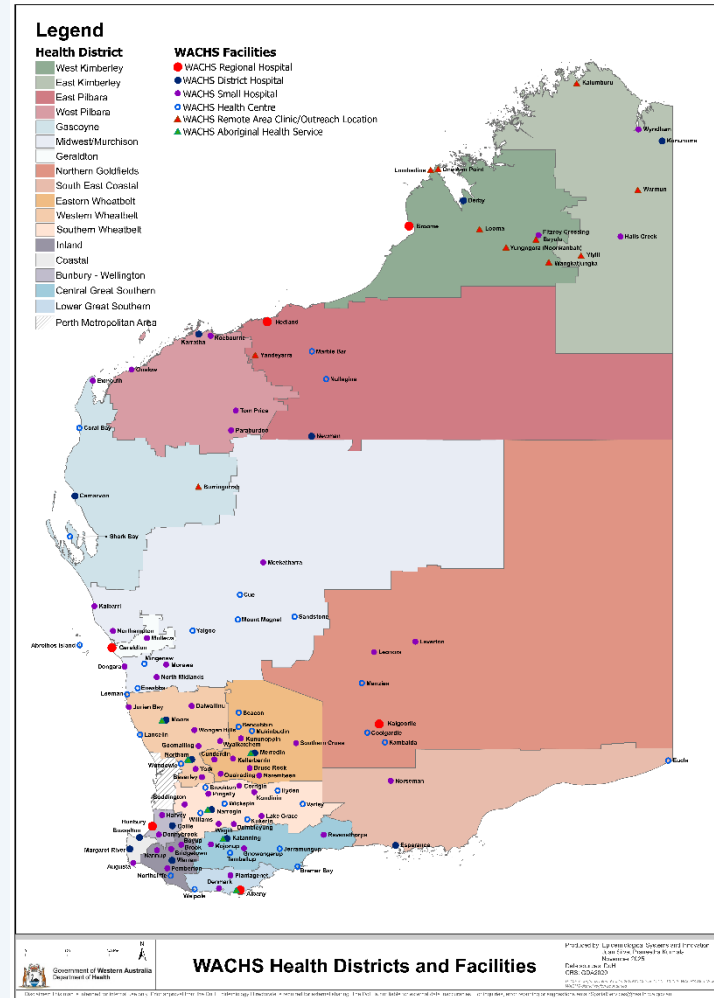
The background of the slide is a vibrant Aboriginal artwork. It features a variety of patterns and colors, including a blue whale swimming in the upper left, a yellow and green floral pattern in the center, and a purple and white pattern with circular motifs on the right. The artwork is composed of many small dots and lines, creating a rich, textured effect.

WA Country Health Service's First Specialist Chronic Kidney Disease (CKD) Nurse Practitioner Service: A New Model of Care for Remote Communities

Sonia Mupotaringa NP
Helena Lane ALO

Acknowledgement of Country

“We acknowledge the Traditional Custodians of the land on which we gather today, the Whadjuk Noongar people, and pay our respects to the Elders past and present. As a healthcare community, we recognise the deep and continuing connection Aboriginal and Torres Strait Islander people have to land, waters, culture and wellbeing, and we acknowledge the important role this connection plays in health. We extend our respect to all Aboriginal and Torres Strait Islander people here today”.



Contents

- Background of CKD
- Framework
- Renal services structure – West Pilbara
- Nephrology Nurse Practitioner Model of Care

Background

- 3 in 4 Australians with risk factors for Chronic Kidney Disease
- 1 in 7 adults have indicators of CKD
- 1 in 6 hospitalisations related to kidney disease
- Need for Renal Replacement Therapy has doubled

- Increased cardiovascular disease risk
- Reduced quality of life
- Reduced life expectancy
- Social, emotional impact
- High financial cost burden

