Interregional Heart Failure Network

Welcome

24/04/2025

Programme

- 13h – 13h10 : Welcome Karolien Baldewijns
- 13h10 – 13h30 : The Heart Failure patient pathway in Germany Franziska Otternbreit
- 13h30 – 13h40 : Discussion
- 13h40 – 14h : Challenges in multidisciplinary and transmural heart failure care in the Netherlands Marlies Niessing
- 14h – 14h10 : Disucssion
- 14h10 – 14u30 : Towards a heart failure care path in Belgium Miek Smeets
- 14h30 – 14h40 : discussion
- 14h40 – 15h : wrapping up and take home messages

Who are you?

Name

Organisation

Your Connection

With heart failure

A heart failure care path in Germany

Franziska Ottenbreit

KLINIKUM NÜRNBERG

The German Care Pathway

Franziska Ottenbreit, APN (M.Sc.) HF
Klinikum Nürnberg Süd

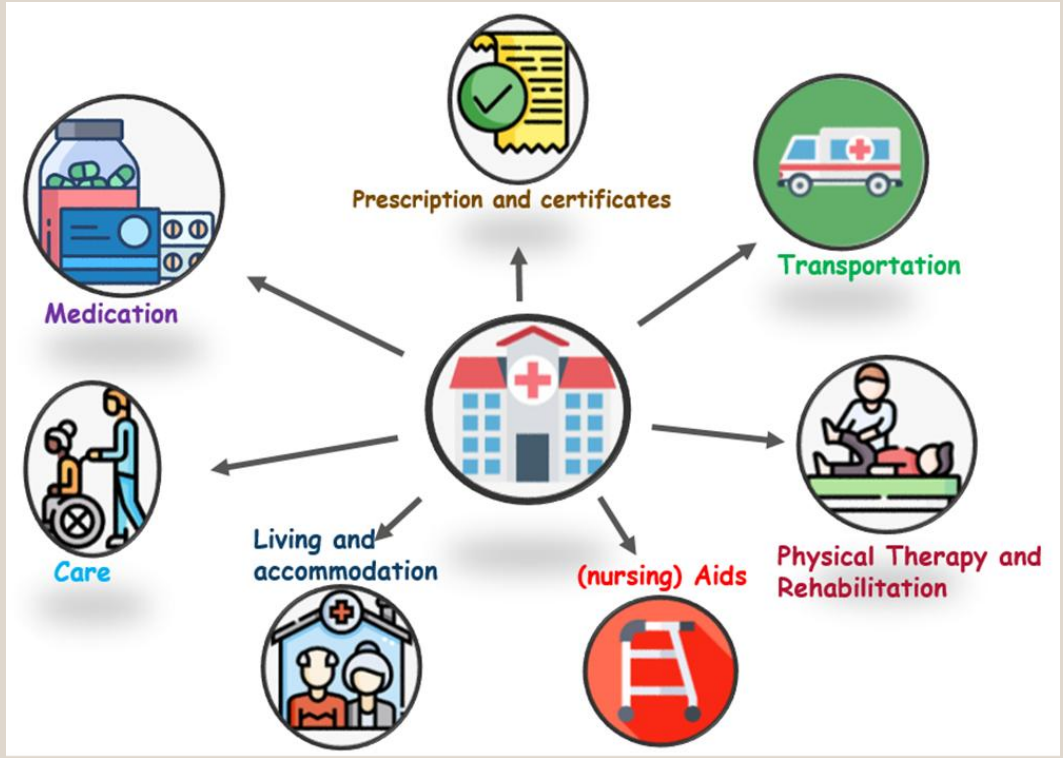
Usual Care vs. HF Care Pathway

PARACELSUS MEDIZINISCHE UNIVERSITÄT

From admission to discharge- Usual Care Pathway

Discharge Management in Germany

- **Defined within the Social Code Book V**
  - Frame contract
  - Obligation to offer Discharge Management
  - Pt. has to agree
- **Aim: securing trans- sectoral care**
- **Multidisciplinary approach**
  - Social service
  - Medical Assessment & therapy plan
  - Nursing Assessment, Care Plan and Evaluation
- **Expert Standard „Discharge Management“ in nursing**
  - Obligates Nurses to assess, plan, cooridnate and transfer information



From admission to discharge- Usual Care Pathway

Early planning:

Ideally, discharge planning should begin when the patient is admitted.

