

# Heart Failure in Midlands Region

## Primary Health Care Nurse Leaders Forum

30 May 2014

Brigitte Lindsay

Cardiac Nurse Practitioner Taranaki

# Overview

- Heart failure burden
- Current models of care
- Midlands Region Network
- Planning for the future

# Heart Failure Burden

- Significant increasing global burden
- 45% hospital admissions in NZ - 5500 per year
- Heart failure accounts for 2% total health budget
- High Mortality: 20% at 6 mths, 30% at 12 mths
- Heart failure occurs 10-15years earlier in Maori with higher mortality
- Heart failure prevalence 10% in >65yrs age.
- Approximate 50% increase over next few decades

HF PREVALENCE  
**>8 MILLION**  
BY 2030<sup>3\*</sup>

IMPROVED POST-MI SURVIVAL<sup>4</sup>

AGING POPULATION<sup>4</sup>

INCREASING PREVALENCE  
OF RISK FACTORS<sup>4,5</sup>

## Recommendations

**A structured approach to chronic disease management is recommended for patients with heart failure, especially for those at high risk, such as those with recent hospitalisation.**

*Level of evidence I: Grade of recommendation A*

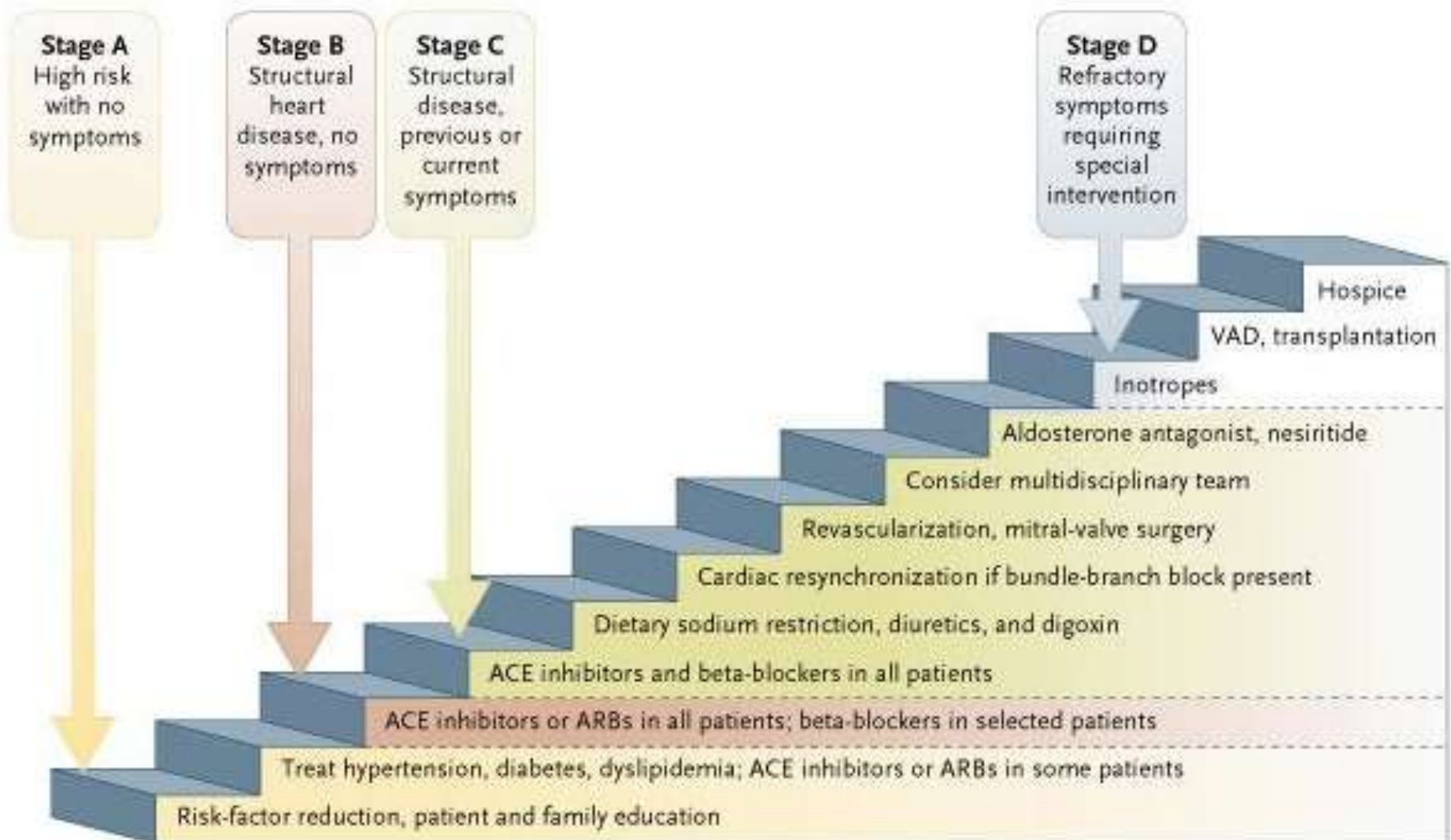
## Clinical Practice Points

- .....
- .....
- **The heart failure nurse specialist has a key role in management and often will work as part of a multidisciplinary team.**
- .....
- **Adequate funding is required to sustain such management interventions.**