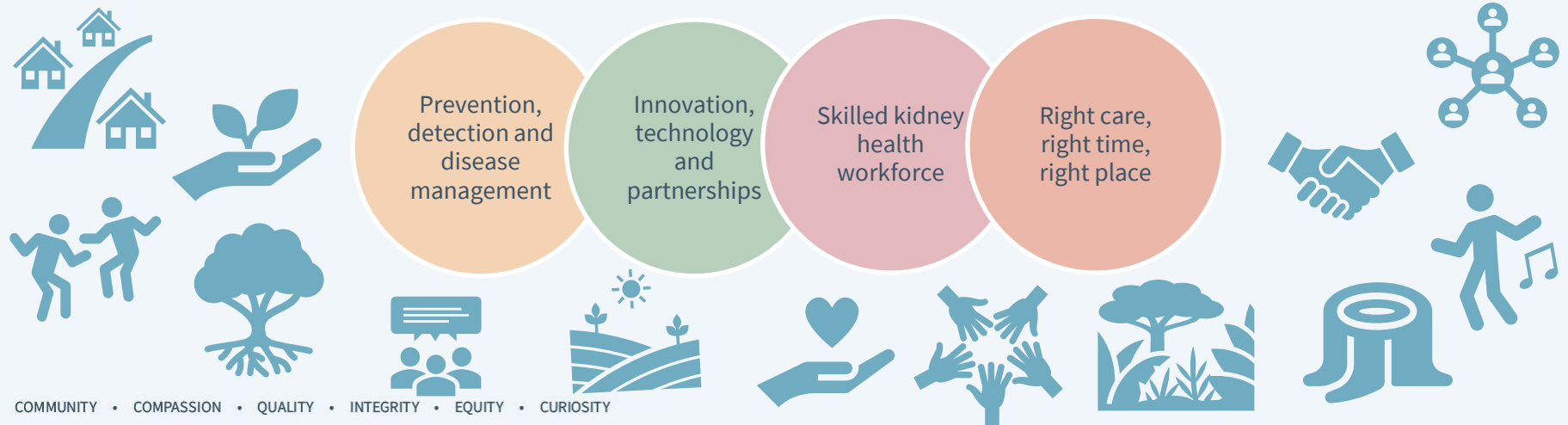
- Limited CKD infrastructure
- Limited specialist care
- Geographical remoteness
- Limited GP resources

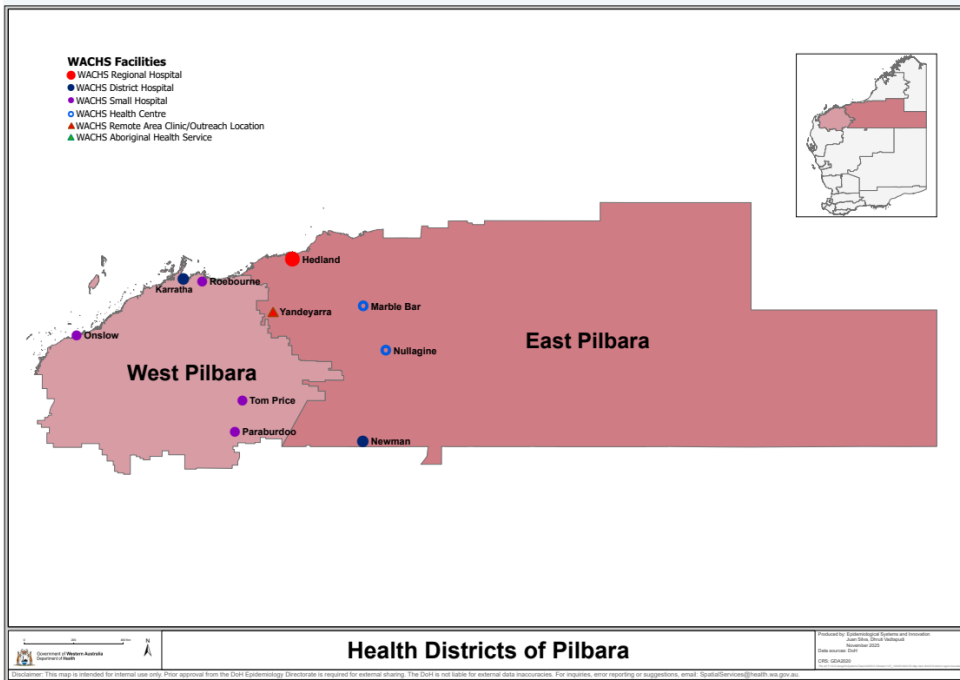
Chronic Kidney Disease impact for Indigenous Australians

- 2x more likely to have CKD
- 5x more likely to be hospitalised
- 6x likely to receive dialysis
- 8x greater burden of disease

Mission:

Reduce the impact of kidney disease through excellent, culturally secure kidney health care closer to home and on Country.