Determine needs:

The patient's post-discharge care needs are determined.

Plan care:

A plan for follow-up care is developed that takes into account the patient's individual needs.

Passing on information:

Information relevant to care is passed on to the continuing care providers.

Coordination:

Follow-up care is coordinated with the providers involved.

Support:

The patient and their relatives are supported in the organisation of follow-up care.

Discharge:

Doctors and nurses report gets passed to pt. So are receipts and prescriptions. Nursing aids and care is organised.

Transportation is organised.

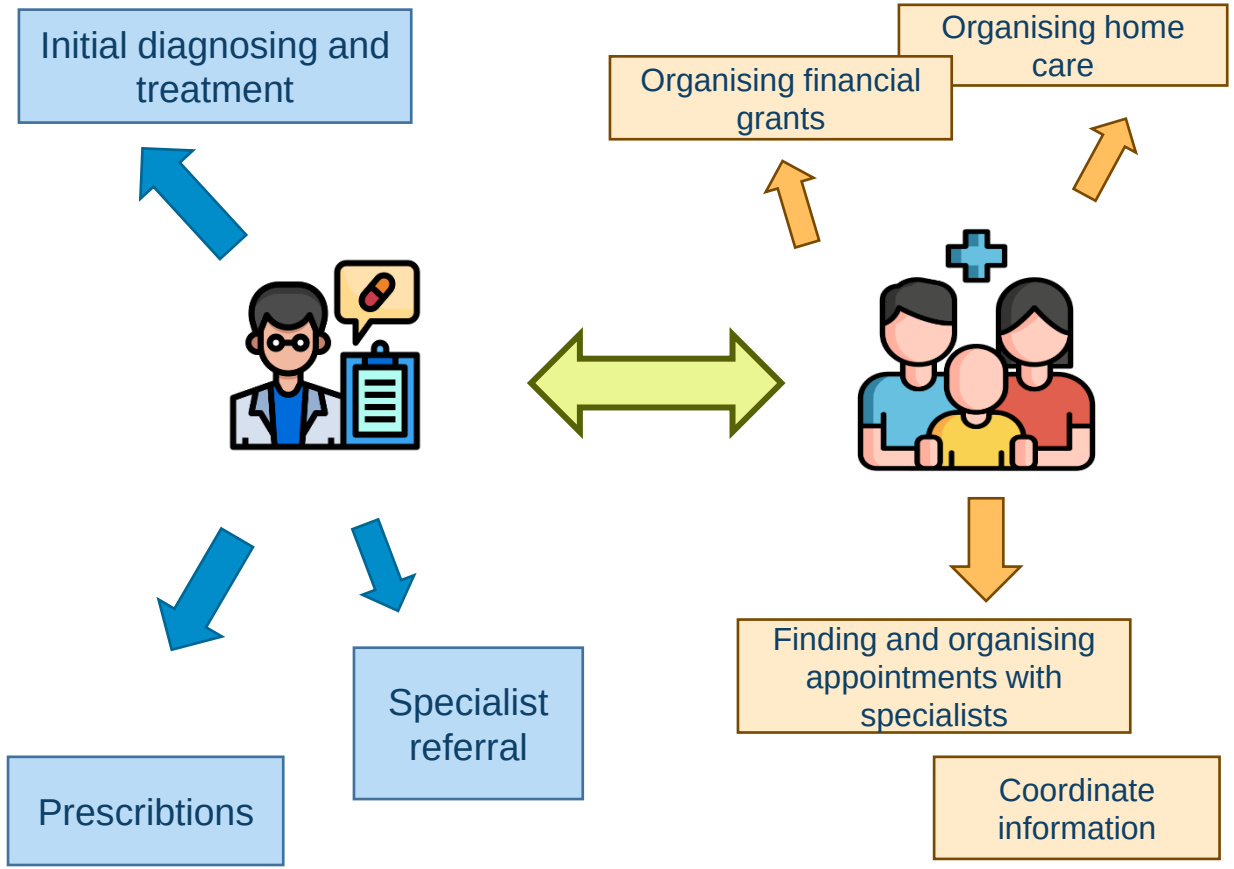
Family is informed.

