
CONFERENCE ABSTRACT

A Nurse-led Integrated Chronic care E-enhanced Atrial Fibrillation (NICE-AF) clinic in the community: A preliminary evaluation and reflection

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Introduction: An ageing population, together with a greater awareness for atrial fibrillation (AF) screening, have increased the worldwide prevalence of AF. AF patients are known to have increased risk of heart failure and stroke, translating into greater mortality and lower quality of life. Current clinician-centric care based in tertiary hospitals may not be able to cope with this rising tide of AF. Much deliberation amongst health policymakers to move care of AF patients from acute settings to the community. The integrated care model together with the utilisation of Advanced Practice Nurses (APN) and technological tools, have been proposed as a possible solution.

Short description of practice change implemented: In Singapore, the government polyclinics provide subsidised primary health care, outpatient medical care, health screening and pharmacy services. In September 2018, a novel Nurse-led Integrated Chronic care E-enhanced Atrial Fibrillation (NICE-AF) clinic was implemented in one of the polyclinics. The NICE-AF clinic is led by an APN. She works in collaboration with a Family Physician and has tele-consultations with a Cardiologist from a tertiary hospital. Stable chronic AF patients are referred to this clinic. AF management is optimised through technological tools such as a computerised decision support tool and educational resources. The NICE-AF clinic also receives priority listing for radiological investigations in the tertiary hospital.

Aim and theory of change: Care for AF patients has conventionally been managed in hospitals' outpatient specialist clinics. Commonly, AF patients have other chronic comorbidities. Hence, the NICE-AF clinic serves to integrate chronic care management. The Chronic Care Model guides the design of the clinic. The aim of the implementation is to improve clinical and patient-reported outcomes.

Targeted population and stakeholders: Targeted population is patients living with AF. Stakeholders are policymakers, health administrators, physicians and advanced practice nurses.

Timeline: Two years.

Highlights: Preliminary findings has shown a great improvement in healthcare providers' adherence to AF management protocol with the use of the computerised decision support tool. Initially, patients were apprehensive about seeing an APN for their AF condition. However, patients' attendance for follow-up visits have been good and patients' level of acceptance with the APN improved with time.

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Comments on sustainability: Sustainability of the NICE-AF clinic requires the patients and stakeholders to experience and see the value it brings to care.

Comments on transferability: Great potential precursor to other clinics devised to optimise chronic disease management in the community.

Conclusions: Preliminary findings found greater adherence to AF management protocol and patient satisfaction. No significance change was observed in clinical outcomes, AF knowledge, and medication adherence.

Discussions: Despite the lack of improvement observed in most outcomes, the preliminary findings were heartening as it demonstrated that the NICE-AF clinic was not inferior to hospital outpatient services.

Lessons learned: Patients in Singapore are accustomed to physician-centric hospital-based specialist care. The role of integrated care in the community requires greater publicity. With more time and exposure to such models of care, patients' acceptance and trust will improve.