with posters and flyers so that drivers and AHPs for example can promote it among their contacts.

Challenges:

Staff continuity and availability

Emergencies in the health centres

Technical, access to Communicare reports and printer functions to create lists

Driver availability

Creating the language for Promotion by drivers and AHPs for example in communicating with potential participants.

MHAC MYU champions identified to date:

Name	Role	Community or Program	Information session	Training Facilitator/GP	Training complete
Sharon Atkinson Briggs	Co ord	MYU	Yes Nhulunbuy	Yes	
Amanda Dhagapan	AHP	Gapuwiyak	Yes, Gapuwiyak and Melb		
Leonie Wunungmurra	ACW	Gapuwiyak	Yes Gapuwiyak and Melb		
Terese Ngurruwuthun	AHP	Gapuwiyak	Yes Gapuwiyak		
Damien Guyula	AHW	Gapuwiyak	Yes Gapuwiyak		
Gwen Dhamarrandji	AHP	Galiwin'ku	Yes, Nhulunbuy and Melb	Yes	
Nathan Garrawurra	AHP	Renal (Darwin)	Yes, Nhulunbuy and Melb	Yes	
Shannon	ACW	Renal (Nhul)			
Connor Lobenwein	AHP	Yirrkala	Yes Nhulunbuy		
Tegan Lorens	RAN	Yirrkala	Yes Nhulunbuy		
Jenny Jobst	GP	Gapuwiyak	Yes Gapuwiyak		
Penny Ramsay	GP	Gapuwiyak	Yes Gapuwiyak		
Bianca Watson	GP	Nhulunbuy	Yes Nhulunbuy		
Charlie Bligh	GP	Yirrkala			
Rob James	GP	Yirrkala			
Eileen Gourley	GP	All	Yes Nhulunbuy	Yes	
Lou Sanderson	GP	All	Yes Gapu, Nhul and Melb	Yes	

Going forward it is expected that as training is rolled out and communities are consulted, MYUs will be incorporated into usual business and the usual roles of the above and upcoming champions are defined. This will be supported by our consultants initially, handing over to our MYU workforce, who will train and support staff in communities using a train the trainer model. By the end of the project, we hope to have established if MYUs are a viable concept for Yolngu and Miwatj healthcare provision. If the POC is

successful and community engagement is supportive of the concept, we hope to have a plan going forward in relation to sustainable staffing, funding, ongoing training and embedding MYUs into Miwatj core business in all communities.

Tasks November December 2023:

- Enable training time in health centres for MYU facilitator online training ACTION Lou
- Appoint Yolngu project worker ACTION Lou/Sharon
- Run MYU sessions as appropriate in Nhul, Guny, Yirr, Gapu, Gali ACTION Sharon
- Recruit more nurses/ Yolngu staff/GPs as facilitators/cultural interpreters ACTION Sharon
- Sharon to spend a week In Galiwin'ku with Lou to observe the biggest busiest clinic in action to further inform how to incorporate MYUs into Miwatj business ACTION Lou/Sharon
- Communicate with Raypirri Rom (Yolngu staff in Nhulunbuy) about how we can work together to access Yolngu cultural interpreters ACTION Sharon
- Develop Yolngu name, logo and promotional materials, ie. Tshirts, lanyard, water bottles... utilise local artist through art centre Yirrkala, Galiwin'ku ACTION Lou and Sharon
- Report on funding deliverables as required. ACTION Sharon

Workforce plan

Gapuwiyak	Yolngu	Facilitator	GP
Dirramu (man)	Damien (T)	John S	? Teams
Miyalk (woman)	Amanda, Terese	Kellie, Sharon (T)	Jenny, Penny
Nhulunbuy/ Gunyangara			
Dirramu	Raypiri Rom (T)	John S, Naizel (T) Toby (T)	Charlie (T), Rob (T)
Miyalk	Shannon (T)	Kellie, Sharon	Bianca (T), Eileen
Yirrkala			
Dirramu	Raypiri Rom (T)	John S, Connor (T)	Charlie (T), Rob (T)
Miyalk	Shannon (T)	Kellie, Sharon (T), Tegan (T)	Bianca (T), Eileen
Galiwin'ku			
Dirramu	Nathan	John S	?onsite locum or Teams
Miyalk	Gwen	Kellie, Sharon (T)	Lou (T)

"T" indicate training in progress

APPENDIX 7

Interim report July 2023 to Dec 2023

PROGRAM ACTIVITY REPORT TEMPLATE

INTEGRATED TEAM CARE SERVICE DELIVERY PROGRAM (ITC) ADAPTING AND IMPLEMENTING SHARED MEDICAL APPOINTMENTS/MEDICAL YARN UPS (MYUs) IN DARWIN

Provider Name (organisation)	ASLM
Agreement Term:	01 July to 31 December 2023
Contract Number:	C
Liaison Officer:	Dianne Bates

Reporting Schedule	<table><tr><td>Reporting Period</td><td>Due Date</td></tr><tr><td>☒ 1 July – 31 December</td><td>31 January</td></tr><tr><td>☐ 1 January – 30 June</td><td>31 July</td></tr></table>	Reporting Period	Due Date	☒ 1 July – 31 December	31 January	☐ 1 January – 30 June	31 July
Reporting Period	Due Date						
☒ 1 July – 31 December	31 January						
☐ 1 January – 30 June	31 July						

Please ensure you complete and return this Program Activity Report by due date to:
contracts@ntphn.org.au.