Guideline appropriate treatment and diagnostics

From admission to discharge- Usual Care Pathway

By the point of leaving the hospital…

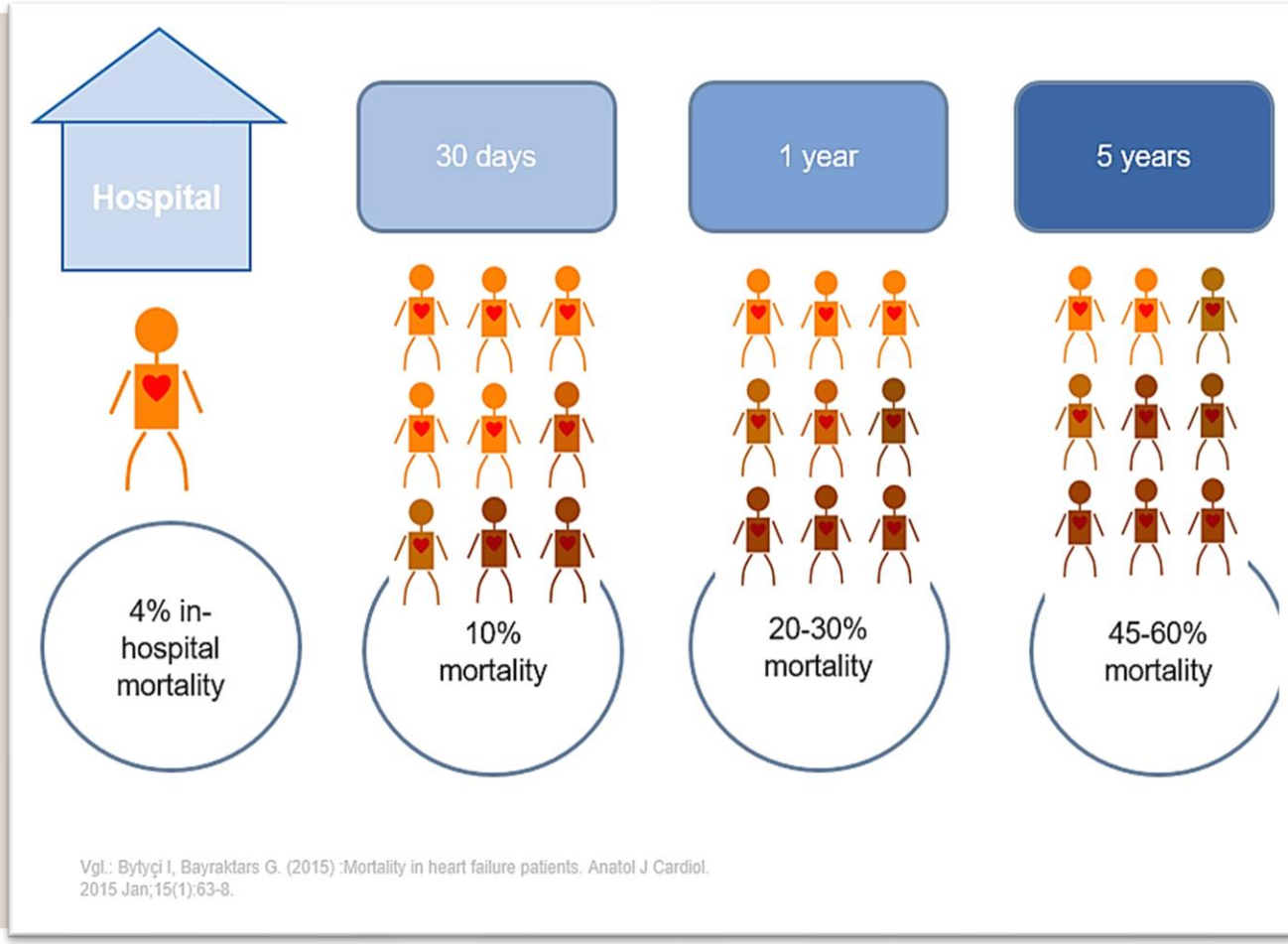
- Pt./Pt. Family has to organize care by themselves
- GP as main coordinator and prescriber
- Nursing advisory centres in every district
- If outpatient care is involved they report back to GP
- Apart from that, no mandatory interfaces



