New Models of Care in Heart Failure Management – 5 tips to implementing a model of care

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Context

- 22 Heart Failure Support Services in Qld
- Coordinated with a steering committee

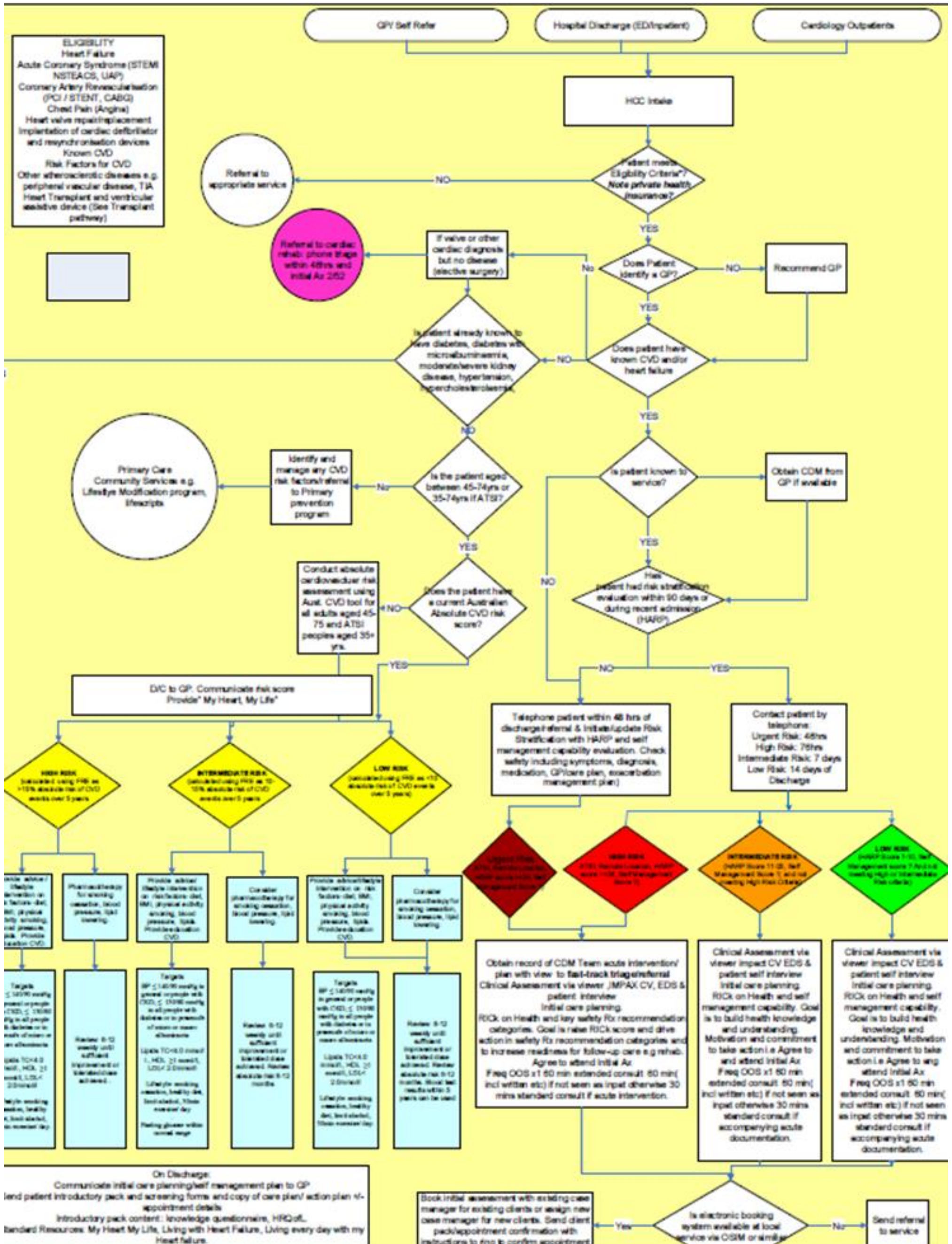
2017 statistics

- 4,535 new referrals
- 65% male
- Median age 70
- 71% of referrals from inpatient setting
- 78% HFrEF
- 4.1% ATSI