# Model of Care Outcomes (Moser,2005)

|           | Hospital days and/or readmits                          | QOL and/or functional status    | Cost                              |
|-----------|--|---------------------------------|-----------------------------------|
| Clinic    | <p>↓ ↓ ↓ ↓ ↓ ↓ ↓</p> <p>↓ ↓ ↓</p>                      | <p>↑ ↑ ↑ ↑ ↑ ↔</p> <p>↔ ↑ ↑</p> | <p>↓ ↓ ↓ ↓ ↓ ↓</p> <p>↓</p>       |
| Home Care | <p>↓ ↓ ↓ ↓ ↓ ↓ ↓</p> <p>↓ ↓ ↓ ↓ ↔ ↔</p> <p>↓ ↓ ↓ ↓</p> | <p>↑ ↑ ↑ ↑ ↔ ↑</p> <p>↑</p>     | <p>↓ ↓ ↓ ↓ ↓ ↓</p> <p>↔ ↔ ↓ ↓</p> |
| Telemon   | <p>↓ ↓ ↓ ↓ ↓ ↓ ↓</p> <p>↓ ↓ ↓</p>                      | <p>↑ ↑ ↔ ↔</p>                  | <p>↓ ↓ ↓ ↓</p>                    |

# Stages of Heart Failure



# Heart Failure Management

- Broad approach patient-focused, involve family and MTD with awareness of wider determinants health.
- Clinical assessment/optimisation treatment
- Non-pharmacological interventions





# Non-pharmacological Management

- Heart failure education/counseling
- symptom recognition/reporting



**1. Weigh yourself everyday**



**2. Check for swelling everyday**



**3. Be aware of changes in your breathing**

# Non-pharmacological Management

Cont...

- Adherence to treatment-medications
- Diet/nutrition (low salt) & fluids
- Lifestyle modification, alcohol, drugs, smoking
- Exercise
- Immunization
- Family participation



# Checking Medication!

**1 VENTOLIN In 100mcg/dose CFC Fr**

Shake well and inhale TWO puffs in the  
rectum for asthma.

