Heart Failure in Midlands Region

Primary Health Care Nurse Leaders Forum

30 May 2014

Brigitte Lindsay

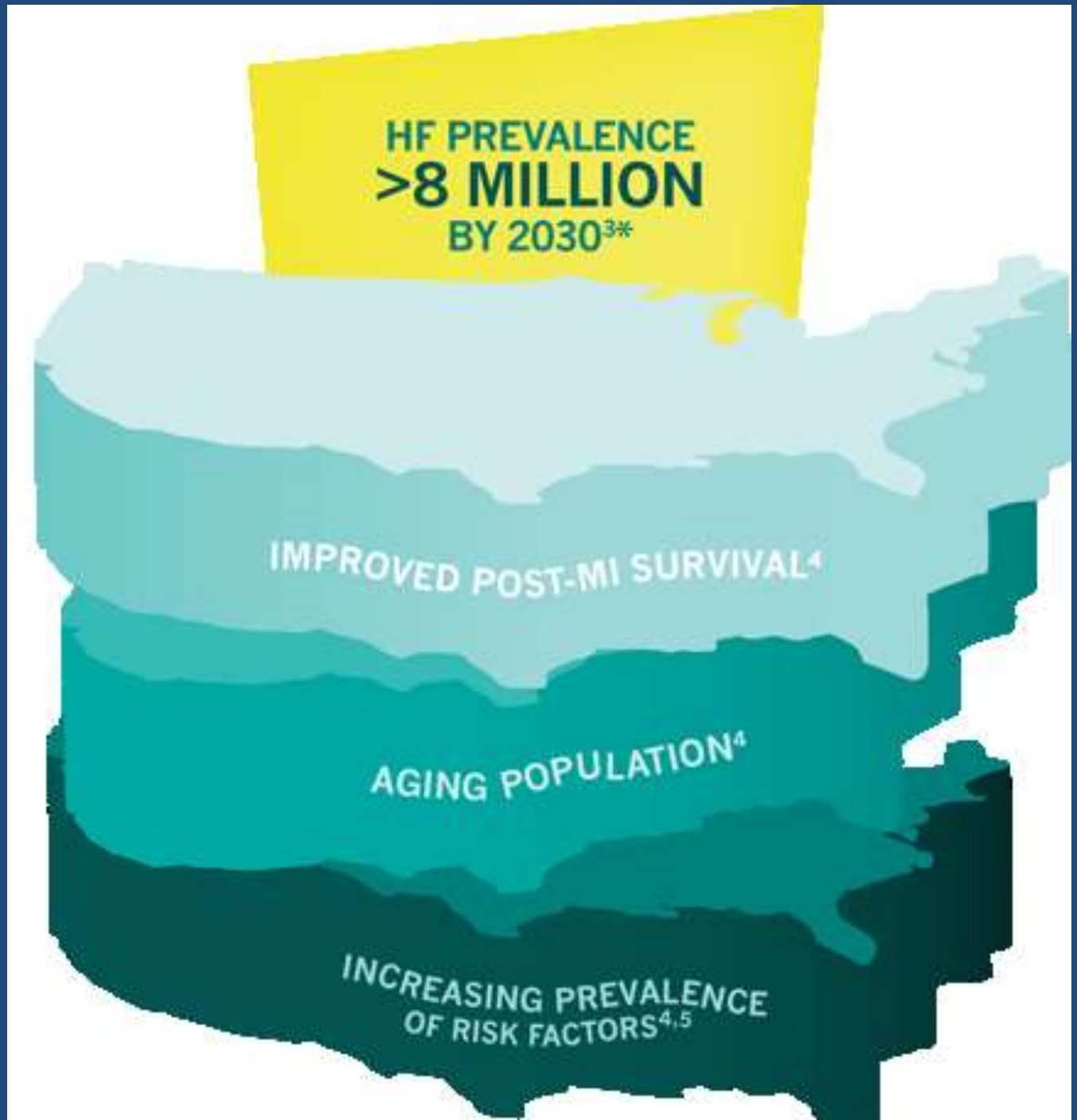
Cardiac Nurse Practitioner Taranaki

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[3*]
IMPROVED POST-MI SURVIVAL[4]
AGING POPULATION[4]
INCREASING PREVALENCE
OF RISK FACTORS[4,5]

