New Model of Integrated Care

Carys Barton
BSH Heart Failure Nurse
Study Day
20th June 2018
Presentation title: New Model of Integrated Care

Speaker: Carys Barton

Conflicts of interest: None

Presentation slide distribution: These presentation slides will be added to www.bsh.org.uk after the meeting.
Overview

- KHP model
- The key role of heart failure specialist nurse
- Role in acute setting
- Role in community setting
- Which model is most effective?
- KHP Lessons Learned
- Future Direction
Guy’s and St Thomas’s and Kings College Hospitals NHS Foundation Trusts received funding for 2 years from Guys and St Thomas’s Charity to develop an Integrated Multidisciplinary Heart Failure Service across the two hospital trusts and the communities of Southwark and Lambeth to improve outcomes for patients.

The four main goals:

- Early and accurate diagnosis of heart failure
- Equitable access to specialist care
- Good long term condition management and patient centred holistic care
- Unnecessary hospital admission avoidance
**Kings Health Partners Integrated Heart Failure Model (2)**

- The service launched in Spring 2016 - joining up the specialist teams to deliver an innovative service model aligned with Local Care Networks

- A dedicated multidisciplinary team were allocated to work in each of the 5 localities to provide specialist support to primary care clinicians and other services

- Virtual clinics- GP, Pharmacist, Consultant, Nurse

- Significant work was undertaken to align/standardise practice across King’s Health Partner’s and the community which included producing:
  - New prescribing guidelines and GP referral pathways
  - Standard Operating procedures for the HFSN team
  - A HFSN competency framework
  - Standardised patient education information/resources

- Mind and body care for patients, 3DLC was also put in place
MDT-KCH AND GSTT

- HF pharmacist
- 3DLC
- Elderly care
- Cardiologist
- HF physiologist
- Acute/Community HFSN
- Palliative care
- GP champions

Patient
The HFSN is key in the integrated service

- Follow entire patient journey
- Able to work across all sites
- Care co-ordinates across care settings
- Liaises with MDT
- Most patient contact
What is the Evidence?
What do the studies say?

- Randomised trials of nurse-led interventions in HF management have shown that specialist HF nurses have the potential to make a substantial impact on the overall burden of HF in limiting costly admissions, in addition to improving quality of life on an individual basis.

- Review of heart failure disease management studies, reported reduced hospital admissions for patients followed up post discharge, focusing on:
  - optimising evidence based medicines,
  - education and self management strategies.

- 2004 - 2007 BHF evaluation of 76 HFSNs working in the community across 26 NHS organisations in England. The programme demonstrated a 35% reduction in all cause admissions with associated cost savings of approx £1,826 saving per patient.

- A meta-analysis found that showed that this type of intervention may even reduce mortality.

- Patients under the care of a HF specialist nurse are five times less likely to be hospitalised.
ADMISSION PHASE

COORDINATE CARE ADMISSION TO DISCHARGE

- Identify HF admissions - BNP, referrals
- Support generalist teams outside cardiology
- Uptitrate evidence-based therapies
- Assess risk factors - educate self-care
- Collect data for national audit
- Palliative care
- Onward support and referral to OP and community team
- One team

MDT working

Recruit and assist in research trials

Psychosocial support, refer to cardiac rehab

Recruit and assist in research trials

Palliative care

Assess risk factors - educate self-care

Coordinate care admission to discharge

One team
National Heart Failure Audit

• 79% of all HF admissions are seen by a HF Specialist - INCLUDES THE HEART FAILURE SPECIALIST NURSE

• Over a ¼ of all HF patients see a HF Nurse on admission - 90% at GSTT

• Limited study evidence available but HFSNs play a key role from admission to discharge

• Patient outcomes continue to be influenced by HFSN input both as in patients and post discharge.

• More studies are required
TELEPHONE REVIEW AND CONTACT POST DISCHARGE
DISCHARGED PHASE

*Patients are seen at home, in hospital clinics or local clinics as required*

- **CALL PATIENT WITHIN 2 DAYS OF DISCHARGE**
- **SEE PATIENTS WITHIN 2 WEEKS OF DISCHARGE**
- **OPTIMISE EVIDENCED THERAPIES AND DIURETICS**
- **MONITOR BLOOD CHEMISTRY AS APPROPRIATE**
- **REFER TO OTHER SERVICES AS REQUIRED**
- **LIAISE WITH GP AND REPORT CHANGES WITHIN 48 HOURS WITH ASSESSMENT**
- **ESCALATE CONCERNS AT MDT**
- **DIRECT ACCESS TO HF CARDIOLOGIST FOR ESCALATION TO ADVANCED THERAPIES, DETERIORATING SYMPTOMS TO AVOID OR FACILITATE ADMISSION**
- **DELIVER EDUCATION AND SUPPORT TO PRIMARY CARE TEAMS**
  - Rapid access HF clinics
  - Virtual clinics
  - Register reviews
  - Study days
- **DISCHARGE APPROPRIATE PATIENTS BACK TO PRIMARY CARE WITH MANAGEMENT PLANS**
- **REGULAR CASELOAD REVIEWS TO ENSURE OPTIMUM CARE**
Which Model?

