Kayley Meredith – Chronic Disease Coordinator

Kayley is an Enrolled Nurse who has worked in primary health since graduating with a Diploma of Nursing in 2013

Kayley is employed full-time as the Chronic Disease Coordinator at Coffs Medical Centre

She is a proud Gadigal woman and single mum to 2 beautiful boys with a genuine empathy and interest in patient's needs

She has qualifications in Chronic Disease Management and nutrition, is committed to ongoing professional development and motivated to lead change

I acknowledge the Traditional Owners of the land on which we meet today. I recognise the people of both the Turrbul and Jagera nations and pay my respects to Elders past, present and emerging.

Acknowledgement of Country

APNA's Building Nurse Capacity (BNC) Nurse Clinic Project

COFFS MEDICAL CENTRE

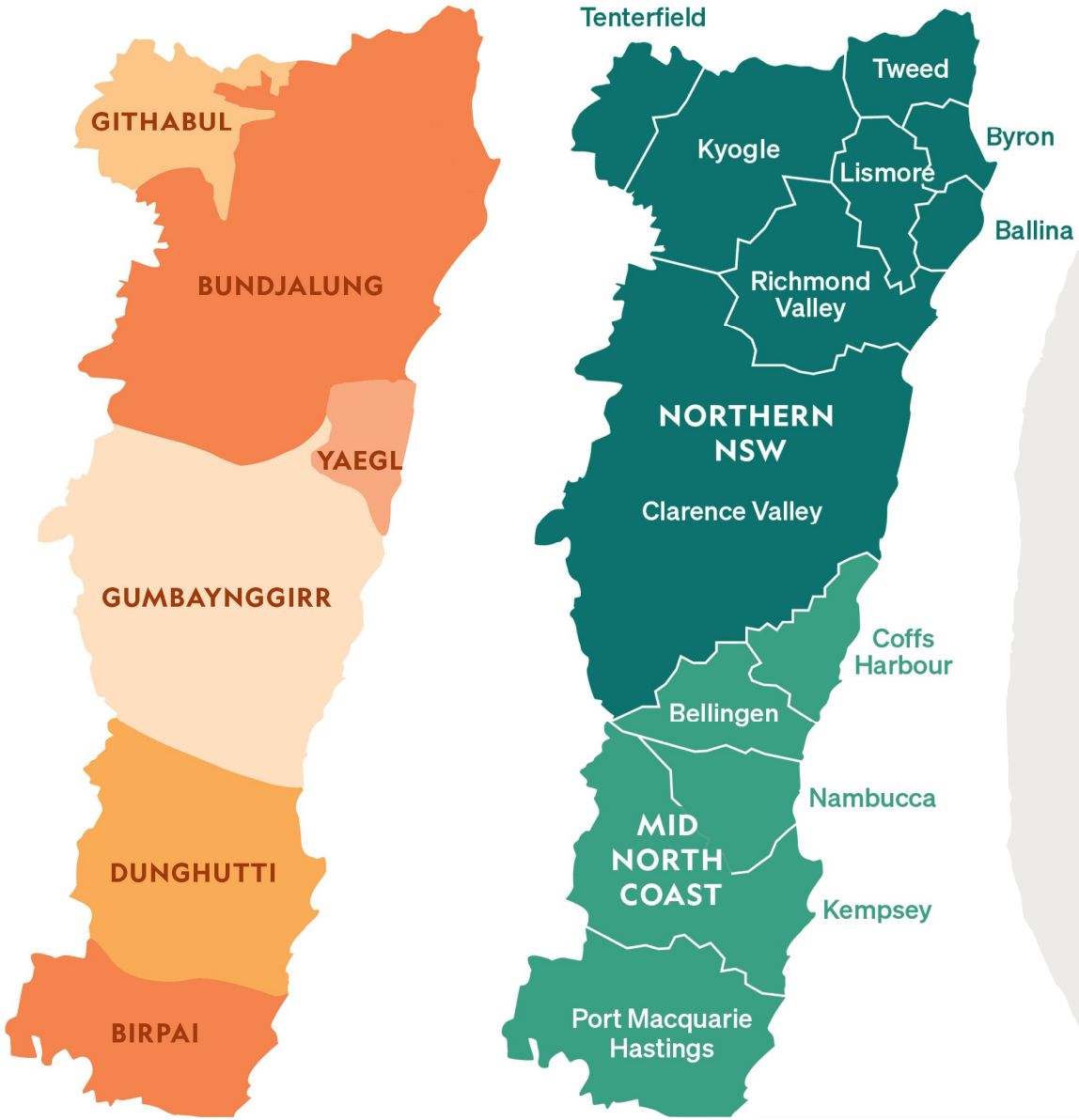
45–49-YR-OLD CARDIOVASCULAR DISEASE PREVENTION CLINIC

Kayley Meredith

Enrolled Nurse

Chronic Disease Coordinator

https://www.apna.asn.au/profession/buildingnursecapacity



Our region

- 32,000+ square kilometres
- 540,000+ population size
- 150 general practices sharing data with local PHN
- High rates of disadvantage
- Specialists and allied health service access in regional areas is challenging