***1 Repeat before 10 Sept 07***

ONLY MEDICINE

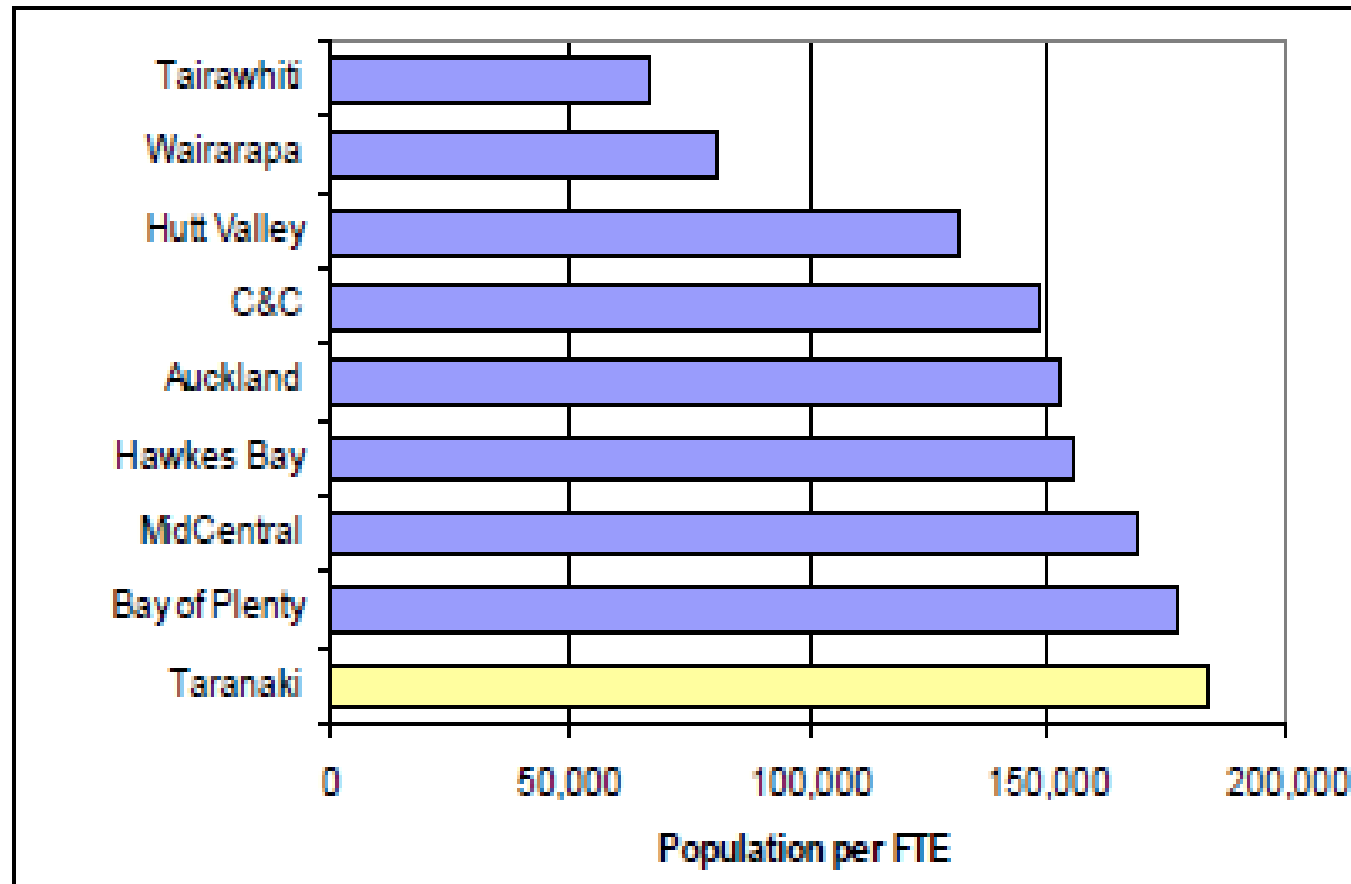
SmithKline

# Heart Failure NP Taranaki

- 0.6 FTE
- 2011-2012 New 144 FU 828 – reduced ++ due stricter admission/discharge criteria
- New Plymouth 72%, Hawera Hospital 18% Waitara 10%, home visits 2%
- Was also seeing general cardiology patients SouthCare – but 79% heart failure

# Data from Taranaki Cardiology review

Figure 63: Heart Failure nursing services – FTE per population



*Note: Hawkes Bay and MidCentral included extra FTE approved (both have 1.0 FTE in total)*

# Referral Criteria

Class III – IV (NYHA) Heart Failure.

