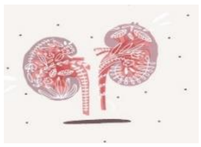


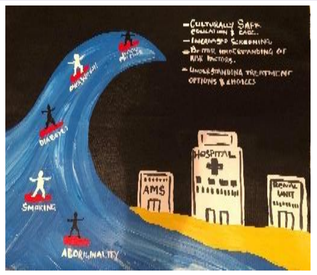
Mid North Coast Health Kidney Collaborative

(Primary health Network, Local Health District, Aboriginal Medical Services)

NSW GOVERNMENT | AGENCY FOR CLINICAL INNOVATION

Solutions Rreport Date: 9/12/19

❶ Goal and Objective



Goal: *By June 2021, improve renal primary health care for Aboriginal people in the Mid North Coast Local Health District to reduce the progression to end stage kidney disease and prevent the forecasted renal disease and dialysis tsunami.*

Objectives

1. By July 2020, there will be a 50% increase in community awareness of chronic kidney disease and associated risk factors that cause the disease.
2. By December 2020, there will be a minimum 8% increase in Chronic Kidney Diseases screening conducted in Aboriginal Medical Services located within the Mid North Coast Local Health District.
3. By July 2021, there will be a 30% increase in the number of Aboriginal people with early stage kidney disease receiving culturally relevant multi disciplinary care.

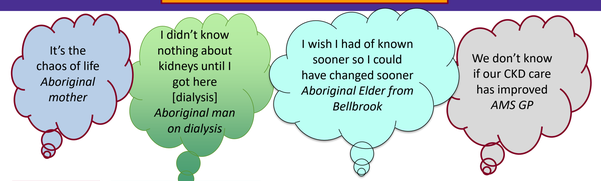
Renal Tsunami: painted by Jason Ridgeway {Dhunghuitti Artist and carer of dialysis patient}

Planned Dates

	Initiation	Diagnostics	Solutions	Implementation Planning	Evaluation
	x 27/8/19-20/9/19	21/10/19 – 5/11/19	6/11/19 – 4/12/19	5/12/19 – 1.2.2020	01.06.2020 – 01.12.2020
Actual Dates		X 29/8/19 – 4/11/19	x **21/10/19- 13/1/20**	x 7/1/20 – 1/3/20	x March 2020 ongoing

❷ Vision

Current state

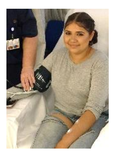


1.Birth and life → 2. Primary Health care → 3. Early detection → 4. Secondary Management

1. Intergenerational trauma, social determinants of health, high risk factors, low awareness of Chronic Kidney Disease (CKD) and risks (community interviews and health stats data)
2. CKD has low profile, screening not routinely performed in primary health (1 AMS in region had worst CKD screening rates in the state)
3. Late referrals and missed opportunity to prevent disease progression (Nephrologist interview)
4. Lack of integration between primary and tertiary health care and minimal patients receiving mutli-disciplinary care (District Manager Renal Services)

Future state

Up-skilled Aboriginal Health workers



Community champions supported by Kidney Health Australia

1.Birth and life → 2. Primary Health care → 3. Early detection → 4. Secondary Management

1. Renal health has a high profile and screening is routine for clients with risk factors and comorbidities. Led by Aboriginal Health Workers and Nurses.
2. Community empowered and aware of CKD and lifestyle risk factors and comorbidities
3. Earlier detection and improved management will delay disease progression to end stage kidney disease (Tiwi Project Results – 50% reduced progression)
4. Primary and tertiary care integrated offering a seamless pathway including shared care and multidisciplinary team care.

❸ Key Solutions

Issue / Focus Area	Root causes	Solution	Ability to Influence	Impact	Priority	Output / Measure
Community members have limited understanding of kidney disease and the causes of kidney disease within the Aboriginal community	Renal health has a low profile in the community. There is limited specific kidney health information and health promotion.	A tailored co-design marketing and health promotion campaign to reinforce and educate the community about kidney health.	Medium	High	High	Increased knowledge of kidney disease to 50% of patient survey
Aboriginal people over 30 years are risk of developing chronic kidney disease and screening rates are low	There is no routine screening process for full kidney health screens (i.e. albumin to creatinine ratio not collected with estimated glomerular filtration rate)	Up skill Aboriginal Health Workers to assist GP's to increase rates of Chronic Kidney Disease screening	Medium	High	High	Increase in CKD screens by at least 8%
	Poor understanding of co-morbidities and risk factors increasing risk	Through collaboration with LHD clinicians with specialist renal knowledge upskill Aboriginal Health Workers(AHW) knowledge and confidence to provide education about kidney health to clients.	Medium	High	Medium	Clients have improved knowledge and understanding
Gaps in management and secondary prevention	Low screening rates resulting in late diagnosis of CKD	Integrate LHD and AMS services to create a person centered, culturally safe holistic service stream for those living with chronic disease. Lifestyle changes	Medium	Medium	Medium	Increase the number of people with early stage kidney disease receiving multi disciplinary care by 20%
	Poor management of chronic conditions in primary health					