Details of Person completing the report	Name: John Stevens and Bob Morgan Title: Profs Phone: 042828856 Email: Date:
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MYU SERVICE DELIVERY						
Number of staff trained to deliver SMAs/MYUs in this reporting period?	Provider	Oriented to SMAs	Number of Clinicians trained	Aboriginal Health workers	Community Leaders	
	Miwatj	110 +	40	10	6	
	Congress	140+	45	4	8	
	Danila Dilba	42	10	2	0	
	NT Health	20	0			
	NTPHN	20+	2			
	AMSANT	18	1	1		
Brief Description of Service Delivery training Model and how this will be provided in the future.	The best model for training people is an orientation and facilitator training session delivered either directly as face to face or online face to face over 4 hours. This is then followed up by trainees undertaking the online SMA facilitator training module. The training has been be-spoke depending on time and availability and location of staff and community. The SMA teams in place in each ACCHO are being trained and supported by the ASLM team and provided experience so that they can train other clinicians (including AHPs), managers and community as required, using slides provided by consultancy team and having access to enrol staff and community in to the online program.					
FTE, designation and qualifications of staff employed in the reporting period.	Position	FTE	Qualification ¹	Service Delivery Location		
	Please explain if FTE levels for this reporting period differ from your contract.					
Unsure of what is being asked by this section						

Resources developed for use by stakeholders?	A range of materials designed to orientate and train managers, clinicians and community have been brought to this project by the ASLM consultation team. This includes, slide decks, an online training SMA facilitator training program and templates. The consultancy team are also working closely with each ACCHO to help localise the training materials and improve the cultural responsiveness of procedures and materials.
What training and professional development have staff undertaken to deliver SMAs/MYUs during the reporting period? Please include any specific culturally competency training staff have undertaken to meet the needs of the clients.	Training that staff have undertaken has been explained above. Prof Bob Morgan provides general cultural competency for First Nations Australian people. But this then enhanced and localised by various AHPs and community encounters.

What Activities did you implement?

Presentations/Workshops	Number of participants	Stakeholders presented to	Stakeholder feedback
As presented above			Feedback is collected by either formal evaluation questionnaires and in majority by open ended discussion with individuals and groups. Managers and clinicians have been very positive as they see SMAs are conceptually aligning with their practice and are positive about the actual skills they learn in the training. Of the 450 or more NT stakeholders that we have connected with between July and December we have had no negative feedback on our presentations and or training. There have been a small number of challenges to the SMA model and its applicability to specific services. A few reasonable concerns about privacy and for safety of participants. Feedback from community has been overwhelmingly positive as they consistently feedback that this is how they want their chronic care to be delivered as this is how they have always

MYU Clients					
MYU by disease type	Female clients	Male clients	Gender not specified	Total	Total Number of Clients with a Chronic Disease Management Plan
General Medical SMA with Congress in 12 th Sept 2023	8	4			12
Yirrkala Diabetes 24 th October	4	0			4
Gapuwiyak 13 th November 2023 Diabetes for women	8	0			8
Gapu 14 th Nov, Diabetes for Women (different group from the one above)	8	0			8
Gapu 16 th Nov Diabetes for men	0	6			6
					done their health business. They tell us that they are pleased that we are now teaching the services how to do this.

MYU SESSIONS IMPLEMENTED IN THIS REPORTING PERIOD

Challenges and opportunities?

Challenges

Staff continuity and availability

Emergencies in the health centres

Technical, access to patients notes and reports and printer functions to create lists

Driver availability

Creating the language for Promotion by drivers and AHPs for example in communicating with potential participants.

The need for early planning with health centre staff vital
Lists for staff to select participants
Invitations to be circulated prior to MYU
Male or female groups requiring MYU team of same gender
Interpreting MYU in language is essential

Opportunities

There is widespread knowledge of and excitement for MYUs being introduced within the three ACCHOs services

There is a need to create the correct messaging about MYUs with posters and flyers so that drivers and AHPs for example can promote it among their contacts.

Early indications are that the Aboriginal clients, AHPs and other clinical staff have spoken widely through their communities about their experiences with MYU. There is a broad understanding and appreciation of this model and a willingness to participate in all locations.

What Monitoring and Evaluation tools are you using to implement quality improvement of the MYUs in practice?

To be decided by NTPHN meeting on the 5th of Feb 2024

A Narrative Report on:

ACTIVITY AND PROGRESS IN THE SMA PROOF OF CONCEPT PROJECT FOR NTPHN (July -Dec 2023).

By Profs. Bob Morgan and John Stevens

Activity summary

Prior to end of financial year June 30th 2023 activity reported on had a main focus on establishing and building relationships with the three ACCHOs Miwatj, Danial Dilba and Congress with the intention of them signing on with NTPHN to trial the use of SMAs. This appeared to be a successful first step as the three targeted ACCHOs did indeed sign on and commit to employing staff with funds provided by NTPHN to operationalise the Proof-of-Concept project.

To achieve this outcome more than 30 presentations and orientation sessions were provided to a range of organisations with included department and leadership groups among each of the ACCHOs as well other aligned organisations such as NTPHN, Menzies institute, NTHealth, AMSANT, and Sydney University.

Since June 30th the focus has been on keeping up interest and momentum among the participating ACCHOs, continuing to provide orientation to staff new to the SMA concept and facilitator and provider training for those wanting to be involved. In addition, the ASLM consulting team aided by Kerrie Kerin from AMSANT have continue to work with key personnel to develop and train the strategy teams required to roll out the proof-of-concept project at each ACCHO. NTPHN funds have allowed the ACCHOs to employ a project coordinator, and Aboriginal Health Practitioners and other staff to roll out a series of demonstration projects among each ACCHO.

The Consultancy team has networked closely and deeply who each ACCHO to ensure the SMA project was well known through the entire ACCHO workforce, the key leadership and executive teams and the Aboriginal Communities served by each ACCHO.