TIP 1: KEEP YOUR MODEL SIMPLE

Tip 1: Keep your model simple

- High level
- Not too much detail
- Allows individual implementation respecting local cultures and history


GP/ Self Refer
Hospital Discharge (ED/Inpatient)
Cardiology Outpatients
HCC Intake
ELIGIBILITY
Heart Failure
Acute Coronary Syndrome (STEMI NSTEACS, UAP)
Coronary Artery Revascularisation (PCI / STENT, CABG)
Chest Pain (Angina)
Heart valve repair/replacement
Implantation of cardiac defibrillator and resynchronisation devices
Known CVD
Risk Factors for CVD
Other atherosclerotic diseases e.g. peripheral vascular disease, TIA
Heart Transplant and ventricular assistive device (See Transplant pathway)
Patient meets Eligibility Criteria*? Note private health insurance?
NO
Referral to appropriate service
YES
Does Patient identify a GP?
NO
Recommend GP
No
If valve or other cardiac diagnosis but no disease (elective surgery)
Referral to cardiac rehab: phone triage within 48hrs and initial Ax 2/52
YES
Does patient have known CVD and/or heart failure
NO
Is patient already known to have diabetes, diabetes with microalbuminaemia, moderate/severe kidney disease, hypertension, hypercholesterolaemia,
NO
Is the patient aged between 45-74yrs or 35-74yrs if ATSI?
No
Identify and manage any CVD risk factors/referral to Primary prevention program
Primary Care Community Services e.g. Lifestyle Modification program, lifescripts
YES
Does the patient have a current Australian Absolute CVD risk score?
NO
Conduct absolute cardiovascular risk assessment using Aust. CVD tool for all adults aged 45-75 and ATSI peoples aged 35+ yrs.
YES
D/C to GP. Communicate risk score
Provide" My Heart, My Life"
HIGH RISK
INTERMEDIATE RISK
LOW RISK
Is patient known to service?
Obtain CDM from GP if available
Has patient had risk stratification evaluation within 90 days or during recent admission (HARP?)
NO
YES
Telephone patient within 48 hrs of discharge/referral & Initiate/update Risk Stratification with HARP and self management capability evaluation. Check safety including symptoms, diagnosis, medication, GP/care plan, exacerbation management plan)
Contact patient by telephone:
Urgent Risk: 48hrs
High Risk: 76hrs
Intermediate Risk: 7 days
Low Risk: 14 days of Discharge
Obtain record of CDM Team acute intervention/ plan with view to fast-track triage/referral
Clinical Assessment via viewer ,IMPAX CV, EDS & patient interview
Initial care planning.
RICk on Health and key safety Rx recommendation categories. Goal is raise RICk score and drive action in safety Rx recommendation categories and to increase readiness for follow-up care e.g rehab.
Agree to attend Initial Ax
Freq OOS x1 60 min extended consult 60 min(incl written etc) if not seen as inpat otherwise 30 mins standard consult if acute intervention.
Clinical Assessment via viewer impact CV EDS & patient self interview
Initial care planning.
RICk on Health and self management capability. Goal is to build health knowledge and understanding.
Motivation and commitment to take action i.e Agree to and attend Initial Ax
Freq OOS x1 60 min extended consult 60 min(incl written etc) if not seen as inpat otherwise 30 mins standard consult if accompanying acute documentation.
On Discharge:
Communicate initial care planning/self management plan to GP
Send patient introductory pack and screening forms and copy of care plan/ action plan +/- appointment details
Introductory pack content : knowledge questionnaire, HRQoL.
Standard Resources: My Heart My Life, Living with Heart Failure, Living every day with my Heart failure.
Is electronic booking system available at local service via OSIM or similar
Yes
No
Book initial assessment with existing case manager for existing clients or assign new case manager for new clients. Send client pack/appointment confirmation with instructions to ring to confirm appointment with referral site.
Send referral to service

More than one way to skin a cat

"Find out *exactly* how many ways there are to skin a cat."