- Significant Heart Failure
- Elderly
- Multiple co-morbidities
- Frequent flyers
- Maori
- Low socioeconomic status
- Living in isolation
- Care affected due to educational deficits/compliance issues.



# Discharge Criteria

- Cardiac work-up completed
- Medication optimised
- Clinically stable
- non-pharmacological aspects addressed as best as possible

# Primary/Community Health Care

- Needed at all stages: prevention to palliative
- Integration primary/secondary/community service variable - room for improvement
- Some Practice Nurses/Rest home nurses wanting to be involved but barriers due to lack of time, no allocated resource for heart failure and few training opportunities
- Frequent follow up (6-7 visits) often required – costs to patient?

# HF Nursing in Midland Region

- 9 (?) CHF Nurse Specialists  
Waikato, Tauranga,  
Whakatane, Tairawhiti, Lakes
- Cardiac Nurse Practitioner  
Tauranga & Taranaki
- Chronic Disease NP Tokoroa
- NP + intern Elderly care Waikato
- Community Services NP, Taupo
- Disease State Management Nurses Taranaki (4?)





# Waikato Integrated HF Service

- Established 2009 to improve detection, diagnosis, treatment and management of HF and increase access to specialist services.
- Referral Criteria
  - Possible heart failure and/or at high risk for heart failure
  - CHF readmission within 3 months
  - significant co-morbidities affecting optimisation of treatment
  - “Shared care” for end stage/palliative care
  - **Exclusion:**
  - Lack of consent from patient
  - Acute coronary syndrome
  - Patients already under cardiologist, unless referred by them

# WIHFS

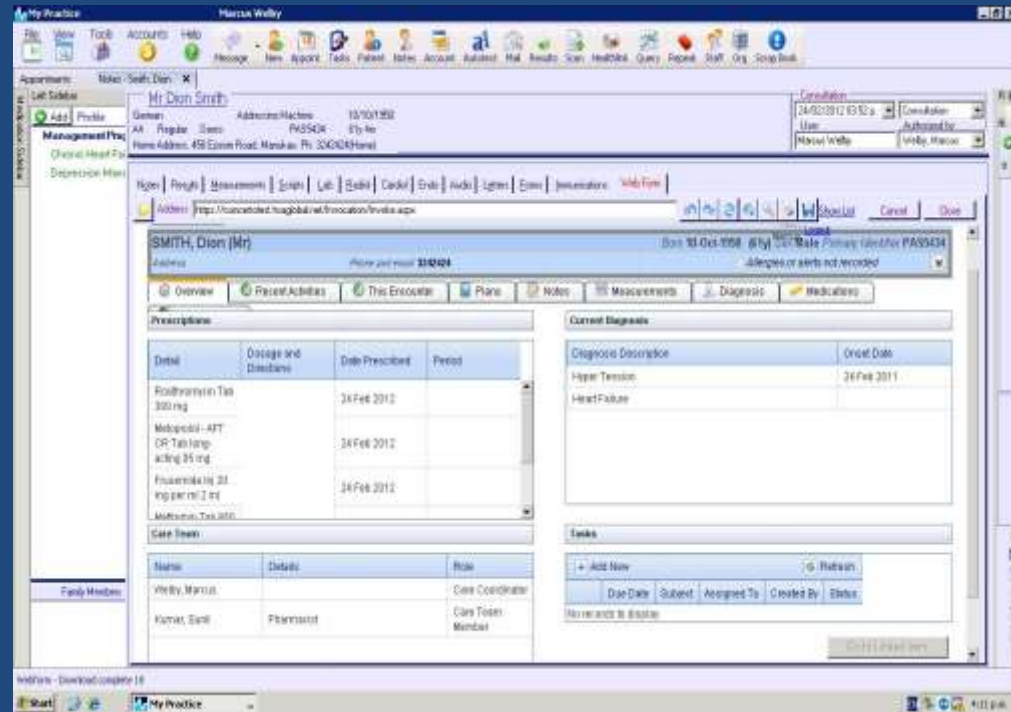
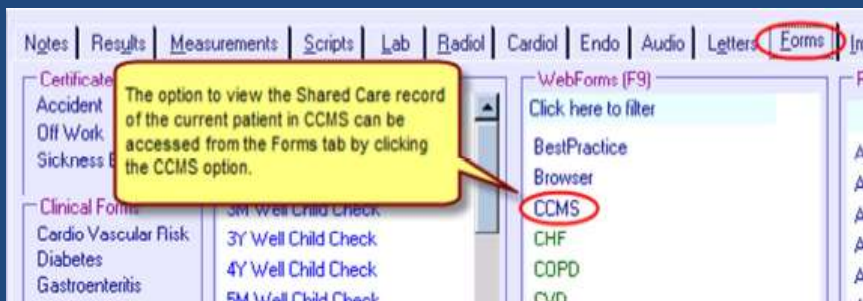
- HF CNS cover area from Bombay, Raglan Coromandel, Hamilton, Te Kuiti, Tauramanui, Tokoroa.
- Community-based: satellite hospital clinic, home, +/- GP clinic
- Echo tech, Cardiologist/registrar clinics
  - mthly Te Kuiti 1-2 mthly Tokoroa
- No charge to patient