Our Aims, Our Learnings

Our specific aims with visits and meetings have been to provide support and leadership for this project to ensure that SMAs (whatever their local name becomes) are willingly adopted through co-design and co-construction with each community. That the SMA process becomes viewed as an enduring Aboriginal model of care, led by Aboriginal people and communities and ideally operationalised by Aboriginal health practitioners or influential people and privileging Aboriginal knowledge and science alongside mainstream health care practice currently provided by the services.

One stand-out and most powerful learning (of many) provided to our team from conversations with Aboriginal staff who have been teaching us about local culture is that: (the accuracy of the author's interpretation the following paraphrasing has been checked with the spokesperson, who asked to remain anonymous):

'that Balunda build their world around the idea of time. For example, their health care system is based on busy activity and they measure their success by the clock – time... how many people get seen in what time frame, how many people turn up to appointments on time or get cured in a certain time frame, how much money was spent in financial year on services etc. This is how Balunda construct their world.'

The world of Aboriginal people is built around relationships – not time. Our relationships with Country, our home lands, our families our community and our interactions with Balunda and their services are not about time or how long something takes.

‘You can see the disconnection when we come together because one works on time and one works on relationships. Medical Yarn Up (aka Shared Medical Appointments) offers a way that these interactions might be much smoother.’ (Aboriginal Health Practitioner, October Nhulunbuy 2023)

As of December 2023, the following activity and progress can be reported among each of the ACCHOs:

Miwatj

The Consultancy team has worked closely with the senior Miwatj leadership team, in particular, with the Senior Medical Director Dr Lou Sanderson. Since June 30th 2023 the Consultation team has formally presented on the project to leadership and management teams and general staff no less than 10 times to communicate the concepts, activity and progress as well as in undertaking SMA training.

The team has physically visited Miwatj in Darwin and on Country 3 times since June 30th.

Visit 1.

Within the Darwin offices a in person presentation, meeting and networking was provided with Darwin-based staff.

A visit to Gapuwiyak followed and the consultancy team under the caring guidance of Dr Lou Sanderson was introduced to the community commencing with a very generous and meaningful welcome to Country. (This was meaningful for all of the consultancy and project team but with deeper cultural need and appreciation for this protocol expressed by both Gumilaroi Man, Prof Bob Morgan and Arente Woman Kellie Kerin). Numerous opportunities were provided for conversations and presentations to clinic and community staff as well as among the community.

The overall outcome from this visit was the establishment of a relationship with the team, the community and the clinic and a much clearer understanding of the intention of the SMA proof of concept project. Follow up reports and subsequent ZOOM meeting appeared to support our observations that our early interactions had some effect. This provided us the impetus for planning future visits and communication, networking and education strategies.

In addition, with support from NTPHN and ASLM, Aboriginal Health Practitioners from Miwatj were able to travel and attend the 2023 ASLM conference in a chilly Melbourne in early September. This was aimed at providing these key workers with opportunity to learn more about SMA and lifestyle Medicine and its integration into practice.

Visit 2.

This visit in late October aimed to further connect and network the consultancy team and Miwatj staff, services and communities which Miwatj serves. The visit was coordinated and guided by Dr Lou Sanderson. It included visits to Nhulunbuy and outlying services at Yirrkala and Gunyangara

During this visit. We were introduced to Dr Sharon Atkinson-Briggs (PhD) who had in the interim, been employed as the SMA Project Coordinator for Miwatj.

Relationships with Aboriginal Health Practitioners were re-established. We yarned over 3 days about the SMA concept, and how it could be presented and undertaken with local Yolngu communities. A discussion about the name and need for local language needed to describe and run the process was considered. It was decided that SMAs in East Arnhem Land would be gendered for men's and women's business. This would include attendance by same gendered staff where possible. Miwatj was in process of employing more AHPs to work with Sharon to continue running the project.

The first SMA was planned and undertaken at Yirrkala with Aboriginal women. The process included, firstly ensuring the empowerment and resourcing of the AHP to take control of the SMA project for women in her health area. The AHP following long discussions with the team then decided to personally invite women from the Yirrkala clinic to join the SMA to talk about their T2DM with Drs Eileen and Lou who were known to the women. The picture below shows that 4 women attended this session. It was facilitated by the local AHP and Drs Lou and Eileen and Sharon Atkinson Briggs. AHP (Gwen) reported that the women responded very positively to the experience. (See Dr Lou Sanderson's report attached for more detail.)

In addition, a CPD training session was held at which 24 Miwatj staff (this included Drs, RNs AHPs, the Mental Health Team, the Chronic Disease team and others??) undertook formal SMA facilitator training. This included a 2 hour+ face to face orientation and individual enrolment to an online SMA provider and facilitator training program equivalent to an additional 4 hours of CPD.

The unanimous enthusiasm for the SMAs and the desire to trial its use in the attendees' various realms of activity was extremely encouraging.

A visit to the local Gove hospital and a talk with the director of services revealed an enthusiasm to trial SMA in the outpatient's clinics – Though this was outside the brief of the NTPHN project, it will be worth following up on. SMA use in Gove Hospital would help with the overall community understanding and uptake of SMA if it was an option offered throughout all services.

Visit no 3.

This visit in late November aimed to re-visit the Gapuwiyak community and clinic to add to the momentum created by the previous visit and staff having attended the ASLM conference in Melbourne during September. In addition, it was an opportunity for Dr Lou to introduce the SMA project coordinator Sharon and for her to develop relationships and understandings with the clinic staff and gain firsthand experience of the Gapuwiyak community. Since our previous visit a new dynamic and enthusiastic clinic manager had been engaged. Ms Kelly Burton is an experienced leader and manager and was excited by the potential of SMAs as part of the service and provided significant support. In particular Ms Burton ensured the AHPs were empowered and resourced to take the lead in the SMA project.