Heart Failure Support (HFS) Model

Home: decompensation

- Early identification of deterioration
- Self-monitoring
- GP consult
- Palliation as appropriate

Hospital: clinically compensated

- Education & review of symptoms, exercise, diet, meds
- Discharge planning
- Individual action plan

Home: clinically stable

- Review & education
- Medication support/titration
- Transfer care once stable and maintain link with GP as required
- Support exercise program

Home: stabilising

- Follow-up by HFS Service within 1-2 weeks
- GP review < 5 days of hospital discharge
- Referrals to allied health as required

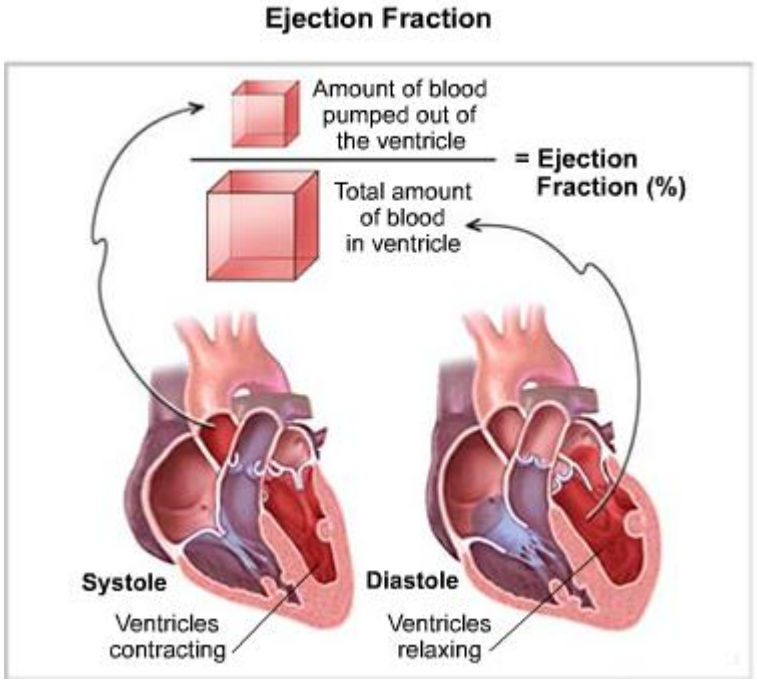
TIP 2: PROVIDE A CLINICAL STANDARD OF CARE

Tip 2: Provide an expectation of standard of care

https://www.health.qld.gov.au/heart_failure

Referrals to a Qld HFSS

- >16 years with symptoms of heart failure regardless of aetiology,
- Confirmed diagnosis of:
  - Heart Failure with reduced Ejection Fraction (HFrEF);
  - Heart Failure with preserved Ejection Fraction (HFpEF);
  - Right heart failure



Mode and place of care

Home Visits

Clinics:
Medical/MD/Nurse

Group exercise
& Education

Telemonitoring &
telehealth

Patient

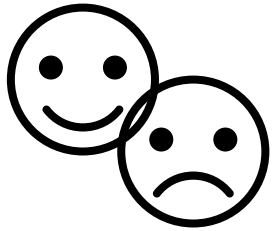
Telephone Care

Adapted from Simon Stewart

Components of support

Clinical Monitoring

Psycho-social support

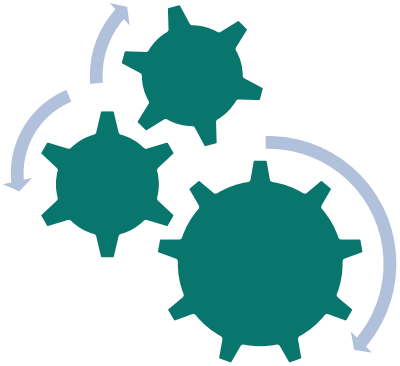


Medication Mx

Exercise & activity

Symptom control: fluid, nutrition, fatigue

Comorbidities Mx



HFSS Deactivation criteria: The Awesome Foursome!

- ✓ Can self-manage
- ✓ Recognise worsening symptoms
- ✓ Uses action plan (or have a carer and/or support services organised)

Be in the care of a GP (and specialist outpatient or palliative care if required)

- ✓ Optimal doses of heart failure meds(if HFrEF)
- ✓ Medication plan provided to GP. (Titration by GP still requires involvement by HFSS until target is achieved.)

