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NNSW INTEGRATED CARE MADE POSSIBLE BY STRONG LOCAL PARTNERSHIPS:

NSW GOVERNMENT Health Northern NSW Local Health District

phn NORTH COAST

NSW Ambulance

United in Aboriginal Health NORTHERN NSW

Susan's Story

Presented by Sandy O'Brien

Integrated Care

Mental Health and Drug & Alcohol

NNSWLHD

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Meeting Susan

- Care navigation viewing the patient journey and experience
  - From hospital to GP and community care & support
- What meant most for the patient in this time?
- What were the gaps?

- 55 year old health professional
- Adult children & grandchildren, no partner
- Social isolation as a result of her illness
- Lives between both sons either side of NSW/Qld border

- Asthma
- Connective tissue disorder
- Epilepsy
- Bipolar diagnosis

In the last 5 years

- 9 medical admissions, including ICU
- 5 long term mental health admissions

Hospital
Psychiatrist
Inpatient clinicians

GP
Managing medical care, medications.

Discharged back to GP care- no DS

Psychologist
Contacted by treating team during admission to update
Will see Susan weekly after discharge
No contact with GP

Community Mental Health
Case manager- mental health OT

Neurologist
No contact with treating team, GP or psychologist in regards to ongoing care plan

Susan's health priorities
Weight gain
Accommodation
Health care advocate


Change BLVD
Same Old ST

GP collaborative

- Enrolled into Chronic Disease Management by her GP
  - CDM Clinical nurse specialist providing care coordination

- CDM nurse coordinating care with mental health case manager (OT) + GP + client

Small Changes

Flexibility- the patient at the center

- in reach, provide hospital clinicians with the patients story in her context

Improved communication- trust- building professional relationships

- Contacting Susan had been difficult- (documented regularly in EMR)
  Turns phone off to sleep. Plan to text message did improve access
- LHD teams linked via EMR. Talking to each other
- GP included in communications- Notification of admission and discharge
  - Susan knows they are working as a team- not repeating her story

Improved care coordination

Whole of health care

The team work together on all aspects of her care an Susan's identified priorities

"**I can plan my care** with people who **work together** to **understand me** and my carer(s), **allow me control**, and **bring together services** to achieve the **outcomes important to me.**"

National Voices 2013

Thank You

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Renal Services – Benefits of a Nurse Practitioner and Supportive Care Service Model

Presented By Graeme Turner

NP Chronic Kidney Disease; NNSWLHD

&

Rodney Hyland

CNS2 Renal Supportive Care; NNSWLHD

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- Dialysis is really expensive!
- Dialysis has a large negative impact on patients quality of life!
- Early Chronic Kidney disease is asymptomatic.
- If treated early progression of CKD can be slowed or even halted but we have to find the patients first.
- Dialysis is not for everyone, people with multiple morbidities may not achieve improvement of quality of life or indeed increased life expectancy with dialysis.
- Frail people on dialysis may find there health burden increasingly overwhelming and may wish to make a planned withdrawal from dialysis – how do we support them?

- When the Chronic Kidney Disease Nurse Practitioner Role was first developed in 2008 we had meetings with the then Northern Rivers General Practice Network. The GP's at this meeting identified that lack of communication between Lismore Base Hospital Services and General Practice was an issue.

- To address this we started some co-located clinics at Tintenbar Medical Centre and Prema House – this was my first dabble into integrated care.

- There were some small teething problems but it made sense and appeared to work for all parties. Myself, the GP's and most importantly the patients. So these clinics continued and some more co-located clinics were commenced.

- In 2014-2015 I was involved in the “Co-locationand Integration of Allied Health Services into General Practice: A demonstration trial in North Coast NSW Medicare Local”.

- For me this provided an opportunity to receive some formal evaluation of what I had been doing and provided access to some different practices and facets of Primary Health Care.