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

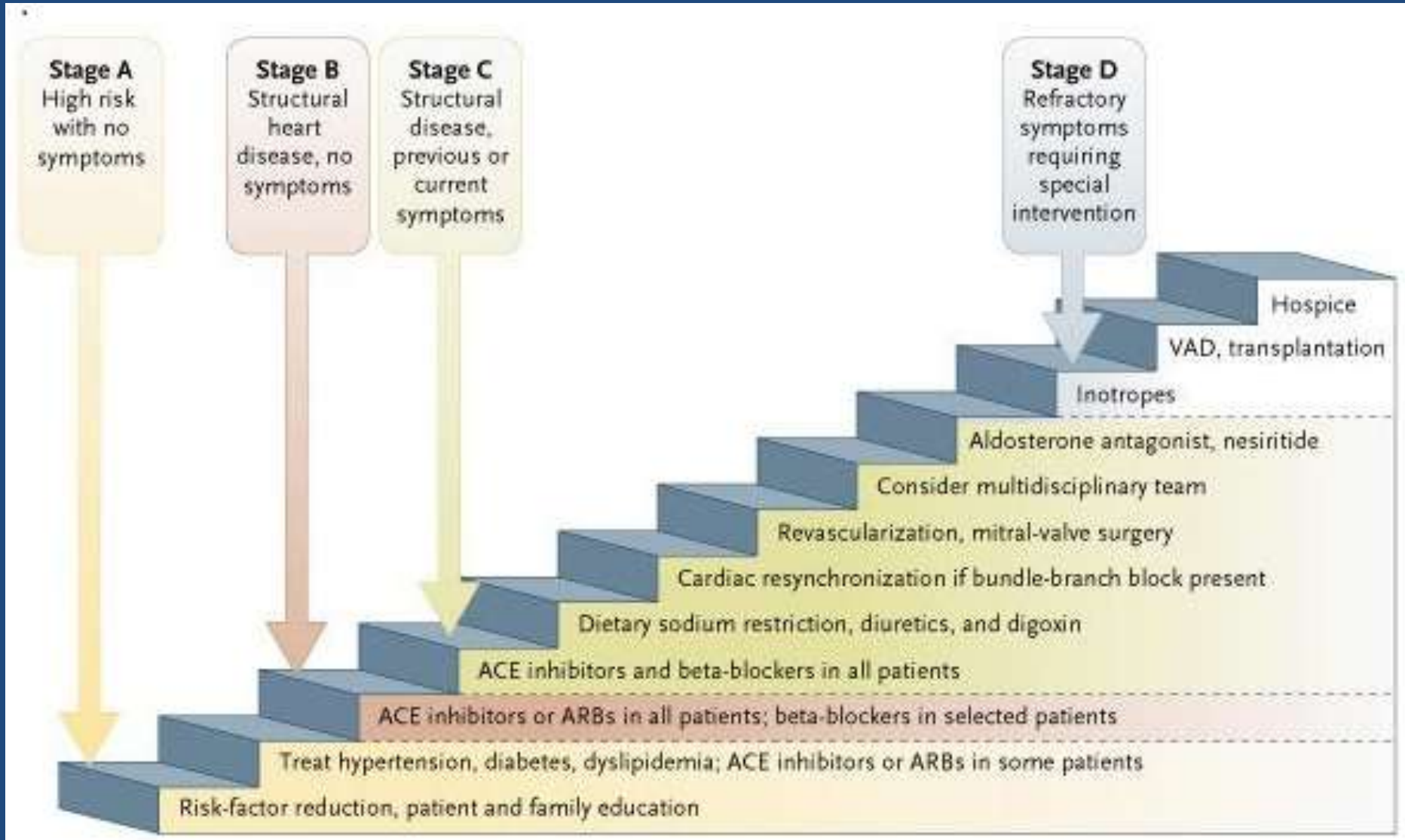
Clinical Practice Points

- ……
- **……**
- **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	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	↑ ↑ ↑ ↑ ↑ ↔ ↔ ↑ ↑	↓ ↓ ↓ ↓ ↓ ↓ ↓
Home Care	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↔ ↔ ↓ ↓ ↓ ↓	↑ ↑ ↑ ↑ ↔ ↑ ↑	↓ ↓ ↓ ↓ ↓ ↓ ↔ ↔ ↓ ↓
Telemon	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	↑ ↑ ↔ ↔	↓ ↓ ↓ ↓