Know how to exercise safely according to his or her condition and participate in life-long activity;

TIP 3: FOSTER WORK FORCE, CLINICAL & CONSUMER LEADERS

Tip 3: Foster work force, clinical & consumer leaders

- Engage medical specialist for every team (sometime remotely)
- Coordinated approach of nurse practitioners, nurses, pharmacists and physios/EP, dieticians, OT, SW
- Promote nurse leadership

Tip 3: Support and value your workforce

- Annual 2 day course
- Specialist courses (exercise, echo)
- Professional interest groups
- HEART Online
- Planning and review session

Tip 3: Workforce recommendation in clinical standard

50-100 patients	FTE	Time in direct care
Medical sponsor	N/A	N/A
Nurses (CN, CNC, NP)	2.0-3.0	50%
Physio/EP, Pharm	0.8 – 1.0	50 – 60%
Dietitian, OT, SW, Psych	0.4 – 0.6	50 -60 %
Admin	0.4 – 0.6	N/A

Direct Care: Outpatient clinics, inpatient consultations, groups, home visits, telephone support and telehealth

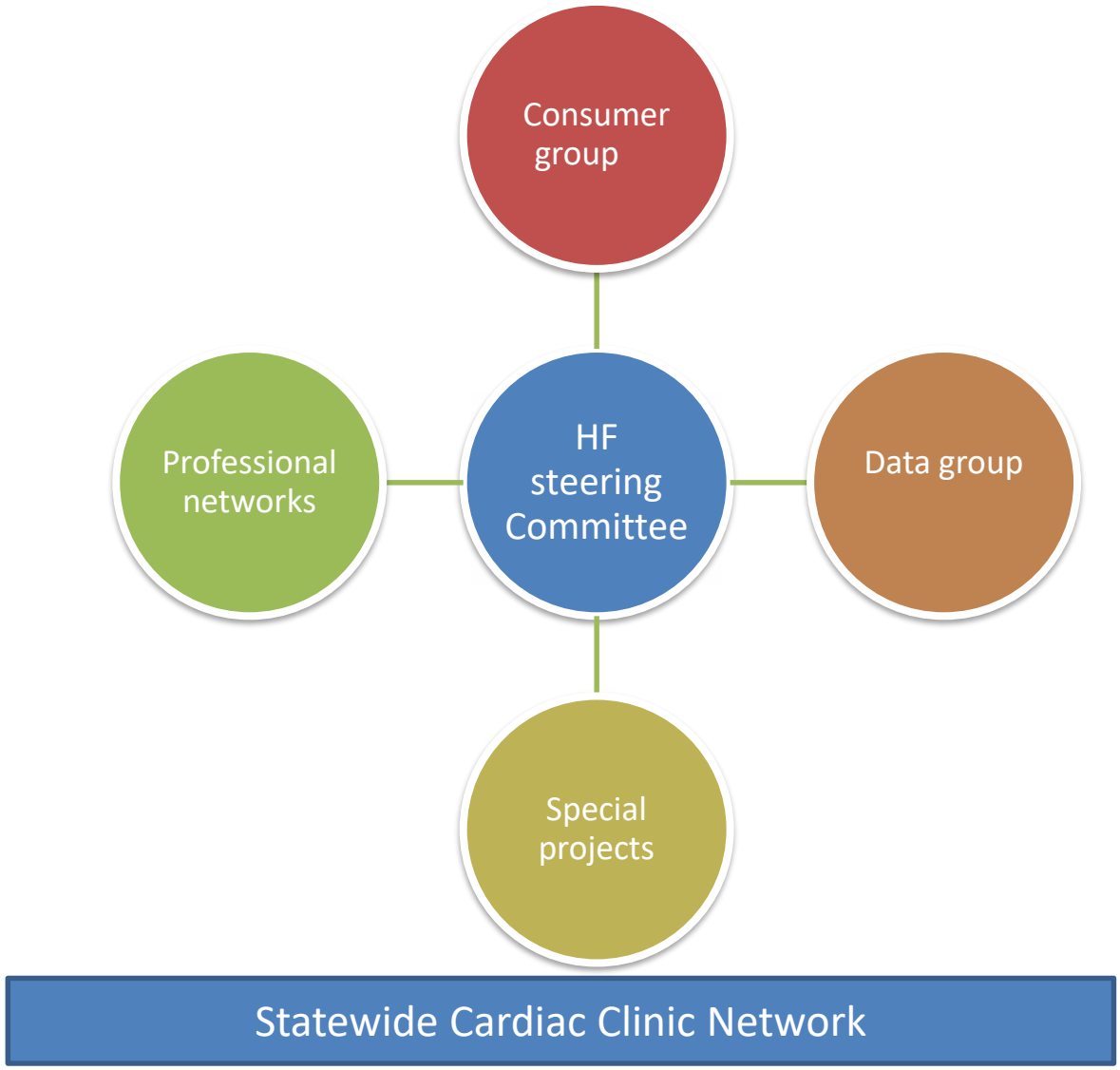
Indirect: travel time, reporting, or case-conferencing; liaison and coordination between different health care providers; and reconciliation of medications.

