MND within a Community Rehabilitation Context: The Evolving Experts

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Introduction

Westlakes Community Rehabilitation Team (WLCRT) is an inter/multidisciplinary team working in the Hunter New England Local Health District (HNELHD). It provides care for people with a range of rehabilitation needs including frailty and falls, chronic disease, subacute stroke and progressive neurological conditions inclusive of Motor Neurone Disease (MND). WLCRT operation is consistent with the NSW Rehabilitation Model of Care. Care is provided to people with MND in line with the Model's aim to "develop functional ability to compensate for deficits that cannot be medically reversed".

The health and disability care landscape is rapidly changing with the introduction of reforms such as the National Disability Insurance Scheme (NDIS). In this context, the use of evidence based models of care has never had greater importance.

To effectively navigate this changing context WLCRT have reviewed their practices in working with people living with MND and their families, which has led to "evolving" expertise in the provision of community based rehabilitation for people with MND.

Location photograph Toronto Foreshore Westlakes local area

Aim

To identify and implement key principles of both the NSW Rehabilitation Model of Care and the MNDcare Approach Model to maintain patient function and deliver quality end of life care as part of routine practise within a community rehabilitation setting.

Method

Service delivery options for people with MND were reviewed. In the Westlakes area there is only partial access to a multidisciplinary palliative care service and no MND clinic. Across HNELHD there is a diverse range of care options but limited access to medium term community based inter/multidisciplinary care particularly for people under the age of 65 years.

At times the team had been challenged on clinical priority of providing care to a very diverse rehabilitation population with a broad range of outcomes. To improve equity and ensure consistent and effective service delivery, our community rehabilitation team reviewed both the NSW Rehabilitation Model of Care and MNDcare Approach to determine how they aligned to support the provision of care.

Results

Our review of practice models and clinical experience demonstrates the MNDcare Approach is consistent with the NSW Rehabilitation Model of Care and can fit successfully within a community rehabilitation context.

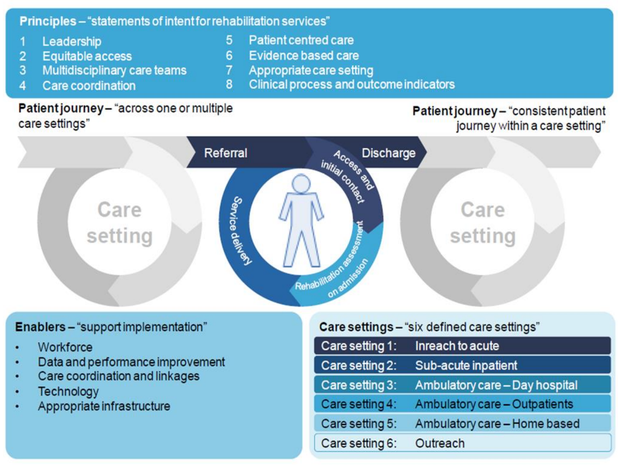

Figure 1: NSW Rehabilitation Model of Care

The models demonstrate alignment of key principles:

- Patient centred care
- Inter/multidisciplinary care team
- Care coordination
- Evidence based care

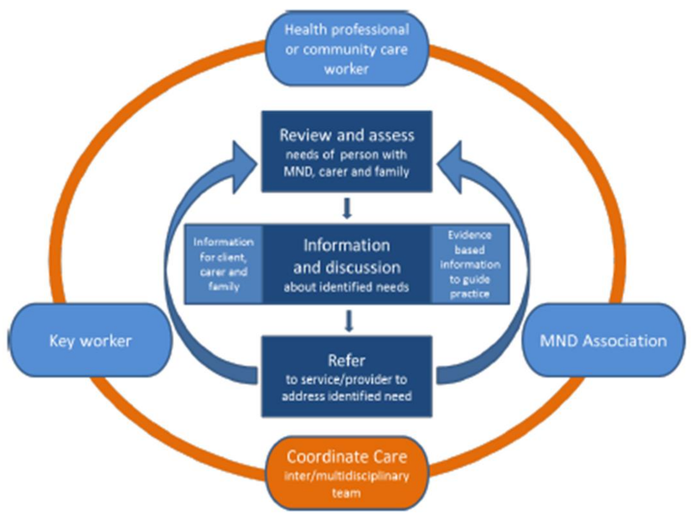

Figure 2: MNDcare Approach

In line with these models WLCRT has further standardised processes to support patient centred practise across it's diverse clinical populations. These processes include:

- Implementation of the Canadian Occupational Performance Measure (COPM). The COPM is a semi structured interview that enables patients and their families to identify what is most important to them as a focus for rehabilitation inputs. Use of the COPM helps to establish partnerships with people and families affected by MND and facilitates the provision of patient centred care.

- Care co-ordination delivered locally by the MND association and a key worker approach has been supported by implementation of quarterly case conferencing. Regular phone and email contact has facilitated responsive care planning and increased access to community care support, equipment and assistive technology.

- Acceptance of an expanded view of the word "team" to encompass services provided under NDIS in addition to health systems with a focus on a collaborative and communicative approach to patient care.

Conclusion

Care of people with Motor Neurone Disease is challenging across all contexts. The WLCRT experience demonstrates that locally available resources can be utilised to meet this challenge.
Models of care such as the NSW Rehabilitation Model of Care and MNDcare Approach provide a framework for maintaining focus on patient centred care, enabling consistency of service delivery and building productive partnerships that bridge the health and disability divide.

Key Messages

The MNDcare Approach can fit within a rehabilitation context and is consistent with the NSW Rehabilitation Model of Care.

Services can have an expanded view of the word "team" to include cross service partnerships.

Care co-ordination is essential to good care for people with MND in the community. WLCRT have regular care planning meetings with the MND Advisor and Coordinator of Supports. This collaboration improves care planning and patient advocacy with the NDIS.

The Canadian Occupational Performance Measure can be adopted by any service to support patient centred care.

System transition such as the introduction of the NDIS can be challenging, however a collaborative approach has increased access to resources, provided choice and improved both function and end of life care for people with MND.

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