Stages of Heart Failure

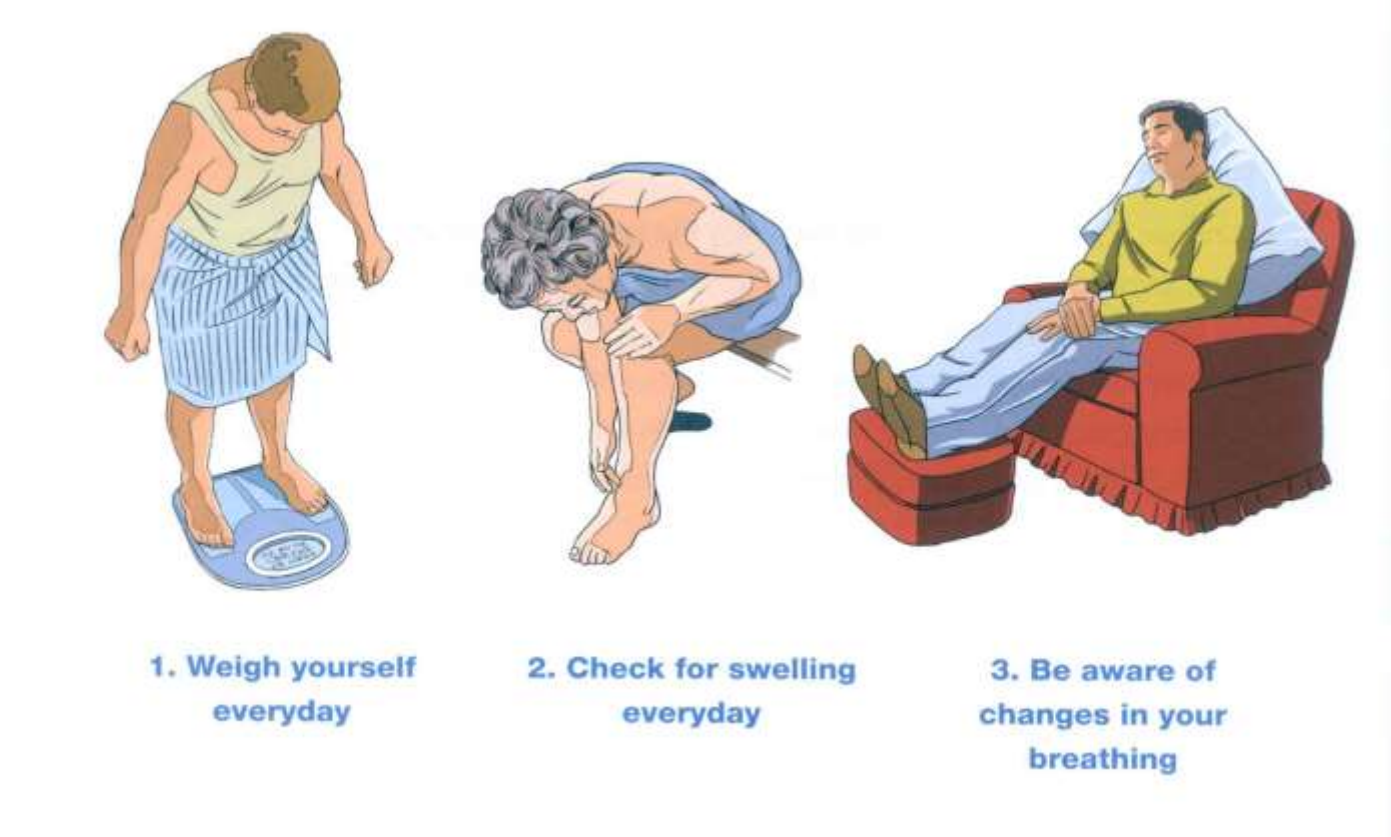


Heart Failure Management

- 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