Tip 3: Develop consumers

Setting the agenda, teaching at courses, participating in research

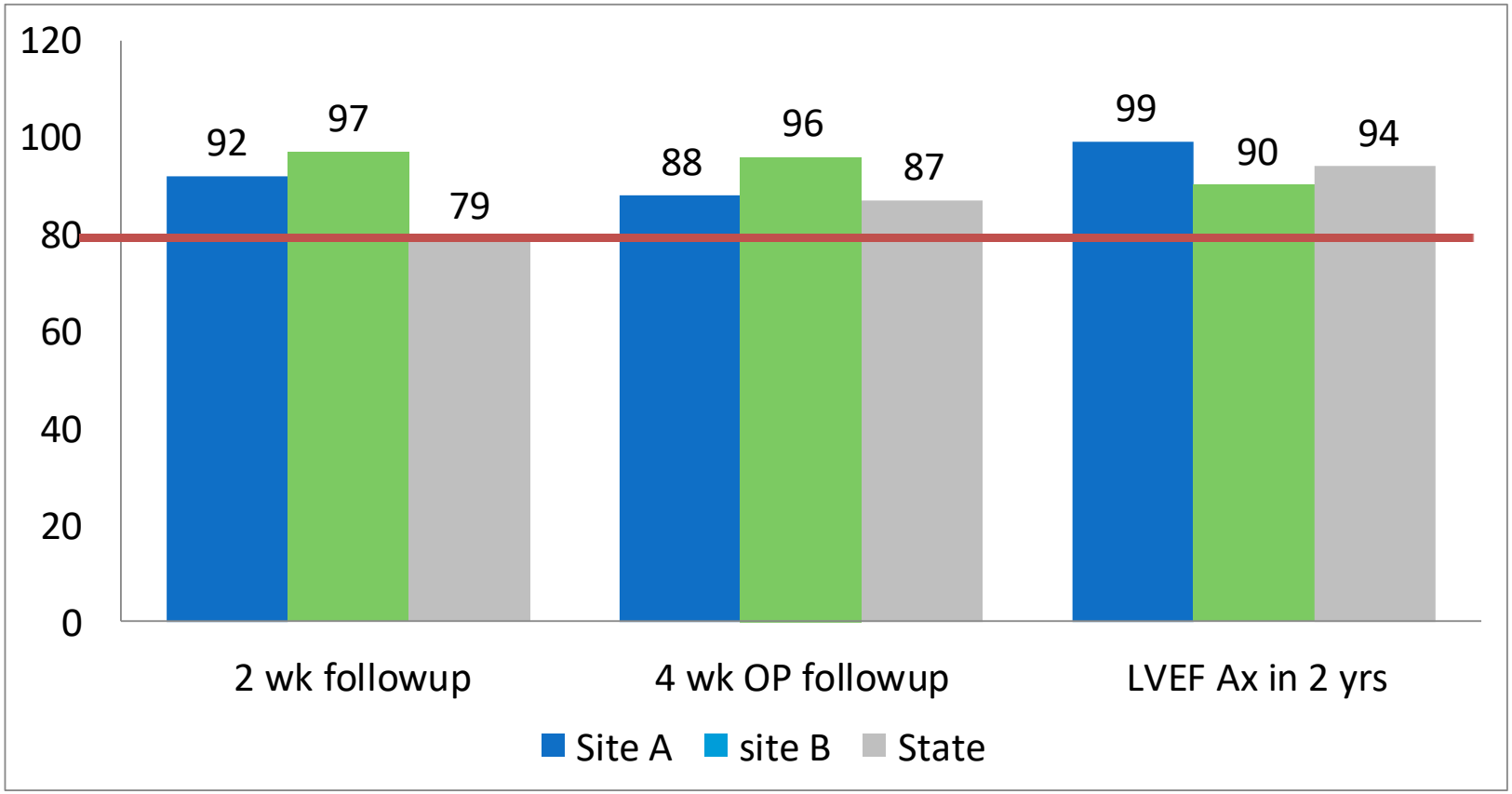
TIP 4: GOVERNANCE