This resulted in the AHPs organising Gapuwiyak's first SMAs. These SMAs were arranged by gendered for cultural reasons. The AHPs spent much time talking with community about the SMA process helping them feel safe with the process. They then planned the SMA they wanted delivered, based on their community feedback. They also sent out personalised invitation to people they thought would participate. The women's groups (x 2) and the men's group (x1) aimed to conduct SMAs about T2DM management as per the participants previous feedback on what they believed they needed more consultation with the Dr about.

Dr Ramsay attended all three sessions (the men's group were comfortable with Dr Ramsay as she has is a familiar person and consulted often as the regular GP for these men). Dr Ramsay reported positively on the experience from her professional role as GP and from the feasibility of the process becoming a regular, integrated part of the Miwatj service.

The Feedback from the AHPs was also very positive. The AHP managing and facilitating the women's' groups reported that they women liked the process and told her, in language that they would prefer to health care like this when it came to managing their T2DM. The men commented in English to one of the authors that: (paraphrasing accuracy was checked with the trainee AHP who was present and is a local Yolngu man.)

'... so your job is to teach the service how to do this? Because you are not teaching us anything new. This is how we have always done our business. ... we'll help you teach the service because this is the best way to do it. Many more will come if this is how it is done from now on.'

It was an unusually stressful and traumatic time in the community while we were visiting. According to the AHPs there was an unusual amount of 'sorry business' and many mental health crises. In addition, there were significant power outages and very limited opening hours of the one food shop in town, adding to the tensions. Yet even among all these added challenges the staff and community were incredibly generous with their time and support of the project. They reported to us that they could see the value of the concept and had a desire to make it work.

It was hoped with a male and female AHP taking control of the project in Gapuwiyak, supported by Sharon Atkinson Briggs as the Miwatj project coordinator, the consultancy team of Kellie Kerin, Prof's Bob Morgan and John Stevens and the Senior Medical Director Dr Lou Sanderson and the local clinic manager Ms Kelly Burton and Gps Drs Jenny Jobst and Penny Ramsay that many SMA opportunities will be created over the succeeding 9 months of the project (and hopefully beyond).

Congress.

Meeting since June 30.

Telephone and zoom meetings preceded a face to face gathering during the week of July 10th.

Visit 1

During this visit face to face staff training in SMA facilitation to approximately 20 Congress staff was undertaken. In addition, broad consultation about the SMA project was undertaken with Alan Kennedy from NTPHN, the Congress senior leadership team, the allied health and Gap Road team. As well Bob Morgan and John Stevens spoke with Inkinge Men's group lead and community liaison Mr Michael Liddle. Visits with community men's and women's groups were also undertaken, including a session with the 'Aunties' exercise group who were very keen to engage the SMA process and bring their 'young ones' with them. They told us

that they believed 'the SMA process would encourage more of their community to feel safe and attend medical consultations'.

Planning for projects was undertaken with the allied health leadership team in preparation for the employment of their SMA project team which was intended for Sept-October 2023.

The first SMAs were conducted with Kellie Kerin facilitating sessions with Dr Theron in remote locations many hours' drive from Alice Springs. (Kellie's report of these first SMA's is in Appendix 1.)

3 clinical staff attended the ASLM conference in Melbourne in Sept and participated the First Nations Round Table facilitated by Kellie Kerin (AMSANT) and Prof Bob Morgan (ASLM).

The Congress Project coordinator and lead SMA facilitator were engaged in October. A number of ZOOM meetings ensued to help orientate this team to the project and the processes of SMA. With the goal of meeting face to face in November.

Visit 2

The week of the 20th November Profs Morgan and Stevens and Kellie Kerin worked face to face with the Congress project team.

It had been an important goal of the Consultancy team to have a gathering of Congress Aboriginal staff to explain SMA and ask for their input into its integration in to Congress. The insights gained were very positive and encouraging. The outcome of the meeting inspired the tag line developed by the project coordinator 'Different for Doctors not for Mob!'

This was a common sentiment expressed by Congress Aboriginal staff and service users in our consultations and during the first few deliveries of SMA in the community:

That we were not teaching the community anything new, as this is how business was always done in yarning circles. They could see that we were teaching the Service how to do this and they were very supportive as a result. (This was the equivalent response found among the East Arnhem Land people that we consulted with)

Our community consultations resulted in unanimous support for SMAs.

The Congress Project team were left with skills and confidence to move forward with Congress to staff to support many future SMA trials. They were planning a more systematic approach for the new year 2024 when they believed staff and patients would be most receptive.

As always, the Congress Medical and Allied Health staff were extremely welcoming and supportive.

Danila Dilba

Progress meetings were conducted by telephone succeeding the face-to-face visit in June.

There were reports of large staff turnover causing difficulty in progressing the project. However, by November there was renewed enthusiasm for the project with Coordinator and Lead SMA facilitator employed.

Visit 1

A visit and training session conducted on November 17th resulted in 8 DD staff (including 2 senior medical Doctors) being orientated and SMA facilitator trained. Unfortunately, the new project staff were unavailable for this gathering. An overall project lead was established with physiotherapist Ms Phillipa Cotter.

The session resulted in identifying DD sites and potential projects that could be conducted with the start of the new year.

It was planned that the new project staff would be in contact to begin their orientation and training with the consultancy team asap.