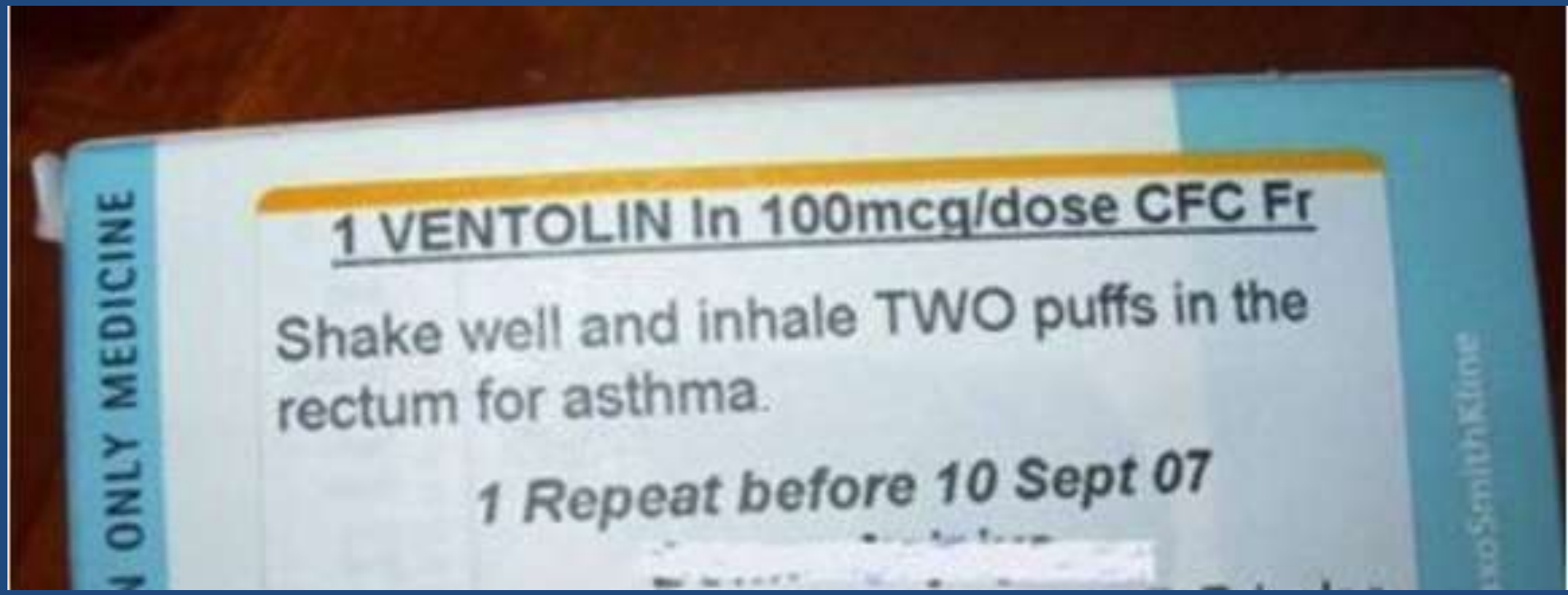


Non-pharmacological Management

Cont…

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

Checking Medication!