Tip 4: Strong governance to oversee model or care



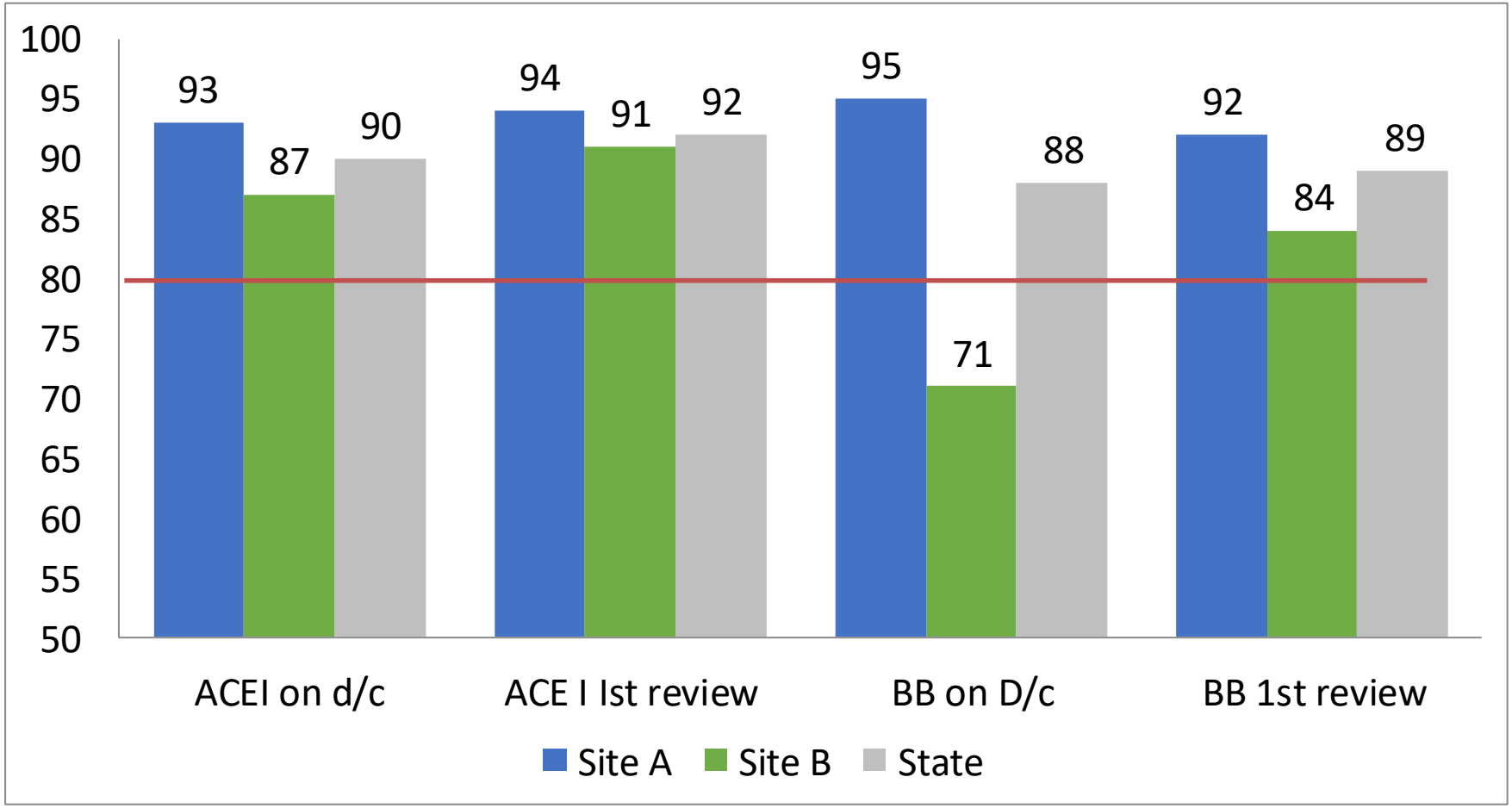
Tip 5: Promote practice improvement

Non pharmacological indicators



Tip 5: Promote practice improvement

