

**RENAL ACTION PLAN (C&C DHB) 2008/10**

The table below indicates activity intentions, using a systematic approach based on Wagner’s CCM Model (1999) adapted for C&C DHB.

*(Funding Dependant)*

Activity	Community Including: Community resources and policies	Health System Including Patient safety	Self Management Support	Delivery System Design Including; Cultural competence Care Coordination Case management	Decisions Support and Clinical Information Systems	Timeframe
Planning Evaluation Information		<p>Joint primary/secondary clinical interface governance structure in place</p> <p>Utilise to discuss issues between primary and secondary care for renal patients</p>		<p>Measures to cope with expected increase in referrals due to implementation of NationalRenal Advisory Board Guidelines</p> <p>e.g.</p> <ul style="list-style-type: none"> <li>○ Triage referrals</li> </ul> <p>Nurse led clinics</p> <p>System in place to support increase in early recognition of renal disease</p>	<p>Health Needs Assessment (DHB) to include PHO input re diabetes + co-morbidity information</p>	2008/10

			Complete Stocktake of current information and support services for Renal patients including resources in appropriate languages & formats			2008/10
Prevention Primary and Secondary		Joint primary/secondary clinical interface governance structure in place Work together to disseminate NRAB Guidelines	Develop & distribute consumer friendly information sources and support –for individuals, families, different populations			2008/10
Early identification		Joint primary/secondary clinical interface governance structure in place Workforce development to support early identification approaches		Work with primary care to implement National Renal Advisory Board Guidelines (NRAB)and prioritise high risk populations Workforce development re NRAB Guidelines		2008/10

<p><b>Optimal Treatment &amp; Management</b></p>	<p>Improve access to palliative care for people with renal disease</p>	<p>Joint primary/secondary clinical interface governance structure Link renal service input into Palliative care forum and palliative care planning Explore options to improve coordination of care for people with renal disease and other co-morbidity e.g. Co-located outpatient clinics, Nurse –Led clinics ,community based dietetic support</p>		<p>Explore options for improved case management of people with diabetes/CVD/ renal disease Ensure services tailored for population groups with high burden of renal disease – Maori, Pacific, older people</p>		<p>2008/10</p>
<p><b>Equity Reducing disparities</b></p>	<p>Utilise existing mechanisms for community to inform design of resources and service changes</p>	<p>Reduce impact of renal disease for Maori population through earlier recognition + appropriate management. Reduce impact of renal disease for Pacific and other high need populations through earlier recognition + appropriate management</p>	<p>Increase early detection of renal impairment for most at risk populations (links to diabetes programmes, CV risk assessment etc).</p>	<p>Support innovative Maori specific approaches to improve access to services (primary, community support, secondary) for Maori &amp; high need populations with renal disease</p>	<p>Periodic service review to include access and outcomes by age, ethnicity</p>	<p>2008/10</p>

	<b>Reduce impact of renal disease for Pacific and other high need populations</b>	<b>Promote Pacific led primary care and access to primary care for all Pacific people</b>				<b>Ongoing PSAP</b>
<b>Workforce</b>		<b>Education to increase early recognition of renal disease When to refer &amp; NRAB guidelines (utilise GP liaison/primary-secondary clinical governance/ PHO clinical governance)</b>	<b>Workforce development to support self/whanau support for renal disease</b>		<b>Information re prevalence, trends in renal disease in HNA and DHB monitoring reports Decision support tools for renal disease in primary care EHR and information sharing between primary and secondary services</b>	<b>2008/10</b>