Role varies widely according to the infrastructure in healthcare organisations and geographical location but essential to multidisciplinary working

- Hospital based - reviewing and influencing management of in-patients
- Hospital based - reviewing and influencing management of in-patients and also running out-patient clinics
- Community based - practicing in the community, undertaking home visits and community clinics
- In-reach - based in and primarily work in the community but go into the hospital to review patients
- Out-reach - based in hospital but undertake community clinics and home visits

- Single integrated service owning the whole pathway (in-reach and outreach)
Integrated model

The benefits of a single integrated service owning the whole pathway and being one provider has the potential to:

- Improve governance - the HFSNs all working to the same standards, getting the same level of training and education, working to the same level of competence

- Provide greater sustainability and flexibility – reducing the need to cancel clinics/visits as there is always someone who can move from one part of the service to cover somebody who is off sick or on leave

- Increase numbers of patients able to be followed up within 10 working days following hospital discharge

- Improve communication during transition from hospital to community or vice versa
Integrated model (contd.)

• Make it easier to audit what is going on across the whole team and identify when and where problems occur, team members having difficulties can be moved, upskilled and managed without a disruption to the service

• The entire pathway of patient journey is transparent

• Improved joint working-GP’s in the community know their nurses and are able to gain access to the Cardiologists easier

• Patients can have a single point of contact to gain advice from a number of nurses who can assist

• Excellent training and education for nurses who can work across acute and community. This helps everyone understand each others roles and challenges

• Improve patient access through a centralised contact number, enabling access to advice/support in a timely manner
2016 Guidelines for the diagnosis and treatment of acute and chronic heart failure
Table 14.1 Characteristics and components of management programmes for patients with heart failure

**Characteristics**
- Should employ a **multidisciplinary approach** (cardiologists, primary care physicians, nurses, pharmacists, physiotherapists, dieticians, social workers, surgeons, psychologists, etc.).
- Should target high-risk symptomatic patients.
- Should include **competent and professionally educated staff**.

**Components**
- **Optimized** medical and device management.
- Adequate **patient education**, with special emphasis on adherence and self-care.
- Patient involvement in **symptom monitoring** and flexible diuretic use.
- Follow-up after discharge (**regular clinic and/or home-based visits; possibly telephone support or remote monitoring**).
- Increased access to healthcare (**through in-person follow-up and by telephone contact; possibly through remote monitoring**).
- **Facilitated access to care** during episodes of decompensation.
- **Assessment of (and appropriate intervention in response to)** an unexplained change in weight, nutritional status, functional status, quality of life.
- **Access** to advanced treatment options.
- **Provision of psychosocial support** to patients and family and/or caregivers.

ESC, 2016
"Teamwork divides the task and multiplies the success."
unknown
LESSONS LEARNED
Integrated HF Service – Lessons Learned

• IT difficulties – incompatible systems unable to see up to date information/results

• Communication was complex - many work strands, multiple emails send to busy clinicians

• Accessing honorary contracts to work across sites took longer than anticipated

• A number of staff funded by the project did not take up post until after the project started which delayed progress in some areas

• HFSN posts in some of the localities were vacant at the onset of the project

• Prescribing courses difficult to access – funding/labour intensive (helps speed up management if you are a prescriber)

• Speed of change/culture shift often frustrating so slow

• Long Term Condition agenda can get in the way – politically challenging
Bumps in the road…. But one road!
Additional/developing services

- Delivering IV diuretics in ambulatory care units to support early discharge and hospital admission avoidance
- Delivering IV diuretics to people in their own homes
- Delivering subcutaneous diuretics to people at end of life in their own homes
- Educating and supporting healthcare professionals to deliver IV diuretics in nursing/residential care homes
- cardio-oncology clinics- rapid uptitration
- palliative care clinics
- care of the elderly working- co ordinating care for multiply comorbid
- Project is now in evaluation stage
Summary

The management of HF can be complex and for the majority of people this is a long term, progressive condition - we have to find efficiencies in managing the growing burden of HF.

Heart failure specialist nurses as part of a multidisciplinary team are key in identifying and managing patients admitted to hospital with decompensated heart failure and have a significant role to play in planning the patient’s discharge and follow-up.

People with a diagnosis of heart failure require an integrated approach to their care with robust care pathways from diagnosis through to end of life. A single integrated service owning the whole pathway and being one provider across hospital and community has the potential for greater sustainability, flexibility and improved access for patients to services in a timely manner.
THANK YOU, ANY QUESTIONS?
carys.barton@nhs.net
References


National Heart Failure Audit April 2015–March 2016 www.ucl.ac.uk/nicor/audits/heartfailure

www.bhf.org.uk/communityivd