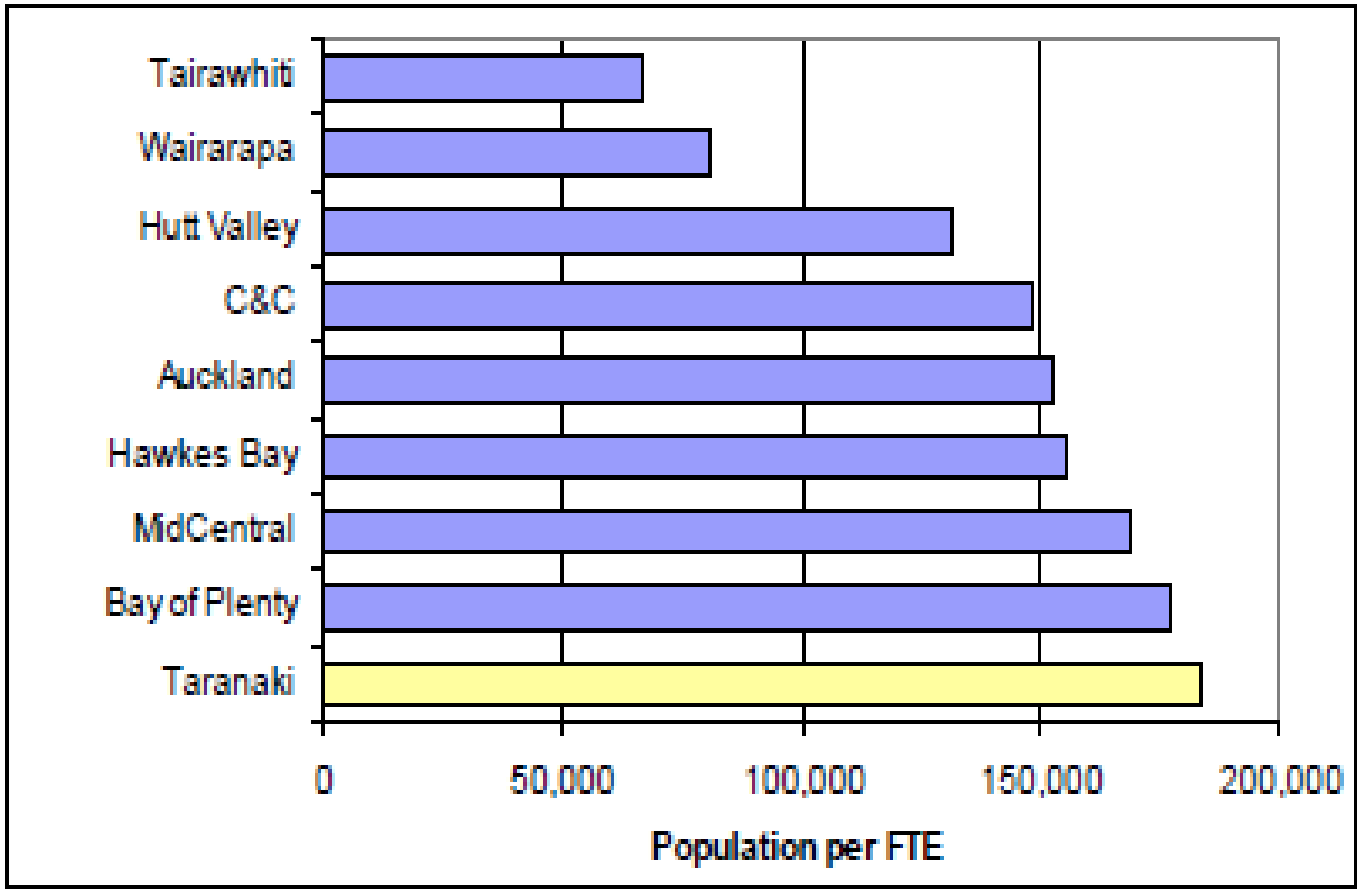


Heart Failure NP Taranaki

- 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

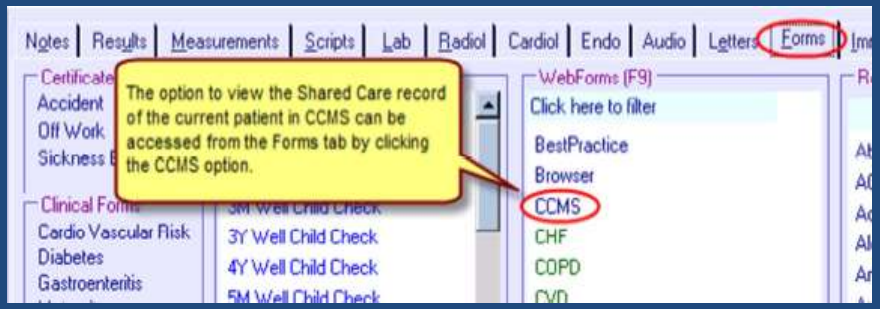
National Shared Care Programme –Auckland DHB

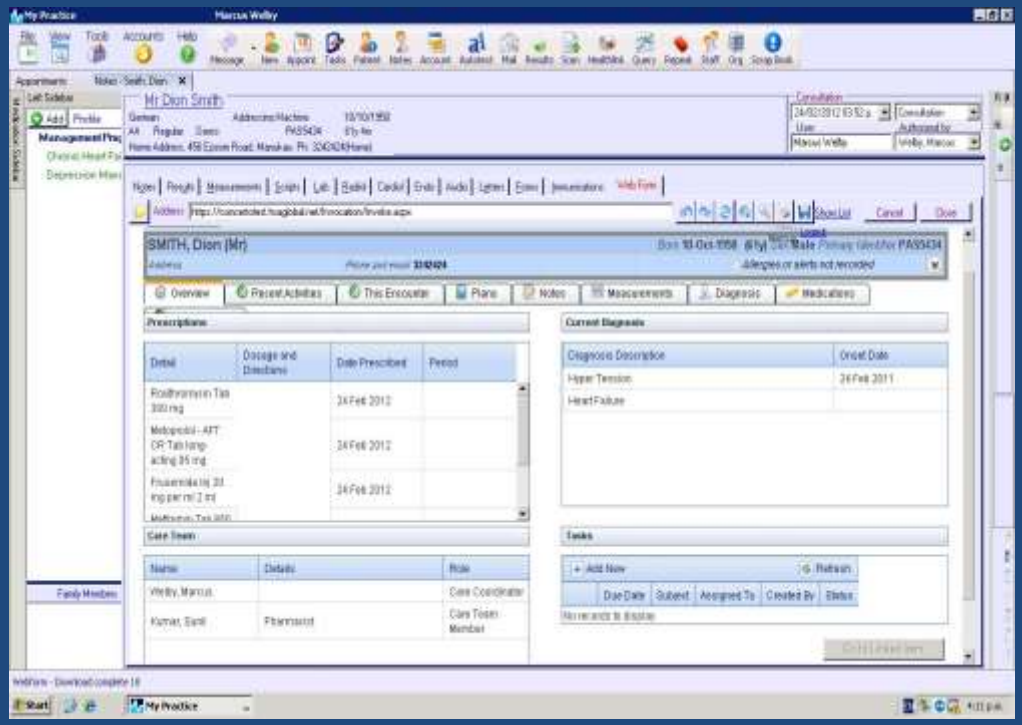
- Key Principles
- Patient-centred care planning (PCCP)
- Electronic, available 24/7 to healthcare team
- Sharing of health information- improve communication across Primary/Secondary health providers
- Patients with LTC benefit from PCCP developed in partnership with care team, improves co-ordination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

(Slides NSCP courteous of H. Mc Grinder ADHB)