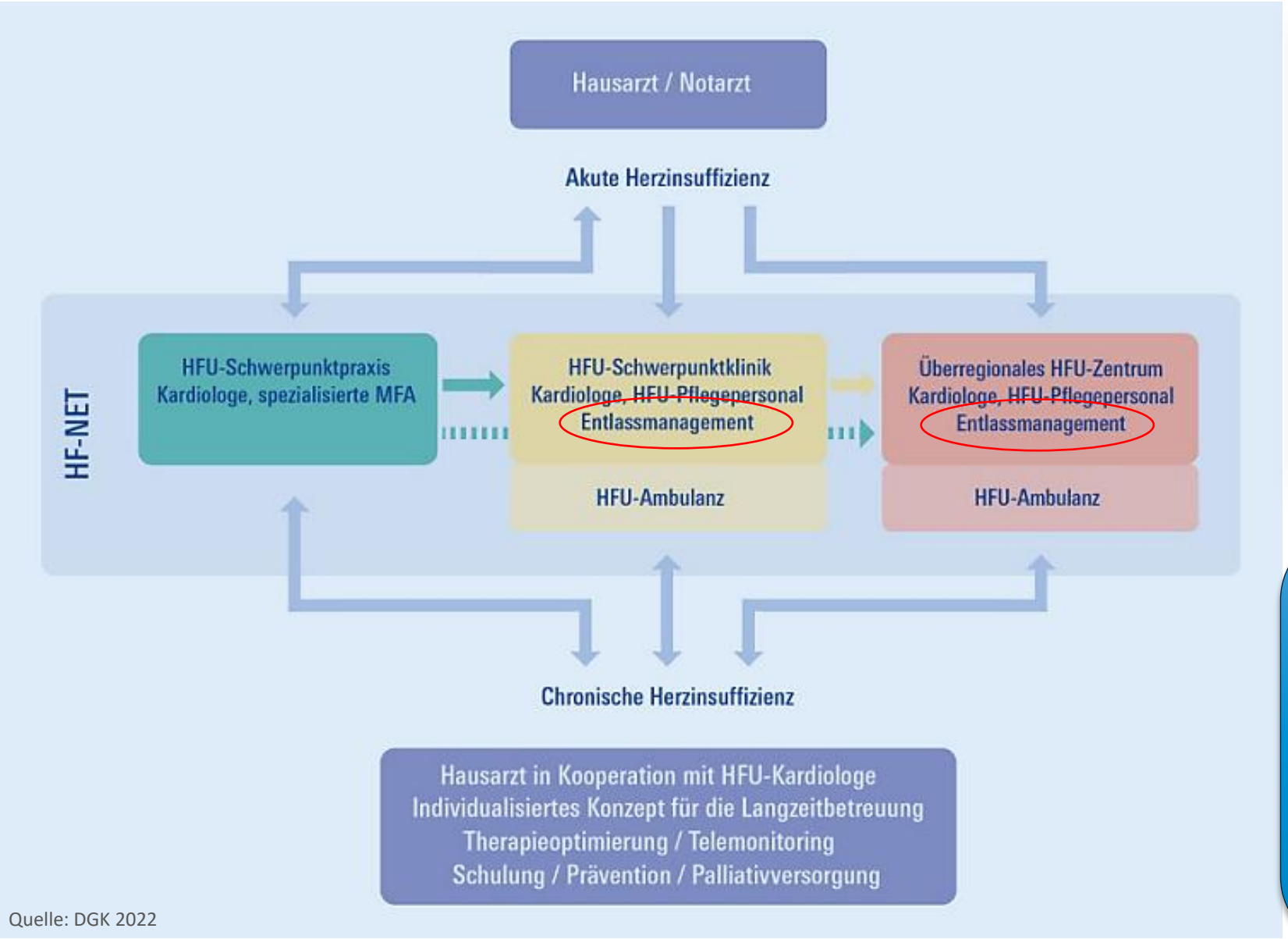
Why the usual Care Pathway isn‘t enough…