NTPHN

There were a number of virtual and face to face meetings with NTPHN since 30th June. The Consultancy team met virtually and regularly with Mr Alan Kennedy to progress strategies and report on progress up until his departure from NTPHN. The NTPHN point of contact became Ms Di Bates.

Visit 1

During the week of the 10th of July meetings in Alice Springs with the NTPHN team were led by Victoria Orpin. Further SMA orientation sessions were conducted with other NTPHN staff based in Alice Springs.

Victoria also conveyed networking gathering with Menzies Institute, Sydney University, NTHealth, Medical staff and specialists during this visit which coincided with our visit to Congress during the week of 10th of July.

Visit 2

Follow-up progress meetings with Di Bates, Jouline Bouwer, Ali Lloyd and Bernie Cummins have been held online and one face to face visit on the 17th of November where we also met briefly with Darcy Godden, Executive Manager, Aboriginal and Torres Strait Islander Health.

During that visit discussions included:

- Supporting the work of Sinon Cooney regarding the introduction of coaching training for Aboriginal health staff.
- Restating that ASLM NTPHN contract and budget being on track.
- A warm and encouraging commitment to the SMA process and project by the NTPHN staff
- A request by the Consultancy team for NT funds that might cover project resources like T-shirts and posters. (~9k was requested by Di Bates)
- A further request by the consultancy team for NTPHN funds to be able to conduct an independent evaluation of the project at the 3 sites. (~50K)

Overall impressions:

30th June till now

That Miwatj and Congress are on track to deliver many SMA projects before the completion of the project.

Both organisations are supportive of the project and the entire leadership and clinical staff groups of these organisations are aware and supportive of the project. Community consultation among these services indicate an appetite for SMAs and an excitement with the opportunity to try them.

Both Organisations have their SMA project staff in place, orientated and trained and with plans developed to move forward with SMA opportunities in 2024.

Miwatj and Congress have developed momentum to provide confidence in undertaking many SMA sessions before completion of the project with only minimal support required from the consultation team.

Danila Dilba are at the beginning stage of the process of raising staff and community awareness of the project. They have also begun planning projects for 2024. The Consultation team will require some more intensive input to DD before there is a rise in confidence of their project completion in the time frame.

Other Observations include:

The growth of knowledge or understanding of SMAs. There was virtually no understanding or knowledge of SMAs at the commencement of 2023. As of writing this report the each of the leadership teams of each organisation, the majority of workforce and large sections of the communities they serve now have an understanding and are supportive of SMAs and the projects that are being planned.

Subjectively from our observations of the few SMAs run within Miwatj and Congress to date – the process can be integrated into service, will be beneficial to the communities they serve by providing culturally safe and responsive care that can be led by Aboriginal people, and it will improve workforce efficiencies, retention and enjoyment.

Final Remarks

The role of the Consultancy team going forward is to provide the leadership and support and encouragement toward the initial goals of developing SMAs as an Aboriginal model of care. Establishing SMAs as a model of care will encourage Aboriginal leadership in care planning and delivery, that will support Aboriginal health practitioners the Miwatj service and the communities that it serves. We will continue to support the Miwatj teams that are in place, assist in training new team members and other Miwatj staff. Offer ongoing orientation and training to staff as requested. To assist with the development localised and meaningful measures and evaluation tools.

We are hoping with further support from the NTPHN that we might support an independent evaluation of the project and its expansion within the ACCHOs.

APPENDIX 8

Report on the first Congress SMA

(Via email from Kellie Kerin 13th September 2023.)

FIRST EVER SHARED MEDICAL APPOINTMENT IN THE NORTHERN TERRITORY

Dear Monica and Brendan,

Congratulations on holding the first official SMA under this framework, here in Central Australia in the context of the **Bush Mobile** – yay!

The Central Australian Aboriginal Congress has had a very successful “lift off” following yesterday’s Bush Mobile on the southern run of the program’s well establish Outreach service to Outstations.

1st Group - Walkabout Bore Outstation

There were **6 participants**, 1 male and 5 females that made up this first ever group. The SMA held a heterogenous theme to the medical consults where several chronic conditions were discussed.

As the facilitator, I provided a cultural introduction to mob, a further introduction to the SMA process in addition to what Monica and Bredan have already covered with the group in a previous visit. The introductions included confidentiality and the importance of maintaining same throughout the SMA.

The session took just over 90 mins and the SMA ran like clockwork, gold standard and was textbook to *Best Practice* of a successful SMA.

The group is a close-knit family that all live out on their Outstation (Country) in a cluster of about 8 homes. Bush Mobile would normally visit each home that can be laborious by simply packing up and then again unpacking medical equipment at each home in a space of a few hundred metres apart. This is just one example of how the SMA hugely benefits this setting and to hold the session in one location.

Photos were taken with permission and additional permission to be used to promote/demonstrate a SMA held at an Outstation out on Country. Will share once edited and collated, I will share with this group.

At the conclusion of the SMA, the group was then asked the survey questions as per the ASLM format/documentation.

1. Did you like the location of where the SMA was held today?
 - a. Yes. Plus there was an obvious sense of pride as the group had cleaned and prepared their chosen area to host the SMA.
2. Did you feel safe to talk about your health today?
 - a. Yes, this group talks about their health and appointments post Bush Mobile visit all the time anyway.
3. Did you feel a sense of trust amongst your mob today?
 - a. Yes. There is a lot of existing trust amongst the family group already.
4. Was the yarning circle and seating arrangements adequate and comfortable?
 - a. Yes, the group had already prepared their own space.
5. What did you like about the SMA?