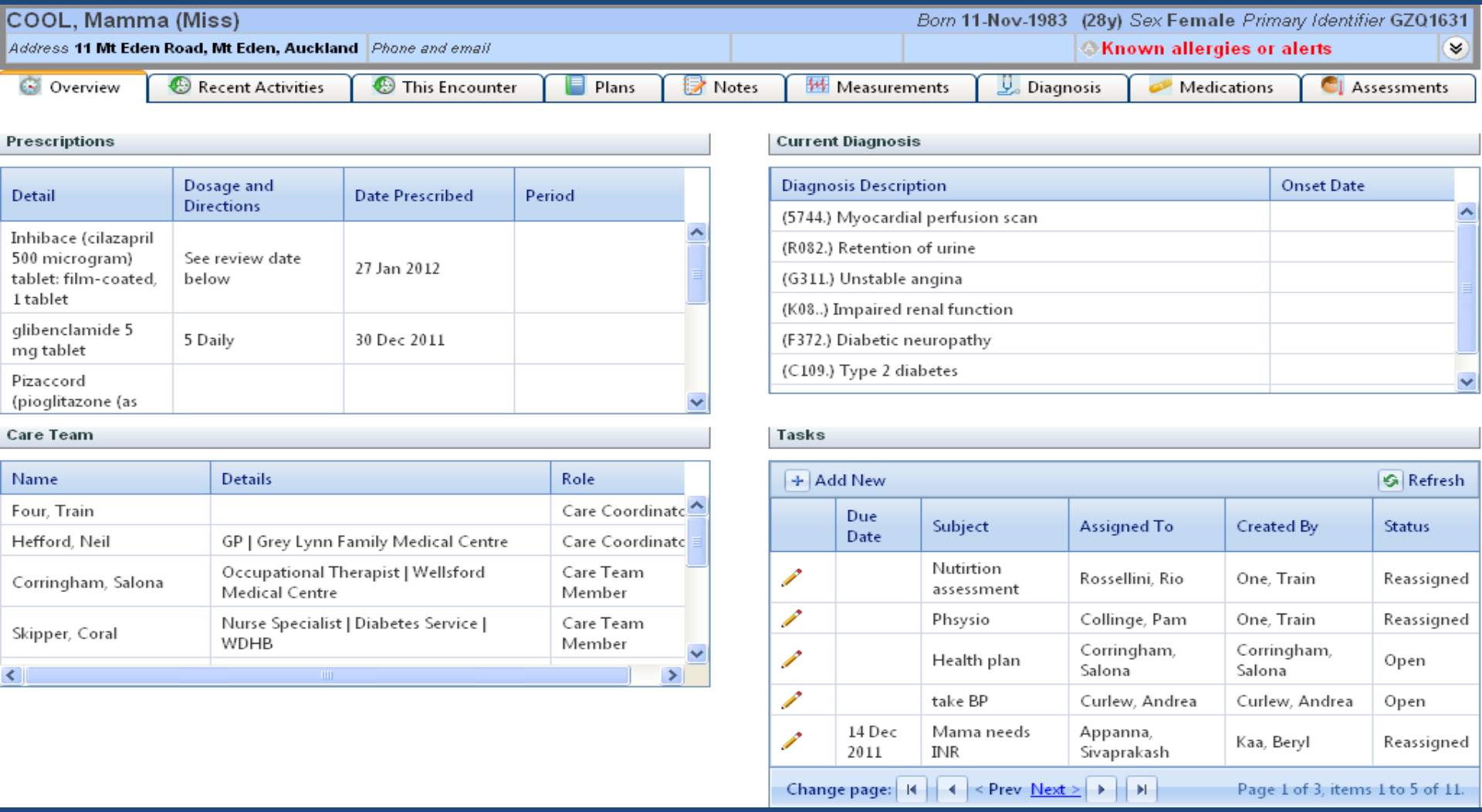
Health System IT Integration for Shared Care