Patient Profile at Coffs Medical Centre

- 2nd highest no. of active patients across PHN region
  - >**13,200 patients registered to our practice**
  - **> 2,500 patients have 2 or more chronic conditions and take 5 or more medications <u>This is 1 in 5 patients who attend our clinic</u>**

Higher than regional average rates for chronic conditions

Chronic disease/ condition	Prevalence in Coffs Medical Centre pts	Average prevalence across PHN region	Difference
Heart failure	1.8%	1.2%	**50%**
Chronic kidney disease	3.2%	2.2%	**45%**
Stroke	2.8%	2.4%	**17%**
Chronic heart disease	**6.4%**	**4.9%**	**31%**

Coffs Medical Centre

- Identified patients at risk of cardiovascular disease with PenCS clinical software
- Set up 45-49-yr old Cardiovascular Disease Prevention Clinic
- Increased awareness and monitoring of at-risk patients

Nurse-led team clinic model

- Patients **invited to attend nurse-led team clinic**.
- **One (1) hour spent with patients to focus on:**

✓ rapport building

✓ conducting assessments

✓ discussing cardiovascular health

✓ undertaking necessary tests like observations and ECGs.

✓ utilising health coaching skills

- **Appointments scheduled with GPs** for further tests, treatment, or other referrals as needed
- **Follow-up appointments made with nurse or GP**