# National Shared Care Programme –Auckland DHB

- Key Principles
- Patient-centred care planning (PCCP)
- Electronic, available 24/7 to healthcare team
- Sharing of health information- improve communication across Primary/Secondary health providers
- Patients with LTC benefit from PCCP developed in partnership with care team, improves co-ordination of care/communication
- Potential to reduce incidents & improve quality of care
- Patient access to own record-increased independence/ sense of control, convenient, virtual consults

# Health System IT Integration for Shared Care

- ❖ Collaborative Care Management System – CCMS
- ❖ Web-based software, integrates across health system IT
- ❖ Contains summary medical record information and a shared care plan
- ❖ GP access to CCMS via their practice management system



# Overview Screen

COOL, Mamma (Miss)

Born 11-Nov-1983 (28y) Sex Female Primary Identifier GZQ1631

Address 11 Mt Eden Road, Mt Eden, Auckland Phone and email

Known allergies or alerts

Overview Recent Activities This Encounter Plans Notes Measurements Diagnosis Medications Assessments

## Prescriptions

| Detail  | Dosage and Directions | Date Prescribed | Period |
|---|-----------------------|-----------------|--------|
| Inhibace (cilazapril 500 microgram) tablet: film-coated, 1 tablet | See review date below | 27 Jan 2012     |        |
| glibenclamide 5 mg tablet   | 5 Daily               | 30 Dec 2011     |        |
| Pizacord (pioglitazone (as  |                       |                 |        |

## Care Team

| Name               | Details   | Role             |
|--------------------|---|------------------|
| Four, Train        |   | Care Coordinat   |
| Hefford, Neil      | GP   Grey Lynn Family Medical Centre              | Care Coordinat   |
| Corringham, Salona | Occupational Therapist   Wellsford Medical Centre | Care Team Member |
| Skipper, Coral     | Nurse Specialist   Diabetes Service   WDHB        | Care Team Member |

## Current Diagnosis

| Diagnosis Description             | Onset Date |
|-----------------------------------|------------|
| (5744.) Myocardial perfusion scan |            |
| (R082.) Retention of urine        |            |
| (G311.) Unstable angina           |            |
| (K08..) Impaired renal function   |            |
| (F372.) Diabetic neuropathy       |            |
| (C109.) Type 2 diabetes           |            |

## Tasks

| + Add New Refresh |             |                      |                      |                    |            |
|-------------------|-------------|----------------------|----------------------|--------------------|------------|
|                   | Due Date    | Subject              | Assigned To          | Created By         | Status     |
|                   |             | Nutrition assessment | Rossellini, Rio      | One, Train         | Reassigned |
|                   |             | Phyisio              | Collinge, Pam        | One, Train         | Reassigned |
|                   |             | Health plan          | Corringham, Salona   | Corringham, Salona | Open       |
|                   |             | take BP              | Curlew, Andrea       | Curlew, Andrea     | Open       |
|                   | 14 Dec 2011 | Mama needs INR       | Appanna, Sivaprakash | Kaa, Beryl         | Reassigned |

Change page: < < < Prev Next > > > Page 1 of 3, items 1 to 5 of 11.

