

POSTER ABSTRACT

Virtual Heart Failure Clinic - An Integrated Care Programme Support for General Practice

18th International Conference on Integrated Care, Utrecht, 23-25 May 2018

Orlaith Josephine O'Reilly

Health Service Executive, Ireland

Introduction: Heart Failure is a serious chronic disease affecting 2% of the population in Ireland, with high hospitalisation rates. National policy "Sláinte Care" directs that care in Ireland should be shifted to Primary Care. The Integrated Care Programme Model of Care addresses heart failure by improving diagnosis and enabling General Practitioners to manage patients in the community, with ready access to specialist medical support.

Virtual Clinics: A pilot project was set up in 2016 which enables General Practitioners to discuss their heart failure cases, which they would otherwise be referring to hospital, with the Heart Failure Specialist and with a GP group via video link. A Clinical Nurse Specialist helps General Practitioners to identify heart failure patients. Necessary diagnostic testing i.e. BNP testing and referring for echocardiography if appropriate is carried out using standard pathways. The other GPs participate in the discussion and avail of the learning opportunity.

Aim: The Clinic aims to build General Practitioners confidence in a diagnosis and management of heart failure.

Population and Stakeholders: Previous audits identify that heart failure is not well proactively managed in primary care in Ireland and in many cases are presenting episodically at acute care services. The stakeholders are the GPs with the community nurse specialists and the Heart Failure Specialist. The pilot study commenced at the end of 2016 and patients commenced to be seen in 2017.

Highlights: 72 virtual clinics held to date and 270 patients reviewed, coming from 50 General Practitioners.

80% of patients NOT referred on to hospital following the clinic which would have otherwise been referred.

30% of these were avoided admissions and 50% were avoided OPD appointments.

Knowledge transfer – 94% of GPs said they were now better able to manage heart failure.

76% of GPs said their confidence in diagnosis had improved.

14834 kms of travel avoided for patients.

Sustainability and Transferability: Clinicians in the area have received this new service well, and are eager to extend its coverage. The hospital service costs are being met ongoing and there are plans for expansion, as this is seen to be a cost saving initiative. Payments for General Practitioners for extension of this service are being considered under the new GP Contract nationally.

Conclusions and Discussion: Significant numbers of patients who were referred to the virtual clinical are not referred to specialist out patients and admitted which would otherwise be the case. Given long waiting times this is a clinical service improvement for patients and a cost saving measure. Qualitative results from GP interviews show promising increases in confidence by General Practitioners in managing heart failure in the community. The transferability of the service depends on adequate funding being made available in other areas and on heart failure specialist champions being prepared to develop this clinic with GP colleagues.

Lessons Learned: Innovative clinically led pilot programmes for integrating care are successful in improving clinical care for patients and can provide cost saving solutions.

Keywords: general practice support; chronic disease; heart failure; e technology virtual clinics; integration implementation