- Key Learning Points

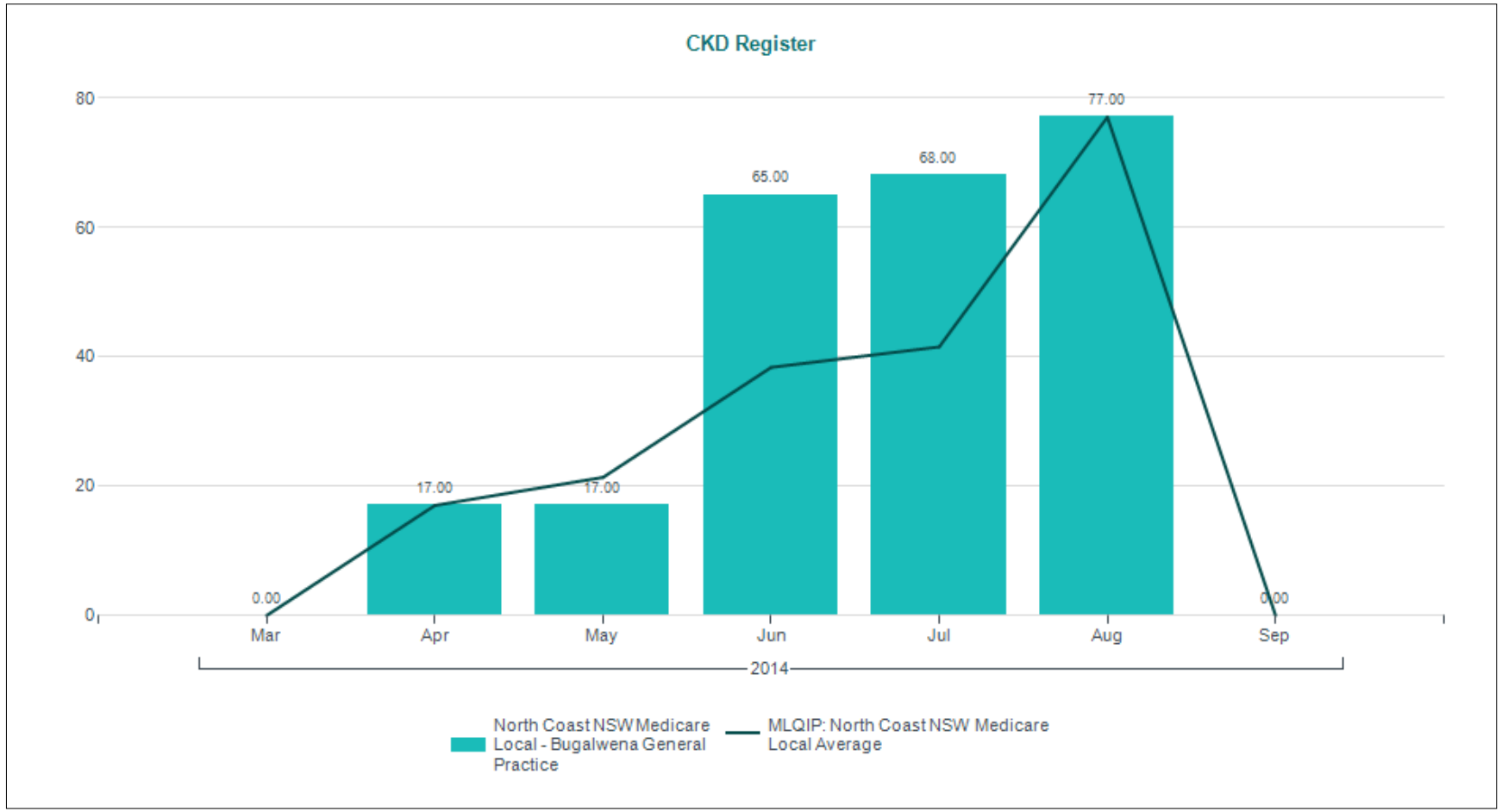
  - ✓Patient satisfaction with co-location was high.
  - ✓GP’s and LHD staff had high level of satisfaction.
  - ✓Co-ordination of patient care improved.
  - ✓There was knowledge sharing between Primary Health Care Staff and Local Health District staff.
  - ✓We have more to learn

- Following the co-location trial an opportunity arose for me to work with Bugalwena GP to improve identification and management of their clients with CKD.

- It provided an opportunity for me to test some ideas that I had formulated during the co location trial.