Team (names – roles)	Sponsor (approval)
Ro Stirling-Kelly, Erin Underhill and Paul Fernon	Teresa Howarth

❹ Quick Wins

- Establishment of the 'Kidney Tribe' in Kempsey. This is part of the Tribal Wave Assembly - an initiative of NSW Government providing a process for Aboriginal community based regional decision making. Short process, quick to establish fifteen members to date, grass roots group providing accountability and consumer engagement. Recommendations and Actions from group measurable during project implementation as number of Tribe members participating in/leading co designed initiatives.
- Partnership established with Kidney Health Australia's youth program. The youth program develops confidence and life skills to motivate and enable those living with chronic illness such as CKD to follow several pathways including community engagement, and education. This program is nationwide, cost free and well established. This program will provide our young change champion with the skills required to co design an education campaign to roll out across the region. By including a young Aboriginal person with lived experienced developing resources in partnership with High School students. Level of knowledge can be measured against data from initial Focus Group.
- Training from The Flinders Close the Gap. Training and resources provide an evidence based model of care for chronic disease management where the patient, family and Clinicians develop a Care Plan with the patient at the centre of the care. The Clinical Nurse Consultant Aboriginal Chronic Care is trained in the Flinders Model and will provide training to Aboriginal Health Workers, upskilling AHW's and strengthening organisational partnerships. Monitor numbers of AHW's trained and develop post training evaluation. Ongoing support from CNC.

❺ Testing

- The community education workshop has been to be piloted at the Many Rivers Mapu Marrung Sista Girls Group with the establishment of the "Kidney Tribe" in Kempsey.
- The Flinders Chronic Disease tool will be in tested in one Aboriginal Medication Service and adapted if required, prior to further roll out
- Social marketing / health promotion resources will be tested with an established Kempsey Elders group and adapted if required prior to further roll out.

❻ Balance Measures

- Improving community's knowledge of renal disease may increase the demand on primary health in areas with limited GP's. This can be measured by wait time for appointments
- This redesign of existing MNCLHD services may result in other services having reduced clinicians. This can be measured by wait time for other Local Health District existing clinic's.
- Increased screening and management in the short term could increase diagnosis of End Stage Kidney and demand for dialysis. The can be measures by Aboriginal dialysis statistics with are already maintained by Renal Services.

7 Solutions Activities

Activity	Stakeholders engaged	Comments / Results
Solutions workshop including Aboriginal Medical Service and Local Health District staff	Aboriginal Health Workers, Clinical Nurse Consultant, Aboriginal Liaison officer, Sponsor, project team Nurses, Pharmacist Staff involved n= 16	Completed brainstorming and blitz activities Solutions were then voted on to establish top 5. Integrated clinics and social marketing were the top recommendations.
Solution Workshop at Kempsey District Hospital	Aboriginal Health Workers. Aboriginal Liaison Officer, 48 hour follow up nurse, project team members Staff involved n= 12	Research and collaborative yarning conducted, informal brainstorming. To refine the solution the "EAST" framework was applied. Literature review and bench marking was used to validate the solutions
Consultations with Kempsey High School completed	Aboriginal Education officers , High school students, project team members Staff involved n= 16	Solutions were documented, "yarning" style conversations were had and then the solutions were tallied to determine the most preferred. Health education was recommended as the top solutions for addressing the root causes.
Literature review	Redesign team members Data base used: n= 3 Articles reviewed n= 28	Solutions identified in the literature suitability in this project. Strong evidence in the literature for nurse and Aboriginal Health lead clinics.
Bench marking	Reviewed 2 program and consulted staff involved in delivery	Reviewing initiatives – Danilba Dilba (renal case management) and Northern New South Wales Primary Health Network (Aboriginal Health Worker and Nurse led clinics. These initiatives involving nurses and Aboriginal Health Workers had improved screening and disease progression.
Clinician interviews	Redesign team members and various clinicians n= 13	The 3 key solutions were tested with various clinicians from the Local Health District and Aboriginal Medical Services. General support for solutions.

❽ Variance to Scope

Project goal and objectives have been refined due to feedback from re-design lead and from ACI review during diagnostics phase. Specific objectives and solutions about intergenerational trauma have been removed from the project. Project team worked closely with project sponsor when changing scope of project.