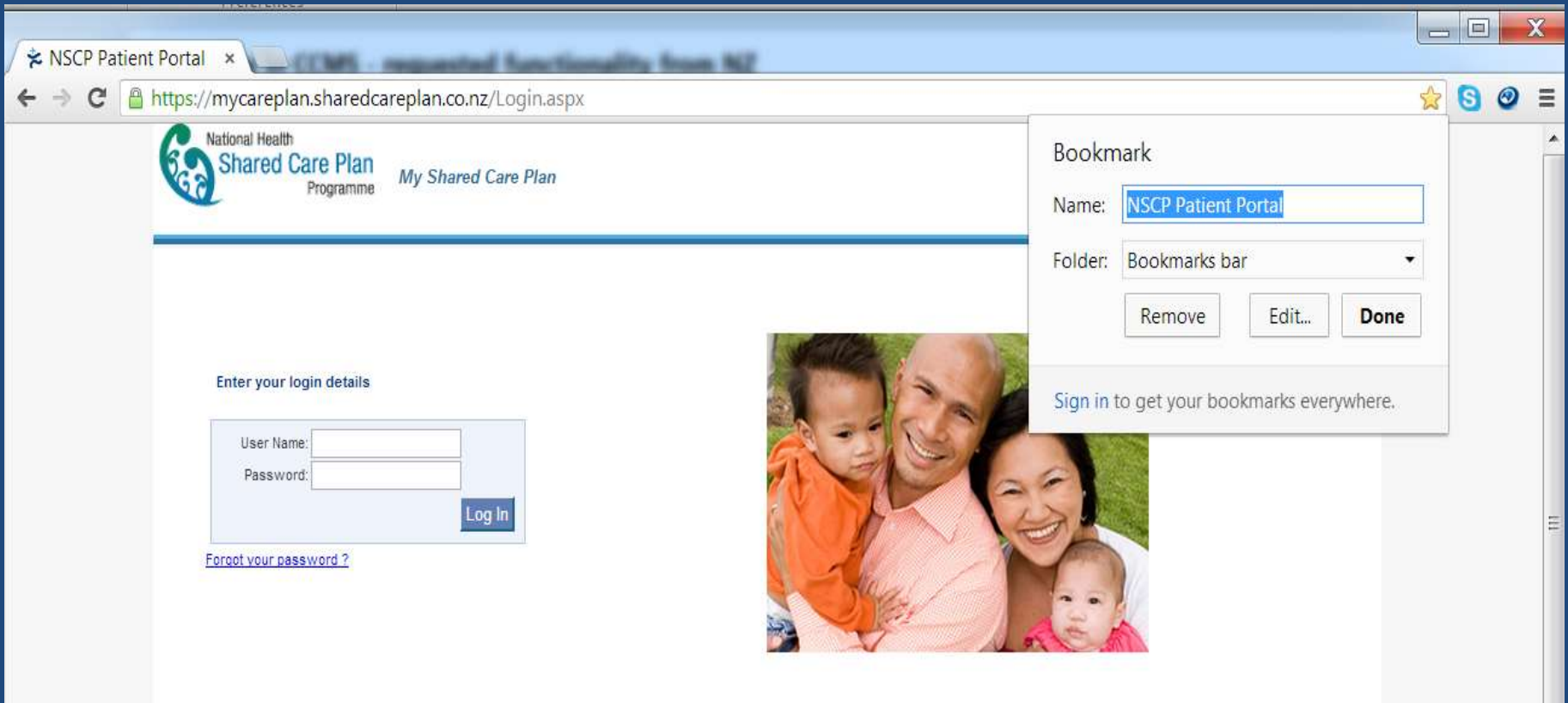
To deliver outstanding shared services that enable healthcare excellence for the Northern Region's population.