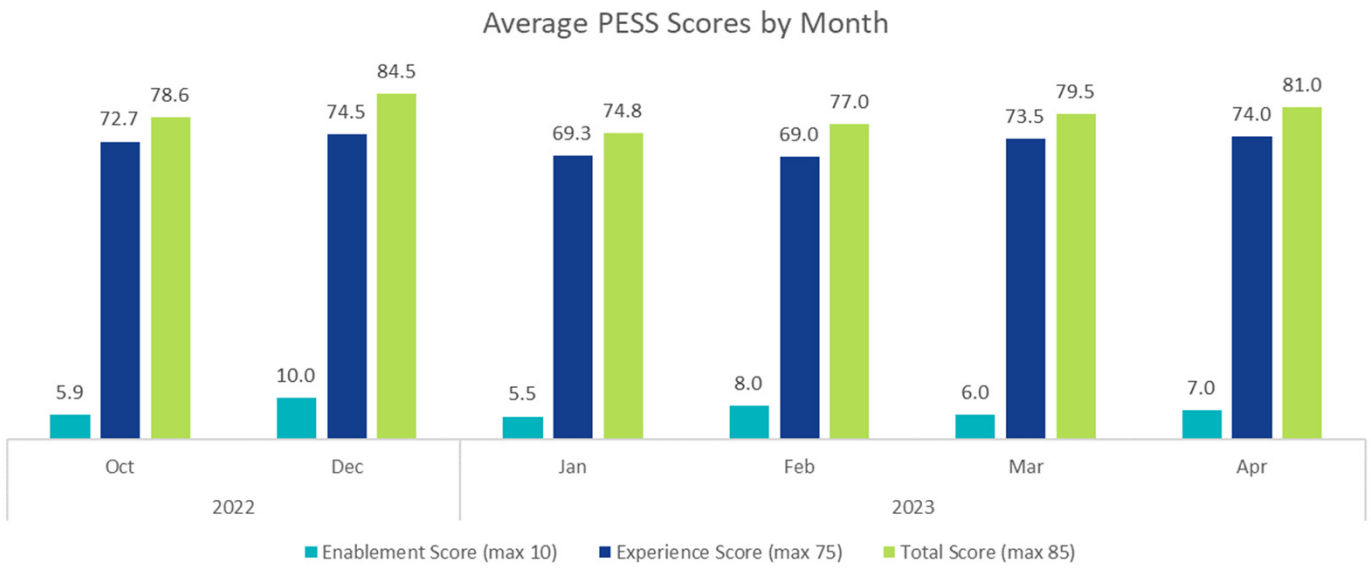
Outcomes for patients

- Operating one (1) day per week - **40 patients seen for assessment, education and follow-up**

- Referrals made to **specialists and allied health professionals as needed**.

- **High levels of patient satisfaction reported in** *Patient Enablement and Satisfaction Survey (PESS)*

Coffs Medical Centre CVD Clinic: Patient Enablement & Satisfaction Survey (PESS) Data



Patient Enablement and Satisfaction Survey (PESS)

The PESS tool is designed to help nurses evaluate their nursing care and seeks feedback from patients about their level of satisfaction with the nursing care they have received; whether that care helps them to understand more about their health and well-being; and whether it has made them better able to look after their health. Patient enablement scores are a separate, yet related, outcome to patient satisfaction. In some instances, due to the nature of the clinic or interaction, patients may not find these questions applicable which may result in a lower score for this measure.

Patient Feedback

*"Wonderful, helpful nurse. Very warm and personable, thorough, professional and supportive… **I felt like we collaborated well on planning for better health. I felt empowered to make positive changes to improve my health and reduce health risks.** I was even offered a follow up in the new year to check in. **I felt cared for**. Very grateful for this service".*

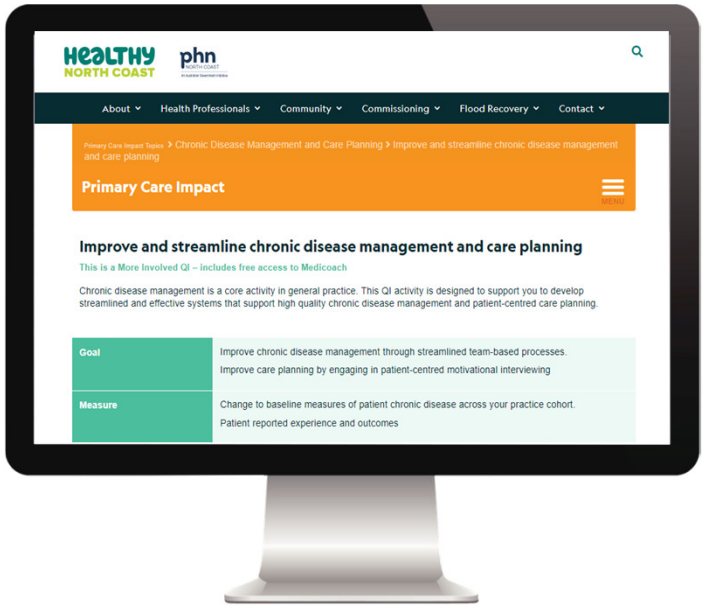
Patient #9 CVD prevention clinic.

Impact on health and service delivery

Nurse-led clinic:

- Improved access to care
- Early identification, intervention & referrals for cardiovascular risk
- Comprehensive care, education, and support to empower patients to self-care
- Supports preventive care, interprofessional collaboration
- Fully utilises my skills & experience in Chronic Disease Management and builds my good relationships with patients
- Funded with some MBS items, practice incentives and my time

Outcome for the region



Nurse-led clinic:

- Supported through collaboration & partnership with Healthy North Coast / PHN

- Experiences, outcomes & impacts are shared through the PHN Quality Improvement portal – ***Primary Care Impact*** – to encourage other practices to adopt similar models

Thank you

For further information please contact me:

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