- 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



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

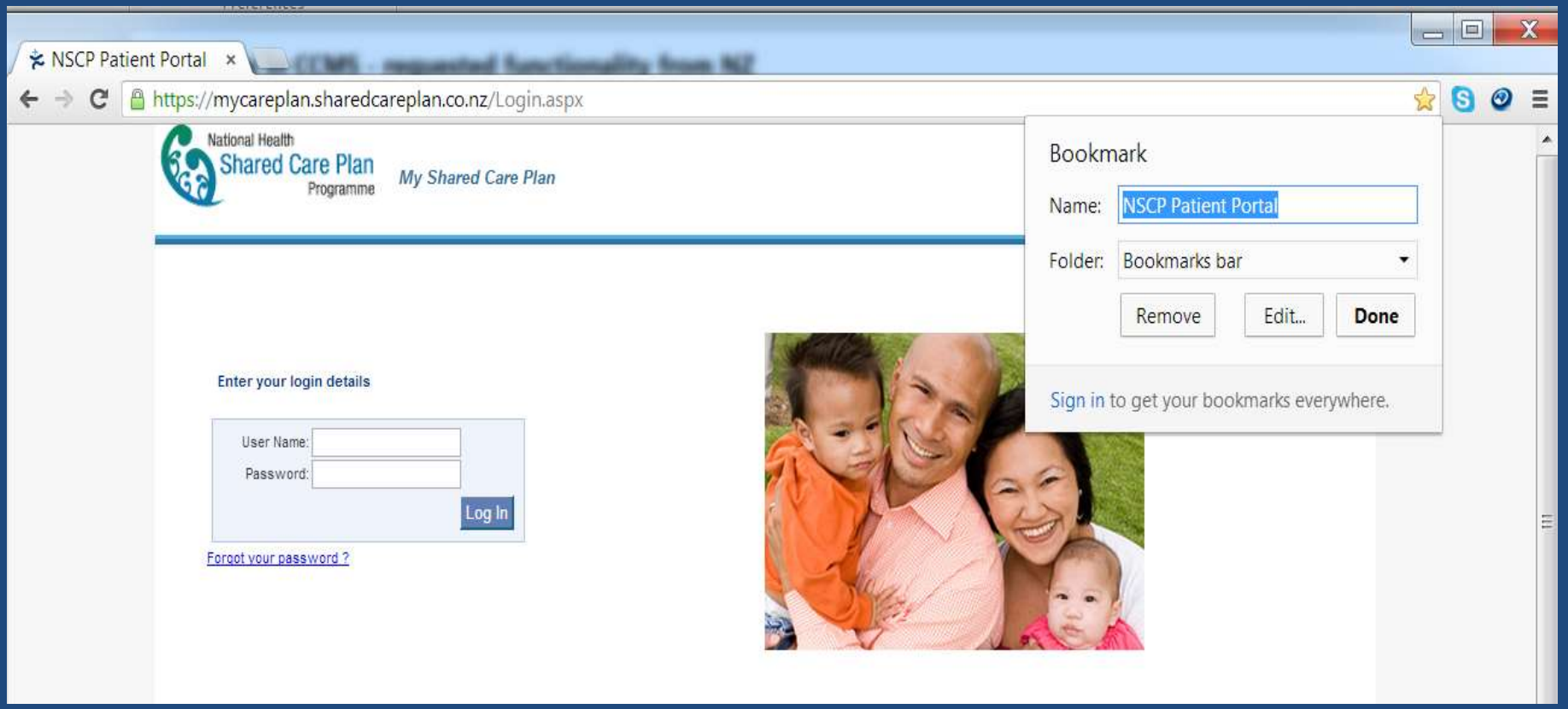
Care Plan

Name	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)			
.: Main Priorities		be able to remain in my own home				
.: About Me		I have poor hearing, please don't leave phone messages. Emails work well. My daughter Carol can be contacted 24/7				
.: 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		
.: My Medicines and Treatments						
goal/action: to understand more about all my medications		medication review with pharmacist	Bycroft, Janine	22 Feb 2013		
.: My Health Targets		We will work to get my HbA1C down from 85 to 65				
goal/action: to haev smaller, more regular meals		The dietitian is helping me work on portion sizes				
.: Things I will work on						
goal/action: I will start walking for 5 minutes 2x day		My daughter will help me on Monday and Wed				

1 2 Page size: 10

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

Patient portal



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