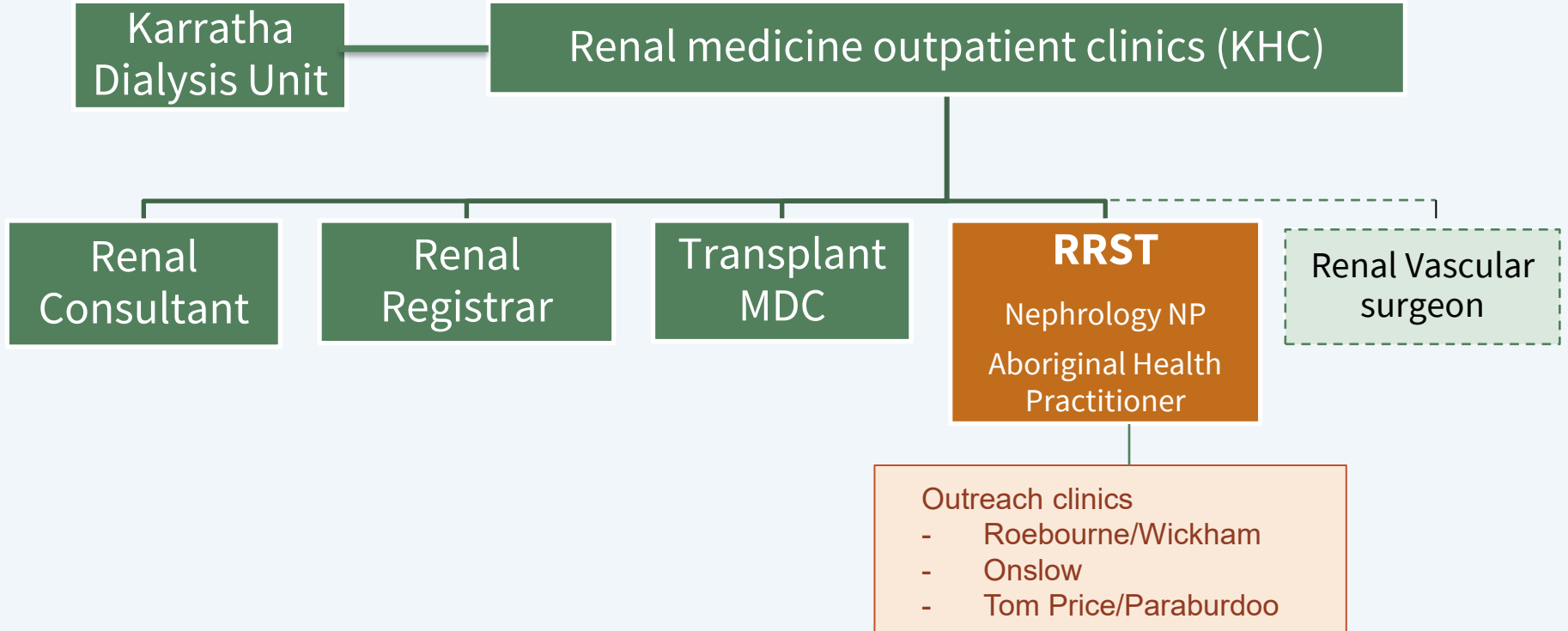




Pilbara region

	Australia	WA	Pilbara
Indigenous population (%)	3.2	3.3	14.8 (East Pilbara 17.9) (West Pilbara 11.4)
CKD (%)	14.2	6	-
Indigenous CKD compared to non-Indigenous (%)	18	12.2	-
Hospitalisations related to CKD (%)	18	-	-

Renal services structure – West Pilbara



Nephrology Nurse Practitioner model of care

Aim: To improve health outcomes for all adult patients with or at risk of CKD/ ESKD by delivering culturally safe and secure care on Country.

Referral criteria:

- All adults with CKD (Stage 3/4/5)
- At risk of rapid deterioration in renal function
- Individuals on Renal Replacement Therapies
- Renal transplant recipients

Excluded: 0-16 yrs, pregnancy and CKD, AKI, complex cases

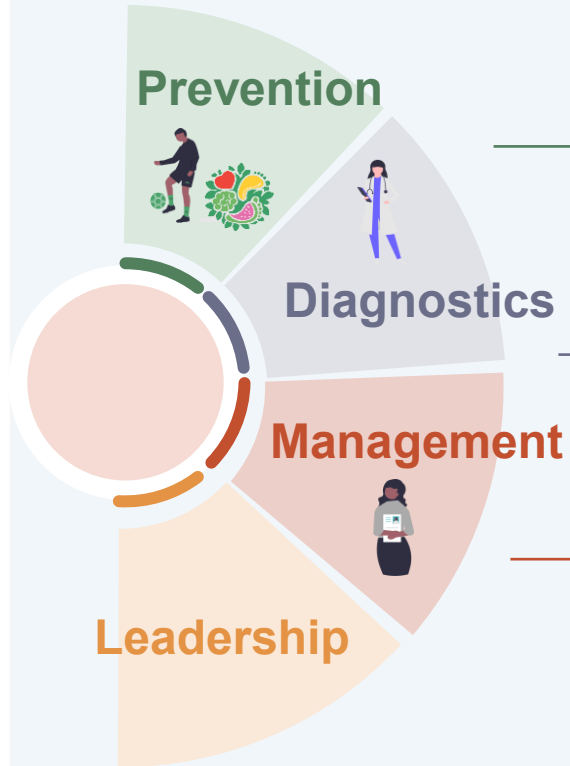
Team members:

