Supporting nurses in primary health care

14 February 2014

Daniel Comerford
Director - Acute Care
NSW Agency for Clinical Innovation

By email: rebecca.donovan@aci.health.nsw.gov.au

Dear Mr Comerford,

NSW Diabetes Model of Care and Standards for High Risk Foot Services in NSW

In response to your invitation, the Australian Primary Health Care Nurses Association (APNA) is pleased to provide the attached response to the review of the *NSW Diabetes Model of Care for People with Diabetes Mellitus* and the *Standards for High Risk Foot Services in NSW*.

APNA is the peak professional body for nurses working in primary health care including general practice. With nearly 4000 members, APNA provides primary health care nurses with a voice, access to quality continuing professional development, educational resources, support and networking opportunities.

We are providing this written submission to ensure that the views of primary health care nurses are considered in the review.

Nursing in general practice is one of the fastest growing nursing specialties. There are now more than 11,000 practice nurses employed in approximately 65 per cent of general practices in Australia[1]. Nurses play a vital role in chronic disease care and management. Employing a nurse enables many general practices to increase their service capabilities and patient access to care.

In many general practices, the nurse coordinates preventative and chronic disease programs. Nurses access practice patient information using data mining tools and disease registers to identify patients for preventative health screening as well as patient at risk of poor health outcomes such as those with diabetes.

As well as identifying patients and calling them in for assessment, general practice nurses perform a significant amount of the physical measurements including foot checks and updating

[1] 2012. "2012 General Practice Nurse National Survey Report". Australian Medicare Local Alliance. Available from: http://amlalliance.com.au/__data/assets/pdf_file/0003/46731/2012-General-Practice-Nurse-National-Survey-Report.pdf#National GPN Survey report [Accessed 20 March 2013].

histories. Nurses in general practice also collate information about a patient's medication management, and perform needs assessments to review lifestyle issues such as diet and level of exercise to help identify gaps in patient knowledge and ability to self-care. These activities contribute significantly to the annual cycle of diabetes care for the individual patient but also aid the general practice to meet targets for additional government funding initiatives, such as the Practice Incentives Program (PIP).

Nurses in general practice will often be the first point of patient contact for teaching blood glucose self-monitoring, and diet and lifestyle education. Nurses can identify key areas of need and will make recommendations for care and in collaboration with a GP, arrange care planning and referrals such as those to a diabetes educator, dietician, podiatrist and pharmacist for a Home Medicines Review. In many practices it is the nurse that collates this information for a GP so the time a doctor spends with the patient can focus on medical needs and treatments.

Nurses help with chronic disease management (CDM) of patients with multiple comorbidities, make appointments for patients and follow-up referrals to allied health professionals and clinics as well as provide support and telephone triage.

APNA and primary health care nurses are well aware of the problems associated with negotiating the referral pathways and locating services and service providers to help meet the care needs for their patients. APNA welcomes the ACI Endocrine Network's NSW Model of Care for People with Diabetes Mellitus and the opportunity to comment on the paper and in particular, share the concern regarding the rapid rise in the rate of persons with Diabetes Mellitus Type 2.

In addition to the information above regarding the role of nurses in managing diabetes care, please find the comments below relating to the paper:

- Pg 24/71: dot point 7 – add MBS item 10997 – patients with care plans can have five visits with a general practice nurse to supply support for their CDM care.

- Pg 27/71: Best Practice – GP education – include general practice nurses as they will often be the first point of contact, especially when taking urgent phone calls from patients and they also need to be in the education loop for symptoms awareness and channelling patients to tertiary care.

- Pg 27/71: Best Practice Type 1 – dot point 6 could link the issue of lack of familiarity with insulin pumps to discharge issues and education for GPs and general practice nurses.

- Pg 27/71: Paediatric service – there needs to be some discussion about diabetes services, parents and patients building strong relationships with the patient's GP and the information flow to the GP. This is especially important for issues such health maintenance, also children get childhood illness that requires GP care, need flu vaccines and facilitate handover once 18 year olds graduate from paediatrics care.

- Pg 34/71: Priorities for Implementation – point 5 – it may be worth mentioning that some NSW Local Health District and Medicare Local partnerships are developing

Health Pathways for GP referrals to tertiary hospital clinics. Many of these Health Pathways have either been published or are in progress and due to be published in the near future. These will be a valuable resource for GP and other primary health care providers.

- Pg 37/71: Centre column – increased utilisation of CDM care plan (enhanced primary care (EPC) is no longer used in the Medicare item descriptors, now referred to as CDM). Also add set-up of a recall system to facilitate planned CDM review visits. Next column, it may be worth noting that many Medicare Locals have diabetes care strategies and assistance for general practice.

- Pg 39/71: Systematic evidence-based management – add MBS item 10997 – five visits to a general practice nurse or Aboriginal health worker. It is also worth mentioning that Aboriginal and Torres Strait Islander patients who have had an eligible health assessment can have 10 health support visits to a practice nurse or Aboriginal health worker (AHW). As well, CDM patients are also eligible for care planning 721, 723 and where needed the five times 10997 practice nurse/AHW CDM support visits.

- Aboriginal and Torres Strait Islander patients and patients over 75 years are eligible for health assessment and this can be coordinated /alternated six monthly with the diabetes cycle of care to provide good coverage of preventative care and monitoring coinciding with six monthly HbA1c testing.

- Pg 40/71: Maximally effective specialist service – practice nurse telehealth MBS item number exist to aide with telehealth consultations. These are coordinated via general practice, often from the patient's home. Also consider in the last dot point that info and resource directories are currently being set up by Medicare Locals, Health Pathway projects and links to New South Wales health information can be sent via professional networks/associations.

- Pg 44/71: Same as pg 39 above.

- Appendix 3 NGO: the Australian Diabetes Council Type 2 program is a great program. ACI might want to consider how this can be funded and replicated in Local Health Districts, Medicare Locals and/or local government areas.

- Another early intervention program is the ComDiab that can be provided locally via Medicare Local and the Australian Diabetes Council.

In relation to terminology, 'GP' is frequently used when, in many cases, the diabetes care is managed by the general practice team and the terminology could be changed to 'general practice'.

The document for *Standards for High Risk Foot Services* is comprehensive. From a general practice perspective, it would be helpful if the High Risk Foot Service had a clearly articulated, easily accessible information referral pathway for urgent referral both within and after normal clinic hours including emergency clinical nurse consultant contact details.

Thank you for the opportunity to provide a submission. We trust our input is helpful, and look forward to hearing the outcomes of the consultation process.

Kind regards,

Karen Booth
Vice President, APNA