- a. Everyone really liked the setting, process, and environment. How open everyone was, and the group reported on the benefits of the social interactions, the opportunity to better support each other, sharing what's going on for everyone's health and how they can remind each other of future appointments or changes made to their health care during the SMA today. Plus, they commented on the fun that was shared and the ease of all being together.
- 6. What didn't you like about the SMA?
 - a. No response as everyone liked the process.
- 7. Would you tell others about the SMA?
 - a. Yes
- 8. If yes, what would you say?
 - a. How good it felt to all be together.
- 9. Did you learn something new about your condition and health during the SMA?
 - a. One person responded and said how easy she found it to open up and share more about herself and how good she felt about that. The rest of the group did not have anything further to add to the feedback already provided. The right at the conclusion on the session, a new issue was raised, and everyone learned the impacts of a high salt intake on foods can contribute to high blood pressure. So further information was provided to that individual and the group also benefitted from this new knowledge and shared how they use salt. Healthier alternatives were offered and everyone learned something new.
- 10. Would you come to another SMA
 - a. A resounding big fat YES

2nd Group

John Holland Outstation

There were **5 participants**, 3 male and 2 females that made up this second group. The SMA held a heterogenous theme to the medical consults where several chronic conditions were discussed. Although, by default, a musculoskeletal theme was noted.

As the facilitator, I provided a cultural introduction to mob, a further introduction to the SMA process in addition to what Monica and Brendan have already covered with the group in a previous visit. The introductions included confidentiality and the importance of maintaining same throughout the SMA.

The session took around 75 mins and the SMA again ran like clockwork, gold standard and was textbook to *Best Practice* of a successful SMA.

The group is a close-knit family that all live out on their Outstation (Country) where their homes are a little more spread out and not clustered like the first group. Bush Mobile would normally visit each home that can be laborious by simply packing up and then again unpacking medical equipment at each home. It was further identified that in previous practice of the Bush Mobile, both the GP and Care Coordinator would be quite fatigued by the time they go to the last house of the run. Both Monica and Brendan stated that they felt that, at times they were not at their best at the end of the day, and this could potentially impact on the quality of the last consult of the day. It was further stated that in the hotter months, it can be a very long and tiring day for everyone, including their last client. Again, this is just one example of how the SMA hugely benefits the process by holding the session in one location.

Photos were not permitted at this location for Cultural reasons.

At the conclusion of the SMA, the group was then asked the survey questions as per the ASLM format/documentation.

11. Did you like the location of where the SMA was held today?
 - a. Yes. The family chose to sit outside as they wanted to keep the inside of the home available for any private matters that may come up.
12. Did you feel safe to talk about your health today?
 - b. Yes, this group talks about their health and appointments post Bush Mobile visit all the time anyway.
13. Did you feel a sense of trust amongst your mob today?
 - c. Yes. There is a lot of existing trust amongst the family group already.
14. Was the yarnning circle and seating arrangements adequate and comfortable?
 - d. Yes, the group had already prepared their own space. The flies invited themselves along for the Sam as well.
15. What did you like about the SMA?
 - e. Everyone really liked the process and how open everyone was. The group reported on the benefits of the social interactions, the opportunity to better support each other, sharing what's going on for everyone's health and how they can remind each other of future appointments or changes made to their health care during the SMA today. Plus, they commented on the fun that was shared and the ease of all being together. *(There was an obvious genuine care for each other was all participants left with food and a stronger sense of belonging.)*
16. What didn't you like about the SMA?
 - f. No response as everyone liked the process.
17. Would you tell others about the SMA?
 - g. Yes. The group was adamant that would not be sharing any details about their own health but would be happy to tell others about a group appointment and how it works.
18. If yes, what would you say?
 - h. How good it felt to all be together. In particular, for one older participant who lost their partner a couple of years ago and how isolated they feel. The SMA was also viewed as a social gathering and an outing.
19. Did you learn something new about your condition and health during the SMA?
 - i. At the time, the participants could not think of Anthony new.
20. Would you come to another SMA?
 - j. Yes, and maintained they would want to keep it to their immediate family group of 5 only. The group wants to remain together but perhaps hold the SMA at different houses as not everyone has their own transport.

Yesterday was certainly a highlight for our mob, dedicated Bush Mobile staff and to everyone that has been involved in getting SMA up and running. Considering the idea of SMA was introduced to our sector in November of last year, a lot has happened in that time. John and Uncle Bob from ASLM first introduced SMA/MYU at the ITC Forum last year here in Alice Springs and have continued to support CAAC and other participating services along their journey.

Very exciting times.

Dr Monica and Brendan – please amend or add to anything I may have missed in my summaries. Plus, please feel free to use for your own reporting.

Thank you for inviting me to be a part of yesterday and a part of history in the positive opportunities we have in delivering Healthcare here in Central Australia.

Kind Regards

Kellie

RN – Workforce Team Leader

CRANApplus Fellow

APPENDIX 9

An SMA Post Card from Milingimbi

Title: Medical Dhawu Dhawu brief report: Milingimbi Visit: 29th April-2nd May 2024

For: Miwatj ASLM and SCU

From: John Stevens

Date: 4th May 2024

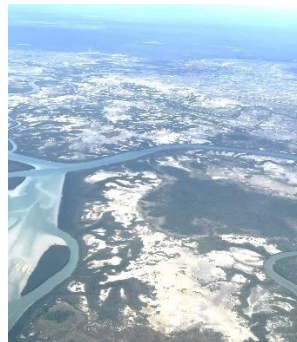
Contact: john.stevens@scu.edu.au tele 0428288526

Background

As part of the development of Medical Dhawu Dhawu (MDD) initiative, A/Prof. John Stevens travelled via Darwin to the East Arnhem Land Community and island of Milingimbi located among the Crocodile Island group. (Latitude: -12° 05' 42.00" S Longitude: 134° 53' 34.80" E)



Milingimbi is a remote small island (10x 11 KM²) accessible by air (rarely by sea) of approximately 1000 people, most of whom are Yolngu. The population lives in 5 established 'camp' locations, the equivalent of small urban suburbs. The main language spoken is Yolngu Mather. For most, English is a second or third language with many older people especially, not speaking it at all. School is taught to year 11 and education is delivered bilingually. Health issues are vast and representative of other Aboriginal communities in East Arnhem Land. There was an estimate by the clinical staff that about 40-50% of the adult population had Type 2 Diabetes for example.