- Nephrologist (Medical oversight)
- Nephrology NP
- Aboriginal Health Practitioner/
Aboriginal Liaison Officer

Referral pathway:

- General practitioners, primary care and allied health providers, chronic disease coordinators
- eReferrals via emergency department, inpatient services, tertiary hospital
- External – fax, email via Central Referral Service

Nephrology Nurse Practitioner – service activities



1

Prevention

Improving CKD awareness in the community
At-risk population screening
Partnering with stakeholders, consumers

2

Diagnostics

Patient assessment
Order investigations, analyze results
Communicate diagnosis

3

Management

CKD clinics, outreach clinics
Medication prescription
Vascular access / transplant preparation, transition

4

Leadership

Upskilling staff
CKD stewardship
Interagency linkages, collaboration

Role of Nephrology Nurse Practitioner – Health promotion

Aboriginal Medical
Service collaboration



CKD community
meetings/
education



Pilot screening for
CKD in prisons



Prevention,
detection
and disease
management

Role of Nephrology Nurse Practitioner

– Chronic Kidney Disease clinics

Clinics: Karratha Health Campus + outreach (Roebourne, Onslow, Tom Price, Paraburdoo)

Collaboration with AMS, chronic disease allied health care providers

- Assessment, diagnosis, medication management
- Pre-dialysis education, Vascular access planning , suitability for home therapies
- Transplant education and work up preparation
- Assessment /monitoring/ follow up of disease progression
- MDT meetings, collaborative care
- Referral to nephrologist, vascular surgeon
- Renal supportive care

**Prevention,
detection
and disease
management**

**Right care,
right time,
right place**

Role of Nephrology Nurse Practitioner

- kidney transplant recipients and home-based therapies

- Regional support and clinical oversight of clients undergoing home-based therapies (home haemodialysis)
 - Education, work up and preparation for kidney transplant
 - Care co-ordination
-
- Transplant transition – post transplant patient education / follow up
 - Care and support on return to region
 - Medication reviews and adjustment of immunosuppression regimens in liaison with nephrologist / renal pharmacist
 - Ensure regular complications screening and appropriate referrals for management

Prevention,
detection
and disease
management

Right care,
right time,
right place

Nephrology Nurse Practitioner- Clinic schedule

Local/ AMS	Bi-monthly outreach clinics*
Karratha Health campus outpatients – 1 day/week	Onslow – 2 days
Roebourne AMS – 1 day / month	Tom Price, Paraburdoo – 3 days

*Outreach clinics – including travel and community visits

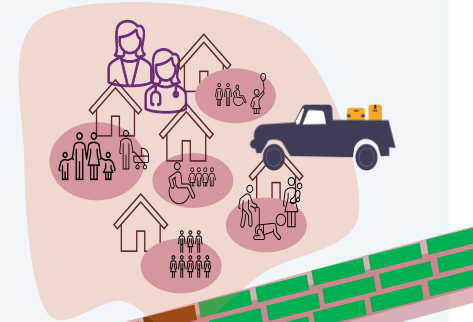
Nephrology Nurse Practitioner - patient contact modes



Telephone
Telehealth appointment



Clinic appointment -
Karratha Health Campus



Outreach clinics

Role of Nephrology Nurse Practitioner - advocacy and leadership

- **Partnerships:** with tertiary hospital Renal team, Regional Renal team, Fresenius Kidney Care, chronic conditions coordinators, AMS, intergovernmental agency linkages
- **Leadership:** participate in relevant committees, promoting CKD awareness / screening
- **Education:** upskilling / mentoring- primary health care staff, WACHS staff
- **Consultancy:** provide advice and consultancy to Executive Committee in relation to renal nursing / service delivery
- **Quality improvement:** participate in audits / peer reviews and case reviews, undertake quality improvement projects, update, create new policies / procedures, program evaluation
- **Administration:** Record and report on KPIs/ ABF

Innovation,
technology
and
partnerships

Right care,
right time,
right place

Skilled
kidney
health
workforce

Outcomes

LEVELS

OUTCOMES

Individual



Short term

- Standardised data entry and recording systems
- Increased access to specialised kidney care on Country