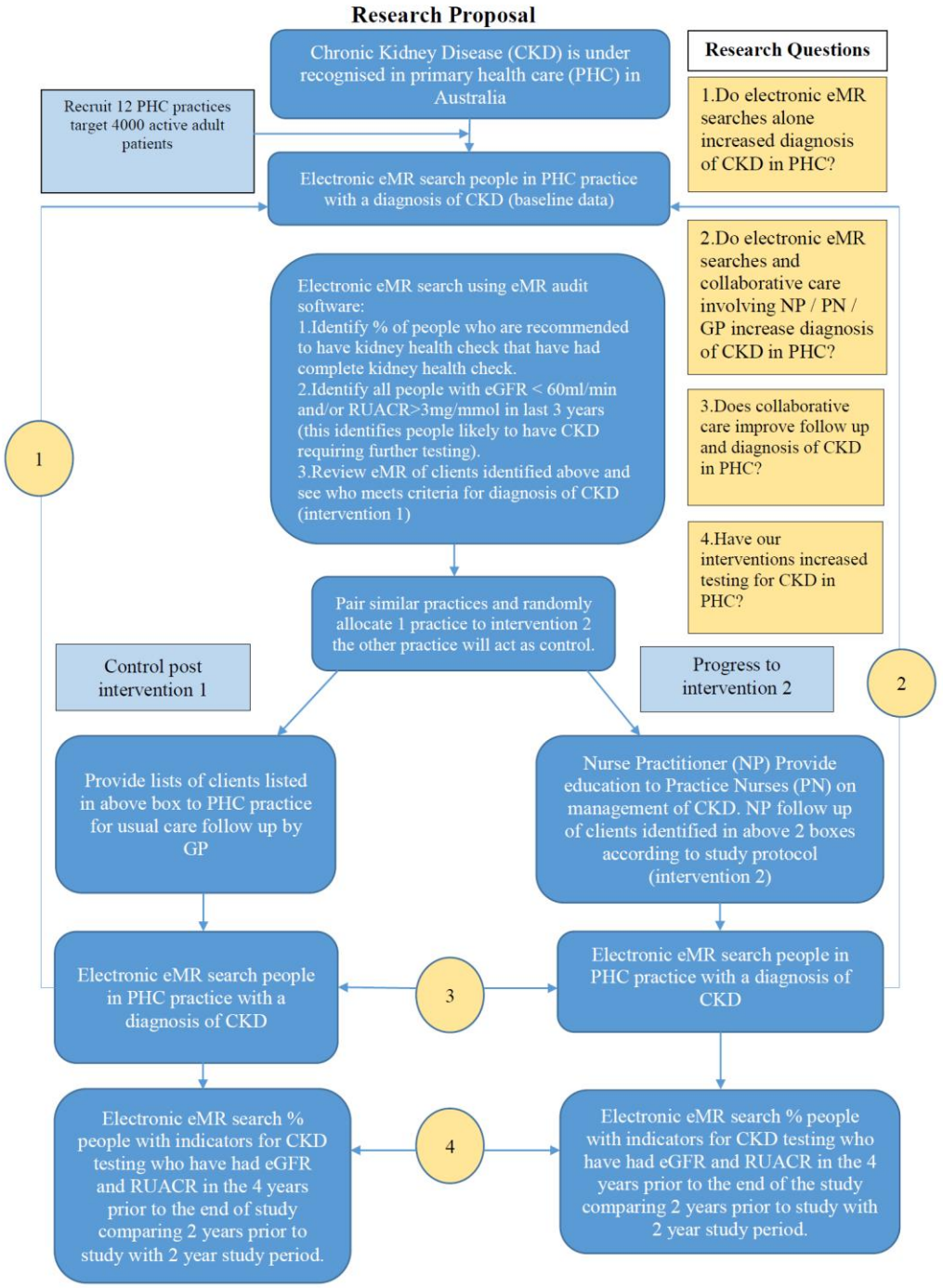
- I wanted to:
    a. Use electronic medical record (eMR)interrogation to identify people likely to have CKD in (PHC).
    b. Increase participation of primary health care staff (GP's and practice nurses) in identification and management of CKD through knowledge sharing and improved integration with LHD.

Bugalwena GP Pilot Project Results



What's Next?

- Research to demonstrate benefits / scalability and sustainability of our integrated care model for detection and management of CKD.
- We have designed a research proposal and built research team.
- We are in the process of looking for and applying for funding to complete the research.
- We have recruited 4 General Practices we are looking for a further 8 general practices to be involved in the research.
- In the spirit of integrated care we have people from NNSW LHD, North Coast PHN, Local General Practices, Consumer Representation and Southern Cross University involved in our research proposal.



RENAL SUPPORTIVE CARE

Patient potential choices are:

- Haemodialysis
  - In-Centre or
  - Home dialysis
- Peritoneal dialysis
  - Home
- Conservative care
  - Renal Supportive Care

Dialysis does not benefit every patient with CKD

The RSC model of care was developed in response to the needs of patients for whom dialysis is a burden not a benefit:

- To improve quality of life
- To improve clinical outcomes
- Manage symptom burden

- The Renal Supportive Care (RSC) service commenced in RCHSG in July 2015.
- We currently have 104 pts.
- A nurse-led model.
- Embedded within existing renal services.
- To be successful we need a good working relationship between RSC and primary health services.

The Renal Supportive Care service provides care and support to patients who choose conservative treatments for their renal disease.

The Renal Supportive Care service is made up of a Clinical Nurse Specialist, Social Worker and Dietician.

RSC provides:

- Pain and symptom monitoring and management
- Advocacy and referral to services as clients are often managed by multiple services
- Assessment
- Advance care planning
- Nutritional support and advice
- Home visits
- Ongoing support

Patient expectations:

- Basic renal failure progression
- Basic dialysis knowledge
- Symptom management knowledge for monitoring and managing
- Community services available to them
- Referral guidelines to palliative care services
- What they can eat to keep them as well and symptom free as possible
- That they are supported in whatever decision they make but can talk to you if they have questions

How do we **sustain** the RSC service?

- We need to continue to integrate with professional working relationships with other primary health care services.
- We have an opportunity to be involved in GP care plans through the Orion Shared Care Tool.
- The LHD have been supportive of developing this service and are looking at making these positions permanent.
- The service continues to evolve based on patient's needs.

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