Improving Chronic Kidney Disease (CKD) outcomes in an Aboriginal Population

Initiative Type

Model of Care

Status

Deliver

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Summary

The Darling Downs Hospital and Health Service (DDHHS) renal service implemented a change management program in June 2014, with the goal of improving patient engagement, and therefore

health outcomes, specifically for the people of Cherbourg. This project was developed and driven by skills learnt during the Manage 4 Improvement program: a six-month integrated leadership and management program designed to build the confidence and capabilities of clinicians to support improvements in health service delivery.

Key dates

Jan 2014

Jan 2019

Implementation sites

Darling Downs Hospital and Health Service

Partnerships

Cherbourg Hospital, CRAICCHS Ltd, DDHHS

Key Contacts

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Aim

Improve CKD outcomes in an Aboriginal population in a regional and remote area of Queensland.

Benefits

Earlier patient review with an emphasis on timely education and preparation for renal replacement therapy.

Background

Chronic disease, including Chronic Kidney Disease (CKD), 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 Darling Downs Hospital and Health Service (DDHHS) patients historically having first contact with a renal service when they were at end stage renal disease. Late presentations are associated with the need for acute clinical management, including catheter access for dialysis, and are a negative influence on patient outcomes.

Solutions Implemented

- Referral guidelines were revised to accept patients with early stages of CKD.
- A telehealth program was initiated, with community engagement.
- The Kingaroy CKD nurse practitioner (NP) provided local oversite and care.
- Specialist reviews were organised via telehealth at Cherbourg.
- Multi-disciplinary care support with onsite dietician, diabetic educator and podiatrist was provided.
- Local Aboriginal health workers were employed for support and advocacy.

Evaluation and Results

- 55 patients were seen so far from the Cherbourg area.
- ATSI patients were much younger (56.4 vs 64.5 years) compared to non-ATSI groups. 26 were female (54 per cent)
- The leading diagnosis was Diabetic Nephropathy (69 per cent), noting that 89.5 per cent had a co-morbidity of diabetes.
- About 83 per cent of patients were overweight with 62.5 per cent categorised as obese.
- Of those with advanced stages of CKD, renal replacement therapy (RRT) was discussed with 10 patients and their families, with 3 choosing a renal supportive care pathway and 7 RRT, inclusive of elective access creation. All patients receive dialysis at Kingaroy renal unit without the need to travel to Toowoomba
- All patients (100 per cent) received multi-disciplinary care and at the time of reporting, there have been no emergency admissions for RRT.

Lessons Learnt

A multidisciplinary team approach with provision of specialist care locally would improve health outcomes for aboriginal population.

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