Community



Medium term

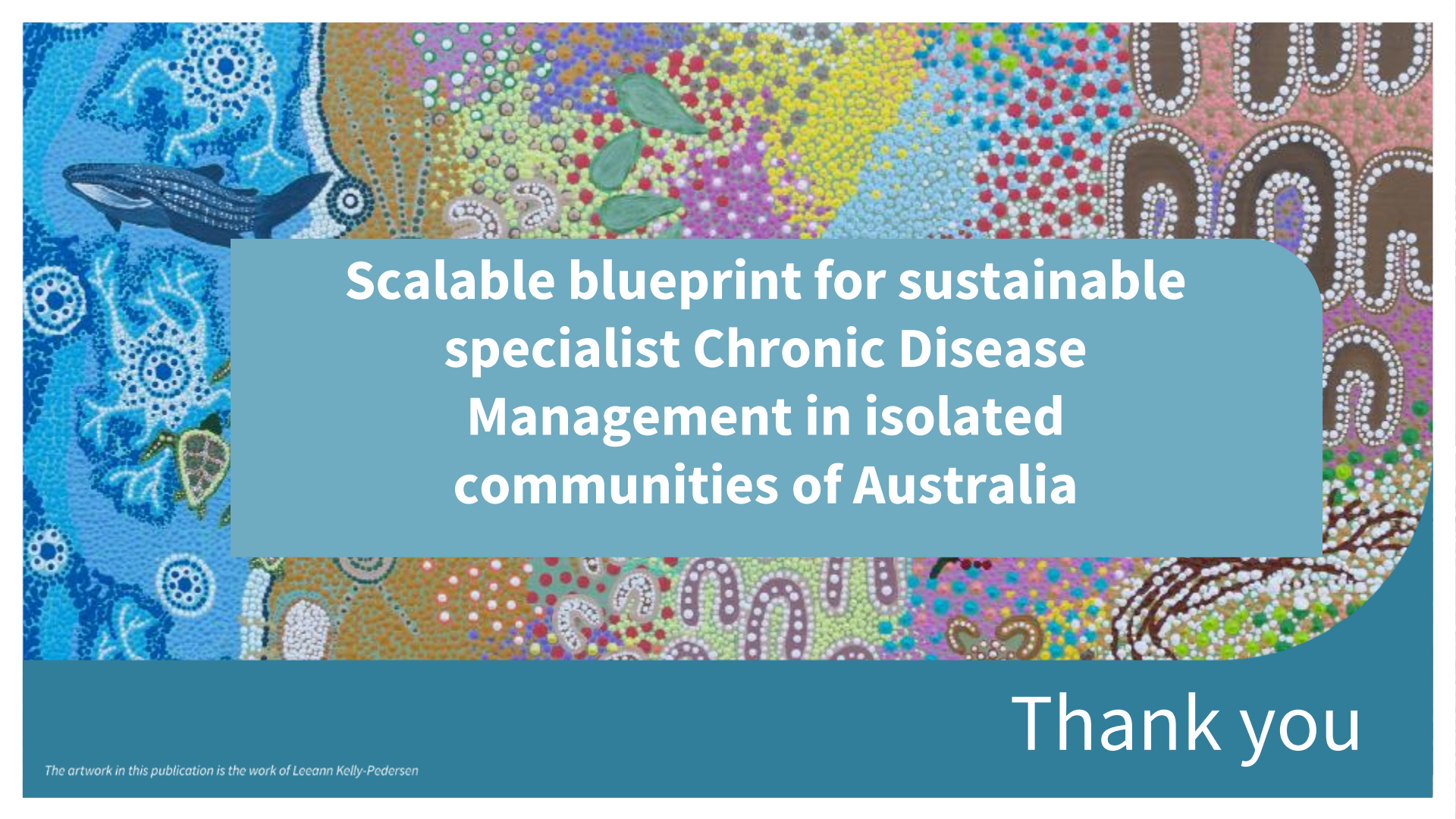
- Increased number of patients receiving optimal medication to delay/ prevent CKD
- Improved understanding of CKD, RRT options
- Improved clinical indicators – eGFR levels, UACR, HbA1c, BP
- Early modality planning for patients requiring RRT
- Early vascular access planning
- Increased transplant work ups, listings
- Improved community understanding and awareness

Service



Long term

- Reduction in CKD progression
- Reduction in hospitalisations
- Increase in home-based dialysis therapies, renal transplants
- Self-sustainability of NNP position



**Scalable blueprint for sustainable
specialist Chronic Disease
Management in isolated
communities of Australia**

Thank you