The community is serviced by one retail shop where all food, clothing and household items are sold. The shop is stocked by a barge from Darwin which delivers fresh food and other items once per week when the tides and weather allows.



Health Services

The main health service for the community is the Milingimbi Health Clinic, managed by Miwatj Health Aboriginal Corporation. The Clinic provides primary health services and is the hub for a range of visiting specialist services. The clinic also provides emergency services including retrieval to and from Darwin or Gove hospitals.



There are a number of local Aboriginal Health Practitioners and service providers as well as some permanent nursing staff. The majority of clinical staff are on, approximately, 4 week rotations. Until recently staff movement was volatile with much churn among clinical and management positions.



Medical Dhawu Dhawu Activity and Outcomes from this visit.

Miwatj and the communities they serve are participating in a 2 year long, proof of concept trial of Shared Medical Appointments (known as Medical Dhawu Dhawu in Yolngu Mather) supported by NTPHN and AMSANT and advised by ASLM. To date the communities of Nhulunbuy, Yirrkala Gapuwiyak and Galiwinku have also participated in the MDD activities.



This was the second visit to Milingimbi by the MDD team which included Dr Sharon Atkinson-Briggs and the first with project consultant Prof John Stevens from ASLM and Southern Cross University.



A report provided by Matthew Dowling about the first visit has been previously distributed. In brief, the previous visit helped to inform the clinical staff about the MDD process and ways of embedding it the normal business of the community were considered. A successful women's session was held and facilitated by Sharon Atkinson-Briggs.

On this visit. Sharon managed the women's MDD and John the men's. This report focusses mainly on the MDD work with the men.

A relationship with a local trainee Aboriginal Health Practitioner, Tristan Baker was developed. Tristan provided great insight to ways of localising the MDD process, especially for the men.

John visited and yarned with some of the Traditional Owner men. This was to pay respect and also ask permission to be able to conduct this work on their Country. The TOs provided permission and also valuable feedback on the MDD process when it was explained to them, unanimously advising that MDD would be a preferred way of seeing the Doctor and other clinic staff for non-urgent, ongoing health issues (this included chronic illness management according to Tristan's translation.)

A number of the TOs asked the MDD team to come to a Learning On Country session to see what health education they were already providing to their younger men and to exchange ideas on health with them.

Dr Steve, Tristan and John attended a men and boys Learning On Country session the next day. Dr Steve and John explained, with the help of Tristan's interpreting, the MDD process that Miwatj would like to establish. Our yarn with the Learning On Country group was well received. We were then invited to all of the camps over the following weeks to undertake MDD.

Tristan and Dr Steve have developed a plan to visit the camps each Wednesday over the next 4 weeks of Dr Steve's rotation on the Island.



Following a yarn with the TO at the Bodiya camp a MDD session was arranged for the following day. Led by Tristan Dr Steve and John met with 8 men and 2 boys. The main aim of this MDD was to establish a relationship with Dr Steven and Tristan especially and the Bodiya camp men and to explain the MDD idea.



The men explained some of their issues at the camp. One major ongoing problem, common to the entire Island community was expressed, regarding the difficulty in obtaining 'good' food from the shop. Nutritious food is expensive, (the author visited the shop on arrival and noted: an iceberg lettuce@ \$8, apples@ \$7kg, 750 ml bottle of Olive oil@ \$22, 1kg rice @ \$7, potatoes @ \$7kg, Frozen rump steak @ \$50kg, 2L Cola @ \$4, Single serve Asian noodles .60c/per packet) the variety of food was limited.

The shop could be difficult to access. The Bodiya camp for example, was approximately 4.5 km away. Roads were often impassable during wet season to people on foot or in vehicles. Indeed, the day we visited Bodiya camp the shop was shut the entire day for stocktake.

The men explained how they used hunting to help them stay healthy, as it gave them bush food, exercise and kept the young engaged in culture. They were keen to tell us about some of their bush medicines.

The men were also keen to explore the MDD concept and said clearly, that they wanted to exchange knowledge not just receive it and this might be a way to do it. They shared stories with us of ill health from diabetes and kidney disease that they believed were healed by hunting. Though they knew plenty of people on the island that needed more help than would come from hunting.

They told us stories about how they hadn't been healthy at times because of drinking too much Cava. One man asked specifically about the dangers of Cava which Dr Steve was able to answer. The men then wanted to hear stories from us about our personal issues, had we engaged behaviours that were unhealthy? Dr Steve and John both provided stories of our past that recalled unhealthy eating, drinking and smoking behaviours.

One man presented a boil on his upper right leg to Dr Steve and it was used as a teaching opportunity to help explain that boils were the result of 'germs' and in some people without treatment those germs could travel by the blood to heart and kidneys. This was new information for many of them and it convinced

the patient that he would visit the clinic the following day to add to his bush medicine treatment of it with help from Dr Steve and antibiotics.

