The Power of Innovation

A health care system to meet our needs

NSW Health Symposium Oct 2012

RENEW – IMPROVING PRIMARY HEALTH CARE EXPERIENCE FOR RENAL PATIENTS FOR DIALYSIS

Category 4: Improving Primary health Care in the Community

Introduction

End Stage Renal Failure has been highlighted as an increasing public health problem in Australia. In 2011 there were approximately 480 patients in South Western Sydney Local Health District (SWSLHD) (Diagram 1) on dialysis. Only 43% of the SWSLHD dialysis population utilise a home based therapy despite proven physical and social benefits.

Aim

To improve the journey of patients with Chronic Kidney Disease from the point of referral achieving one of the key objectives increasing the uptake of home therapies to 50%.

Method

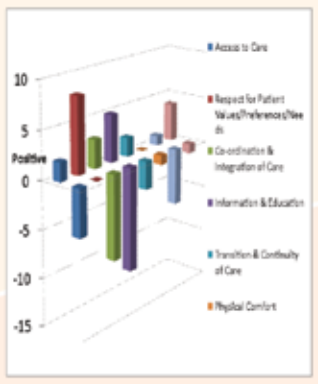
•The project was undertaken in line with the Redesign Methodology involving clear project phases and project governance.

•Commenced with Initiation phase and the development of a Project Management Plan.

•Diagnostic Phase activities included: Staff interviews (Diagram 3), focus groups, Patient and Carer Interviews (Diagram 2), data and process analysis, and observations.

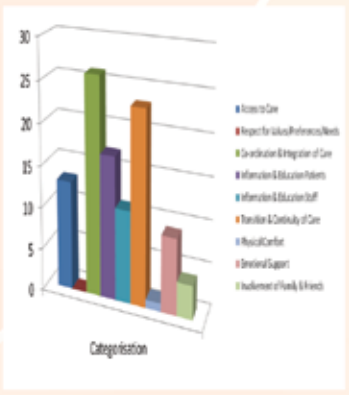
•Solution Design Phase engaged staff and consumers to identify solutions to address identified issues.

•Implementation Phase involved 19 identified solutions.



The Patient Journey- Patient/carer Perspective Diagram 2

The Patient Journey – Staff Perspective Diagram 3.



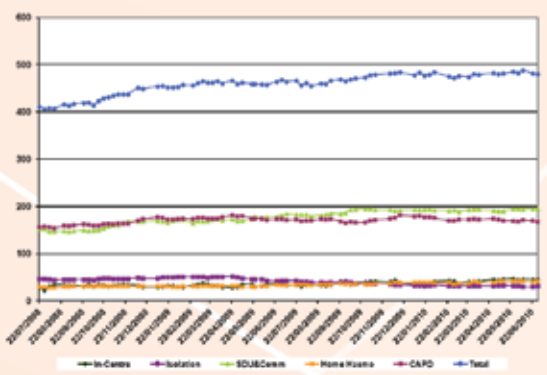


Diagram 1 -SWSLHD Dialysis Trends 2008-2010

Results

•From 19% to 26% increase in pre-dialysis patients planned for home therapy.

•Better self-management and empowerment via earlier education

•Improved surveillance of patients on community dialysis averting acute deterioration

•Reduction in pre-dialysis patients waiting education from 49% to 38%

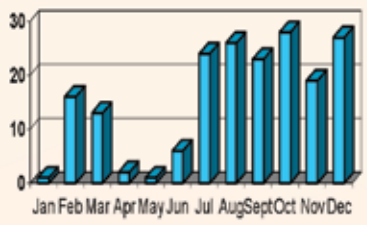
•Staff described the Renal eMR as 'easy to use' and 'have access to current dialysis information'

•Immediate positive impact on communication and patient safety

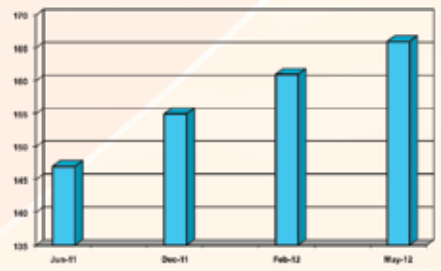
•13% increase in Home Peritoneal Dialysis since July 2011, saving $262,500 (Diagram 5)

•Increased home visits (Diagram 4), saving out of pocket expenses and travel time to hospital clinic attendance

•Ten troubleshooting home haemodialysis visits preventing hospitalisation, saving $18,000



Home Patient Visits 2011 – Diagram 4



Number of Patients on Peritoneal Dialysis in SWSLHD – Diagram 5

Conclusion

It has been demonstrated that this model of care, can, by bridging the knowledge/ practice gap, be replicated by other renal service providers to produce sustainable improved clinical and financial outcomes, improved quality of care, patient safety and efficiency. The success of this programme is attributable to the dedicated clinical and governing leadership, the support of the SWSLHD and the provision of realistic clinical support via redesign of the current service (Diagram 6).

Solutions Cycle- Diagram 6

Acknowledgements

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