



The Heart Failure Policy Network

Continuity and coordination of care

HFPN contribution to Health Policy Platform Thematic Network – Profiling and training the health care workers of the future

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The Heart Failure Policy Network

The goal of the Heart Failure Policy Network is to raise awareness of the unmet needs surrounding heart failure (HF) and its care. The Network is an independent, multidisciplinary group of healthcare professionals, patient advocacy groups, policymakers and other stakeholders from across Europe. All members donate their time for free. All Network content is non-promotional and non-commercial.



Heart failure in Europe: key messages

The burden of HF is significant and growing:

- HF affects at least 15 million people in Europe
- 1 in 5 people can expect to develop HF at some point in their life
- HF is the leading cause of unplanned hospital readmissions
- Hospital admissions due to HF are projected to rise by 50% over the next 25 years
- HF imposes a heavy physical and psychological burden.

Virtually all progressive models of care in HF involve **multidisciplinary care, clinical delegation** and expansion of **specialist roles**. There is often a strong local case for **telehealth** and remote solutions.



ESC (2016) guidelines for HF clearly state the need for multidisciplinary management programmes.

Although prognosis is poor, the right package of care can reduce hospitalisation, and can improve survival and quality of life, benefiting both patients and healthcare systems.



About *The handbook of multidisciplinary and integrated heart failure care*

The handbook of multidisciplinary and integrated heart failure care:

- explains why multidisciplinary and integrated care are essential to providing optimal HF care
- presents a comprehensive summary of evidence of effectiveness/value proposition
- describes current 'state of play' in Europe in terms of performance and barriers
- identifies five key areas where care typically fails patients
- demonstrates a clear progressive consensus for change.

This resource is helping advocates to win the support of key decision makers, and ensure more consistent implementation of best practice.



The handbook of multidisciplinary and integrated heart failure care



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Call to action and endorsements

We call on governments to recognise HF as an urgent sustainability challenge for 21st-century healthcare systems. Governments across Europe must:

- have a formal strategy on HF
- invest in sustainable, specialist HF care models outside of acute care
- ensure national guidelines and local care pathways guide routine delivery
- prepare robust and public national audits of performance.

We call on governments to demonstrate measurable improvement for the following minimum standards and core indicators of quality for all HF patients:

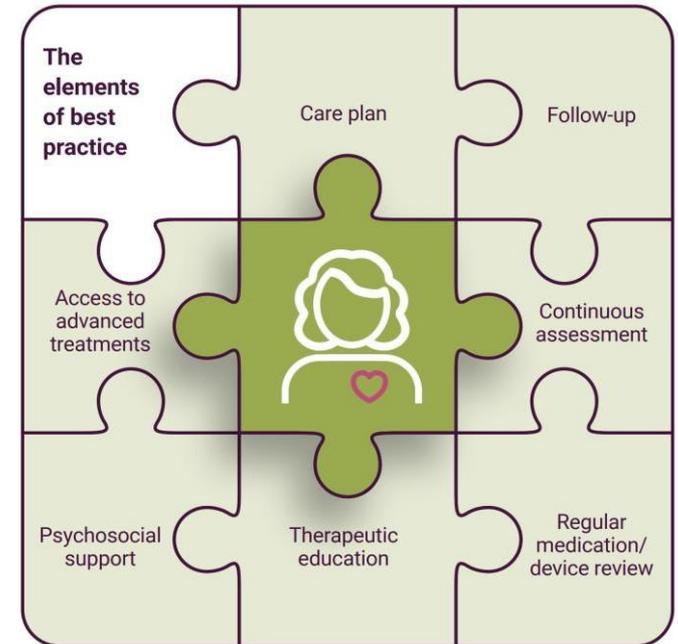
- Specialist-led diagnosis
- Access to natriuretic peptide testing
- Specialist-led care in hospital
- Hospital discharge with a care plan
- Cardiac rehabilitation, patient therapeutic education and psychological support
- A shift in management of HF from the acute to primary care setting.



What is multidisciplinary and integrated care?

Multidisciplinary and integrated care is about delivering the best care possible.

- It focuses on the needs of the individual patient at each stage.
- It supports and empowers patients, their carers and families.
- It requires collaboration and mix of specialisms.



Leading multidisciplinary models achieve up to 30% reduction in hospitalisations. But in reality, major gaps remain. For example, up to 70% of patients experience an unintentional change in their medication during major transitions of care.

Who is in the multidisciplinary care team?

The key roles include:

- cardiologists (ideally with a sub-specialty in HF)
- HF specialist nurses and primary care nurses
- primary care physicians (GPs)
- physiotherapists (and cardiac rehabilitation physiotherapists).

HF specialist nurses are a lynchpin of the HF multidisciplinary team in almost all progressive models.

