

# INTEGRATED CHRONIC DISEASE NURSE PRACTITIONER MOC

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CASSANDRA STONE – NEPHROLOGY NP

# NURSE PRACTITIONERS

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- Maureen Barnes – Heart Failure NP
- Jennifer Abel – Diabetes NP
- Daniel Dobbyn – NPN Chronic Disease
- Cassandra Stone – Nephrology NP

# BACKGROUND:

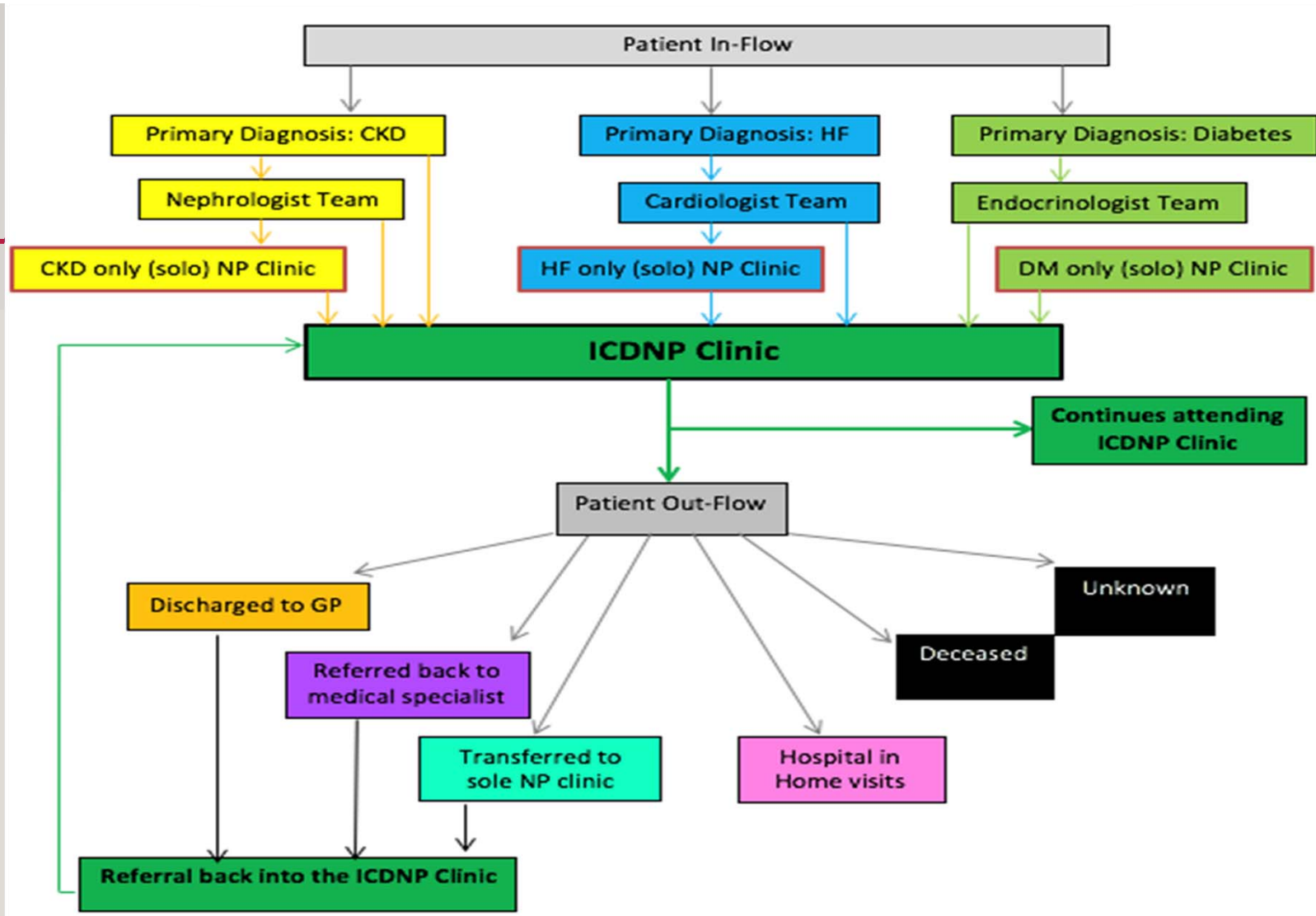
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- Health services traditionally have been organised around each condition (silos) – neither resource efficient nor convenient or effective for patients
- Chronic diseases account for an estimated 43% of overall global burden of disease
- Chronic diseases rarely occur in isolation and >60% aged 65 years and over have 2 or more chronic diseases
- The Integrated Chronic Disease Nurse Practitioner (ICDNP) clinic commenced in 2014 to look at a new MOC that integrates the care of patients with multi-morbidity (renal, diabetes and heart failure)

# BACKGROUND:

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- NPs assume primary care responsibility for this cohort of patients and adopt a team-based approach to coordinate treatment
- The clinic is conducted one day per week - although as NPs are employed full time some patients are being seen in any clinics run by the primary NP
- The MOC is designed to increase patient skills and self-efficacy in managing chronic diseases
- The MOC was evaluated through research conducted by QUT – lead: Professor Ann Bonner



# OPPORTUNITIES/BARRIERS ENCOUNTERED:

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- Have widened individual NP scope of practice
  - Have mentored and trained new NPs in chronic disease role
  - Community Health services have been very accommodating for our clinic
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- Need to consider direct referrals
  - No central area within the hospital where NPs could run a coordinated clinic within the Hospital
  - OPD rooms within the hospital extremely difficult to get although still seeing patients who would otherwise need to be seen in medical clinic or be admitted
  - Need to run 5 days a week with AO support and succession planning