By the end of the approximately 60-minute session there was a positive feeling about the MDD exchange. We were all pleased that it had been an exchange of stories and knowledge and that the MDD team appreciated the men's local health behaviours and bush medicines as being legitimate. They were unanimous about how important it was that we had come to sit with them in the camp under their awning. The men were not wanting their photo taken this time but were happy for us to take a photo of the awning we met under (and their pet Brolga, Maurice).



Before we left, the TO told us that no Dr had sat with them like this in the past, from his memory. The men were looking forward to developing this method of consulting.

In a debriefing, Dr Steve voiced his appreciation of having attended to this first MDD and though we had some refining to do, which he could see would improve in time and with practice, it was for him, a great exchange and a start to developing MDD in the community. Dr Steve fed back, that as well as the positive relationship development and the general health talking, he was able to discern the requirements of billable consultations with some of the men.

Tristan was pleased to report that the men spoke very positively about the exchange in language after we left and that they would be telling others in their camp and on the island about the positive experience they had with MDD.

Before the end of the day Tristen was able to ascertain that men at each of the other camps were keen to experience MDD over the next few weeks.

In Summary

The positives: The Clinical staff were amazing and helpful and were well briefed about MDD. Tristen was brilliant in networking and interpreting for the men and should be encouraged and supported in this role to manage the MDD going forward. Drs Steve and Peter were both willing and able to undertake MDD if it was organised.

A large portion of the community became aware of MDD

Eight men and 2 boys participated in a first men's MDD

Traditional owners have been made aware of the MDD process and have told us that they like it.

The MDD team has been given permission to undertake MDD at all camps on the Island by the TOs.

The Learning Opportunities

That consideration needs to be given for clinical staff rotating through and retaining consistency of approach.

The MDD team need to spend regular time yarning with and paying respects to the TOs .

The Aboriginal Health Practitioners need to be supported to include MDD as part of their job description. Clinic managers need to be supported and resources to provide support to the AHPs.

The AHPs will need access and orientation to a MDD tool kit for the next stage of this project.

Personal Reflection:

It is difficult being a Balunda who flies in and out of these complex communities to try and gain contextual understanding, confidence and trust in such a short time. I was touched at how much trust was given in the short duration of this visit by community and clinic staff. The MDD process can empower the community and I could see that being recognised in every conversation I had. There is a desire within community and clinic to make MDD work. The MDD team need to spend more time in developing relationships and understanding with community. The fire is well and truly alight.



APPENDIX 10

A Post Card from Gapuwiyak

A Postcard From Gapuwiyak, Arnhem Land, Northern Territory- Yolngu Country.

By

John Stevens RN PhD FACN FASLM
Co-Founder and Director of ASLM
Associate Professor Lifestyle Medicine
Southern Cross University



Bob and John Ready to Fly

Professor Bob Morgan, a proud, senior Gumilaroi man and I travelled 500+ kms east of Darwin to the Arnhem Land community of Gapuwiyak.



Where is Gapuwiyak



The Community of Gapuwiyak from the air

We were in the company of Dr Lou Sanderson the Medical Director of Miwatj Aboriginal Health Corporation and Kellie Kerin from AMSANT, both with vast passion and experience working in NT remote communities.



Kellie and Dr Lou

We had been invited by Miwatj and the small Yolngu community of 800 or so to yarn about Medical Yarn Ups (AKA Shared Medical Appointments).



Gapuwiyak Community sign

Medical Yarn Ups (MYU) are not only a process to delivery medical consultations but are also an enduring, Aboriginal and Torres Strait Islander model of care that brings together groups of people with similar concerns, managed by a trusted facilitator, with their healer, in this case the GP. In addition, others in the group are listening, sharing and encouraged to contribute their knowledge and experiences.

We were treated to a most moving and generous welcome to Country and smoking ceremony.



Welcome to Country and smoking ceremony

As well we were introduced to the Tradition Owners of Gapuwiyak. They gave us permission and their blessings to conduct our work and thus began 3 days of yarning with the community and clinical staff about MYUs.



Meeting with the Traditional Owners Jimmy and Helen and their family.



John presenting MYUs

There was a palpable excitement about this way of doing health among everyone we spoke to, especially the Aboriginal staff.



Lou and Bob with The Aboriginal Health Practitioner Terese

MYUs make it possible to practice more Lifestyle Medicine and potentially prevent and better manage lifestyle related illness such as type 2 diabetes and renal disease, both of which are over-represented in Gapuwiyak and most other First Nations communities.

Type 2 Diabetes Mellitus is up to 5 x the rate of Non-Aboriginal Australians. In one community we have visited previously in the NT, the rate was 80% with 50% of the community suffering kidney disease as well. In one shocking statistic, remote living Aboriginal women are 29 times more likely to die from kidney disease than Non-Aboriginal women.

Lifestyle Medicine is the best medicine we have.

Medical Yarn Ups provide the opportunity to deliver the care that is needed for preventing and managing lifestyle-related illness. And, importantly, MYUs are a First Nation's model of care that has the potential to change current colonised-derived models and ways of doing health 'on' First Nation's people so that

Aboriginal and Torres Strait Islander people and communities have greater opportunity to take the lead in managing their health. In this way Non-Indigenous allies and the Health Services can do more health work 'with' Aboriginal and Torres Strait Islander people. This is a desire we heard many times in our conversations with the clinic staff and the community.

Lifestyle Medicine and Medical Yarn Ups provide a vehicle that can have Aboriginal and Torres Strait Islander people drive self-determination and health improvement, **and that will eventually be how the Gap closes.**

Let's close the Gap in Gapuwiyak and everywhere else in Australia.



Gapuwiyak translates in English to 'brackish water lake'. A Gapu Sunset