However, depending on the patient and comorbidities, people living with HF may also need care provided by:

- pharmacists
- pneumologists
- nephrologists
- endocrinologists
- sleep apnoea specialists
- and others... depending on the patient and local systems



Involvement of specialists in HF care lower risk of mortality after hospital admission



Cardiac rehabilitation in HF reduces hospitalisations, improves QoL and survival

Why do we see significant gaps and poor outcomes?

There are significant barriers to best practice, including:

- resource constraints
- limited awareness of HF (among the general public and healthcare professionals)
- limited availability of HF clinics and specialists (especially HF nurses)
- lack of communication of best practice (i.e. guidelines) to wider healthcare professionals
- inadequate reimbursement and access to key components of care, such as cardiac rehabilitation and psychosocial support
- resistance to multidisciplinary working
- difficulties sharing patient data
- low scrutiny of comprehensive care.



Improving heart failure care via workforce transformation



Cultivating a multidisciplinary heart failure healthcare workforce

Known gaps and issues suggest all European countries should:

- **boost HF specialism** among nurses, GPs and allied health professionals
- **support generalists** to consistently understand key elements of best practice and recognise symptoms
- **equip HF specialists** with the necessary skills for future models of care
- **streamline and incentivise multidisciplinary working** at all levels of care.



Boosting heart failure specialism and supporting generalists

How can this be achieved?

- **Allow and incentivise formal accreditation** in HF centres of excellence, and for specialism among nurses and clinical pharmacists
- **Remove legal or other barriers to clinical delegation** – e.g. allowing nurse-led prescribing and titration of medicines, diuretics, or direct referral, or direct GP referrals to diagnostic procedures
- **Consider value of recognition of HF specialism** in other disciplines, such as primary care and internists
- **Formalise person-centred skillsets** around care /goal planning and self-management support, and involvement of carers.



Direct referral by GPs to echocardiography can safely reduce referrals to cardiologists by two-thirds.

A community-based nurse-led diuretics pilot in the UK saved £3k per patient and 1,000 bed days.

Equipping heart failure specialists with skills for future models of care

How can this be achieved?

- **Accredit and advance skillsets in person-centred care**, including patient-led care planning, self-care support, lifestyle/behavioural change techniques and psychosocial support
- **Support professionals to integrate remote and digital technologies**, and so perform routine monitoring at scale
- **Ensure professionals can process and respond to new sources of information**, such as biomarkers and in-vitro devices
- **Clarify accountability** in light of significant growth in data generation.



Telemonitoring programmes can reduce mortality and HF-related Hospitalisations.

A virtual real-time consultation service between GPs and cardiologists found that only 17% of patients needed to go to hospital for specialist review.

Streamlining and incentivising multidisciplinary working at all levels

How can this be achieved?

- **Align policy goals/commitments** to required workforce roles to match the HF population and its needs
- **Align workforce strategies with quality standards/aspirations** – such as disease management programmes and cardiac rehabilitation for HF
- **Promote national, regional and local partnerships** to develop care pathways and protocols, which define optimal workforce roles and actions at different stages
- **Address legal or organisational barriers** to data sharing and new referral patterns
- **Implement audits and evaluations** of patient pathways, to expose gaps and weaknesses and create joint accountability



The Irish Cardiac Society established a working group with GPs and specialists to improve HF diagnosis in the community.

The Spanish Society of Cardiology published accreditation standards for HF units.

Reflections from a case study

Nurse-led HF management programme in primary care (Barcelona, Spain)

Healthcare institutions in the Litoral Mar area in Spain and the Catalan Health Service developed a nurse-led multidisciplinary HF care model that integrated care and reduced the risk of readmission and death.

Adding a telemedicine component has further reduced hospital readmission, length of hospital stay at readmission and cost per patient.

This care model is being implemented and improved in South Metropolitan Barcelona with coordination from the Bellvitge University Hospital

Dr Josep Comín Colet, offering brief reflections on the organisational challenges of building the workforce for multidisciplinary teams



Key messages in summary

HF is a highly prevalent disease, posing structural challenges to the readiness of our healthcare systems.

In terms of the healthcare workforce, we must urgently anticipate:

- demand for specialist roles outstripping supply, unless we invest
- high potential of clinical delegation, in particular HF specialist nursing, to manage costs, meet demand and drive improvements at scale
- need for professionals to work in multidisciplinary teams and to integrate new technologies and protocols (e.g. use of biomarkers or telemedicine)
- formalisation of professional standards for person-centred models that respond to individual goals and motivations, to achieve better adherence, risk management and patient outcomes.

Governments should urgently move to audit and rectify:

- barriers to clinical delegation and rapid referral
- accreditation and recruitment of specialist nurses and other allied professionals
- professional training and recognition/competencies in chronic disease management strategies, and effective engagement in person-centred approaches.

Many thanks for listening

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