Prescribing practices for HF



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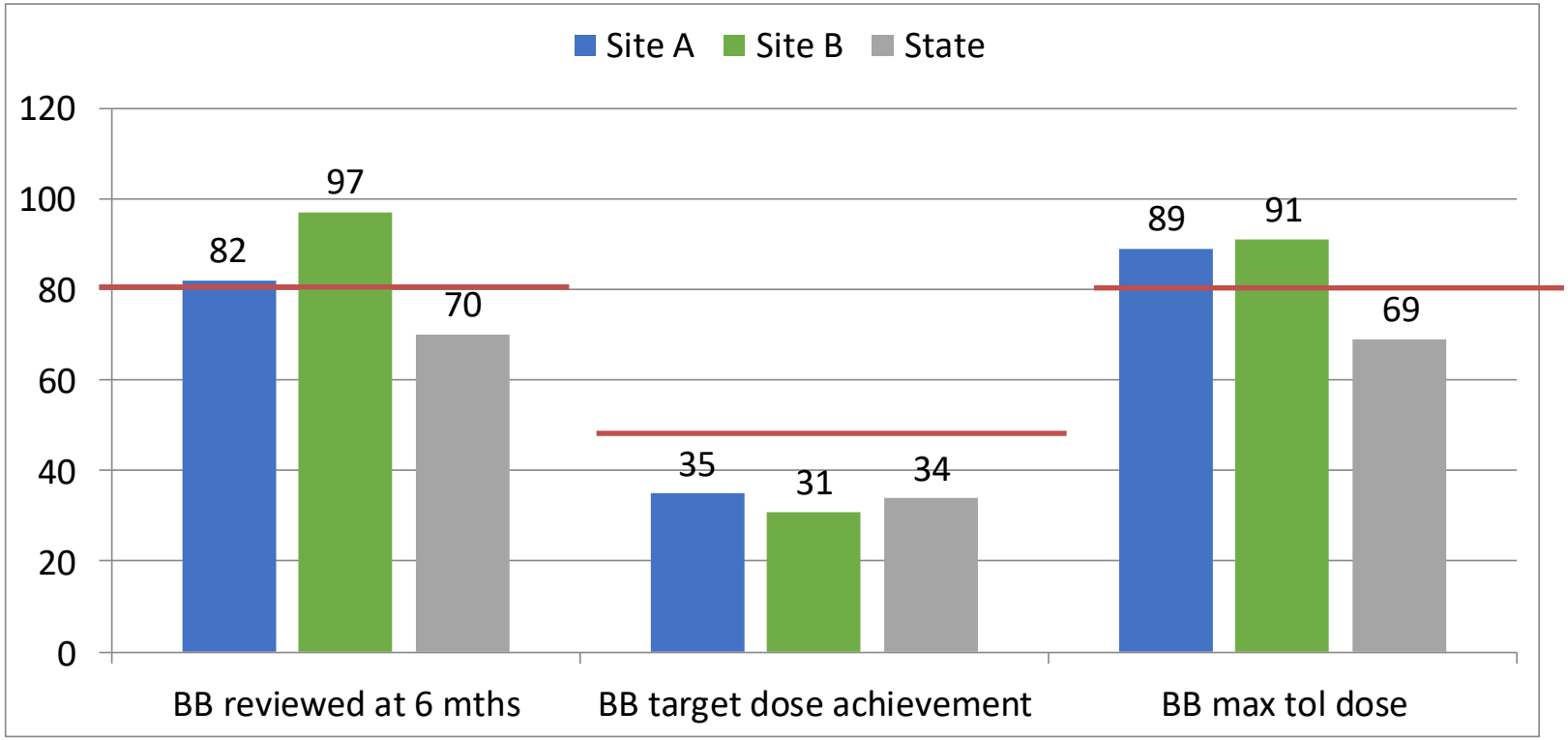

Tip 5: Practice improvement support