# Care Plan

| Name  | <input type="button" value="Add New"/> | Notes   | Who is responsible   | Due Date    | Complete                 |  |
|---|--|---|----------------------|-------------|--------------------------|--|
| .: My Goal(s)   |  | I want to be able to keep gardening twice a week  | Ball, Soft (GYG9995) |             | <input type="checkbox"/> |  |
| .: Main Priorities  |  | be able to remain in my own home  |                      |             | <input type="checkbox"/> |  |
| .: About Me   |  | I have poor hearing, please don't leave phone messages. Emails work well. My daughter Carol can be contacted 24/7 |                      |             | <input type="checkbox"/> |  |
| .: My early warning signs and action plan                       |  | I would like more information about my prognosis and what to watch out for  | Rea, Harry           | 05 Feb 2013 | <input type="checkbox"/> |  |
| .: My Medicines and Treatments                                  |  |   |                      |             | <input type="checkbox"/> |  |
| <b>goal/action:</b> to understand more about all my medications |  | medication review with pharmacist   | Bycroft, Janine      | 22 Feb 2013 | <input type="checkbox"/> |  |
| .: My Health Targets  |  | We will work to get my HbA1C down from 85 to 65   |                      |             | <input type="checkbox"/> |  |
| <b>goal/action:</b> to haev smaller, more regular meals         |  | The dietitian is helping me work on portion sizes   |                      |             | <input type="checkbox"/> |  |
| .: Things I will work on  |  |   |                      |             | <input type="checkbox"/> |  |
| <b>goal/action:</b> I will start walking for 5 minutes 2x day   |  | My daughter will help me on Monday and Wed  |                      |             | <input type="checkbox"/> |  |

To deliver outstanding shared services that enable healthcare excellence for the Northern Region's population.

# Patient portal



The screenshot shows a web browser window displaying the NSCP Patient Portal login page. The browser's address bar shows the URL <https://mycareplan.sharedcareplan.co.nz/Login.aspx>. The page header includes the logo for the National Health Shared Care Plan Programme and the text "My Shared Care Plan".

The main content area features a login form with the heading "Enter your login details". The form contains two input fields: "User Name:" and "Password:". A "Log In" button is positioned to the right of the password field. Below the form is a link that says "Forgot your password?".

To the right of the login form is a photograph of a smiling family consisting of a man, a woman, and two children.

A "Bookmark" dialog box is open over the right side of the page. It contains the following information:

- Name: NSCP Patient Portal
- Folder: Bookmarks bar
- Buttons: Remove, Edit..., Done
- Text: Sign in to get your bookmarks everywhere.

To deliver outstanding shared services that enable healthcare excellence for the Northern Region's population.

# Middlemore Hospital

- Cardiac Failure NP clinics in hospital
- Clinics at large South Auckland GP practice with Practice Nurses and GP.
- No charge to patient



# Midlands Cardiac Network

- Heart failure work stream
- Putting a 10 year plan for management of Heart failure across the region
- What do we have now?
- How will services be delivered and evolve?
- Where are gaps, what are barriers, what can be improved?

# Regional plan for CHF

- Increase training opportunities for Practice Nurses
- Increase nurse resource for HF in GP practice
- Increased communication between sectors
- Access to specialist resource?
- Increase diagnostics?
- Funding for patients? - optimising treatment frequent visits ongoing fu could be costly but ultimately cheaper?

# Midlands Regional Cardiac Network

- Raewyn Fisher, Waikato DHB,
- Ian Ternouth and Brigitte Lindsay, Taranaki.
- Need input from all.

- Suggest email group for region?

[Brigitte.lindsay@tdhb.org.nz](mailto:Brigitte.lindsay@tdhb.org.nz)