New model of care to improve access to tertiary level management of chronic kidney disease in the Western Cape

Initiative Type

Model of Care

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Deliver

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Summary

The remote indigenous communities of the Western Cape in Far North Queensland have significant rates of chronic kidney disease (up to eight times that of the national average), with up to 76 per cent

of those with moderate to severe kidney disease currently not accessing tertiary level Nephrology services either in person or via Telehealth. A new model of care to address this need is to be implemented, utilising a Rural Generalist with advanced skills in Adult Internal Medicine and a Renal Nurse Practitioner to service patients with stage 3B Chronic Kidney Disease (CKD) and higher. The project has successfully navigated healthcare system challenges to deliver change, improvement and innovation in the health service and has presented at the Clinical Excellence Queensland Showcase 2019.

Key dates

Jun 2018

Implementation sites

Torres and Cape Hospital and Health Service

Partnerships

CheckUp, CHHHS

Key Contacts

Dr. Anthony Brown

2109

paul.blee.hiu

Executive Director Medical Services

Torres and Cape Hospital and Health Service

(07) 4030 6131

TCHHS-Medical-Services@health.qld.gov.au

Aim

A new model of care to improve access to tertiary level management of chronic kidney disease in the Western Cape.

Benefits

The primary outcome to be measured is the number of moderate to severe CKD patients accessing the service. Secondary outcomes are biomedical targets including reducing urine ACRs and blood pressure, improved patient and primary care staff knowledge of chronic kidney disease, and patient and primary care satisfaction with the model.

Background

Chronic disease, including Chronic Kidney Disease, is a major health burden in the Aboriginal and Torres Strait Islander (ATSI) population. Many ATSI people face difficulties attending specialist clinics secondary to concerns such as the distance required to travel for appointments and transportation, cultural and community expectations, and possible dislocated trust in the health care system. Limited engagement with the system can lead to delayed presentation with some patients historically having first contact with a renal service when they were at end stage renal disease.

Solutions Implemented

- This service will be delivered to stage 3b and higher CKD indigenous patients in the remote communities of the Western Cape and consist of an RG-IM and a Renal Nurse Practitioner review on a three-monthly basis via face-to-face and Telehealth. These reviews will also utilise Multidisciplinary Integrated Case Conferences (MICC) with allied health, the primary care team and a nephrologist, during which the patient will be holistically discussed, their needs addressed, and barriers to meeting health outcomes mitigated.
- In addition, formal education sessions will be provided on management of CKD and informal translation of knowledge will be facilitated by involvement of Aboriginal Health Workers and primary care staff in patient consultations and MICCs.
- The role of the Aboriginal Health Worker as case worker will be emphasised in this integrated model, as a means of optimising two-way levels of engagement between the patient and primary care environment.

Evaluation and Results

- To assess how this model has impacted on adherence to best practice management of CKD, a pre-post intervention analysis will be conducted.
- Knowledge of health and CKD and factors affecting engagement will be assessed using semi-structured interviews.

Lessons Learnt

There are added complexities of designing and implementing such a project in the remote low resource context. Recruiting the skilled staff, coordinating the outreach and conducting community consultation have been complex.

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