THE LONG AND WINDING ROAD:
EVOLUTIONARY AND INNOVATIVE INTEGRATED NURSE PRACTITIONERS IN RURAL VICTORIA

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THE GOULBURN VALLEY DIABETES CENTRE

GVDC, NADC Tertiary accredited: with Nurse Practitioners, Endocrinologist & specialist trainee program until 2013
3 years with minimal endo & medical support necessitated an expanded nurse practitioner scope of practice to lead multiple high risk clinics

Nurse practitioner/s expanded scope of practice

- GVDC Diabetes and pregnancy program integrated with obstetric unit (obs/gynae request)
- Paediatric Diabetes team integrated with paediatric unit (previously separate teams)
- 2013 NP and podiatry led regional high risk foot clinic
- Acute inpatients – Super Six model excluding renal care
- Multidisciplinary outpatient clinics
- 5 NP regional Outreach clinics, GP based - planning Interim Care model
- NP led CSII/CGM clinics

NURSE PRACTITIONER: DIABETES

(ACUTE AND SUPPORTIVE CARE)

NO: 1 (2007)

New referrals to diabetes centre reviewed in the nurse practitioner clinic. **NP diabetes Scope of Practice**

- initial assessment, pathology, titration of medications in consultation with Endocrinologist
- referrals to dietitian, podiatrist as necessary and clinical assessments by NP
- Patients reviewed and stabilised by NP until diabetes clinic review.

At diabetes clinic the NP co-reviewed patients and continued ongoing management

- offered high quality, appropriate and accessible model of care within the GV Health Diabetes Service

Consensus that NP role an asset in streamlining care within the service and for improving referral practices with General Practitioners.

NURSE PRACTITIONER : DIABETES

(ACUTE AND SUPPORTIVE CARE)

NO:2 (2010)

Five outreach clinics, referred by the GP and stratified by NP
NP complex diabetes Scope of Practice

Complex clients received timely and frequent consults with advanced clinical management leading to:

- Timeliness of clinical interventions by the NP
- Undertaking of advanced clinical assessments
- Recommending and initiating pharmacotherapy and/or pathology with prescribing rights in all clinics

<u>Benefits to GP clinic:</u>

- Liaising with the GP and practice nurse about management strategies
- Practice nurses/diabetes resource nurses with basic diabetes management skills continue to refer more complex diabetes patients to NP at GVDC or GV Health ED

NURSE PRACTITIONER: COMPLEX CARE
(ACUTE AND SUPPORTIVE CARE)
NO:3 (2017)

Improves timely management of patients with chronic diseases in the acute and community setting - diabetes, respiratory and cardiac conditions.

Expansion of NP scope of practice beyond just diabetes

NP works collaboratively with:
Acute ED, medical units & allied health providers, improves timely, well-documented clinical management of these complex patients

Health Independence Programs (HIP) provides hospital substitution and diversion services by supporting people in the community, in ambulatory settings. Including:
Hospital Admission Risk Programs (HARP)

- Emergency Department - complex aged/psychosocial
- Disease Management Team - Cardiac/Respiratory
- NADC Diabetes Centre
- Residential In Reach Program (Aged Care)

Post Acute Care (PAC) and Sub Acute Care services (SACS)

NP EVOLVING SCOPES OF PRACTICE

NP 1	NP 2	NP 2
Consensus role in streamlining management	Triaging diabetes complexity in outreach medical clinics and *Co- management of diabetes inpatients*	*Case finding: Co- management of diabetes inpatients, early discharge* *ED incl. rapid access units* *HIP admission risk - chronic disease*
Unstable diabetes referrals to diabetes clinic	Increasingly complex patients, *more frequent consultations in collaboration with GP's*	*Referrals across multiple referrers, programs: respiratory, cardiac , diabetes*
Advanced clinical assessment (Diabetes)	Advanced clinical Assessment (*Complex Diabetes and High Risk Foot Clinic)*	Advanced clinical assessment *(Chronic and complex diseases, High Risk Foot Clinic, Acute in-patients)*
Advanced problem solving and differential diagnosis	Advanced problem solving and differential diagnosis	Advanced problem solving and differential diagnosis *across expanded scope of practice*
Diagnostic investigation and timely intervention in diabetes management	Diagnostic investigation and timely intervention in diabetes management *and Regional High Risk Foot clinic*	Diagnostic investigation and timely intervention in diabetes management, *high risk foot clinic, diabetes and pregnancy, COPD, CCF etc*
Prescribing formulary Acute and Supportive Care (ASC)	Prescribing formulary ASC in all GP clinics *(Anti Microbial Stewardship AMS)*	Prescribing formulary ASC across acute and ambulatory programs *(AMS)*
Refer back to GP	*Liaison with GP's and practice nurses managing complex diabetes in medical clinics. Implementing Interim care model*	*Development of individualised disease management incl. Residential in-reach, PAC and SACS programs*

ARE WE THERE YET?

- Dr Balvinder Kalra commenced Diabetes/Endo 4 outpatient sessions per week in January 2016 now increased to 6 which include 4 diabetes sessions
- Not funded for inpatients or high risk foot clinic
- Multidisciplinary diabetes clinics with dietetic, CDE, NP and Podiatry (only high risk)
- Advanced trainee endo/physician program (acute), in collaboration with Austin Health, commenced in 2017
- Recruitment and succession planning continues unabated

AND THE BEAT GOES ON ……