Discharge Management in HF Patients…

- More complex needs
  - Fragility/instability
  - Chronification
- No DMP currently
- GP as (only) gatekeeper
- Complex health care system
- Rehabilitation is possible, but often rejected



Vgl.: Bytyçi I, Bayraktars G. (2015) :Mortality in heart failure patients. Anatol J Cardiol. 2015 Jan;15(1):63-8.



Quelle: DGK 2022

Multidisciplinary interventions recommended for the management of chronic heart failure

Recommendations	Class[a]	Level[b]
It is recommended that HF patients are enrolled in a multidisciplinary HF management programme to reduce the risk of HF hospitalization and mortality.[309,314,315,316]	I	A
Self-management strategies are recommended to reduce the risk of HF hospitalization and mortality.[309]	I	A
Either home-based and/or clinic-based programmes improve outcomes and are recommended to reduce the risk of HF hospitalization and mortality.[310,317]	I	A

2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure, S. 3635

DM and und continuity of care recommended

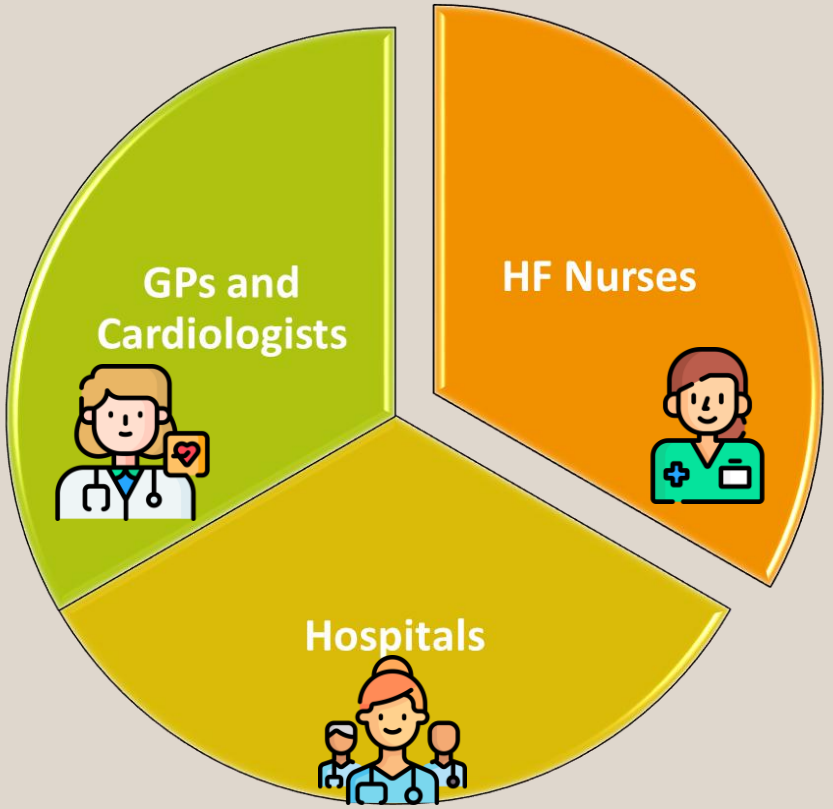
Self empowerment and Integration of Pt. responsibility

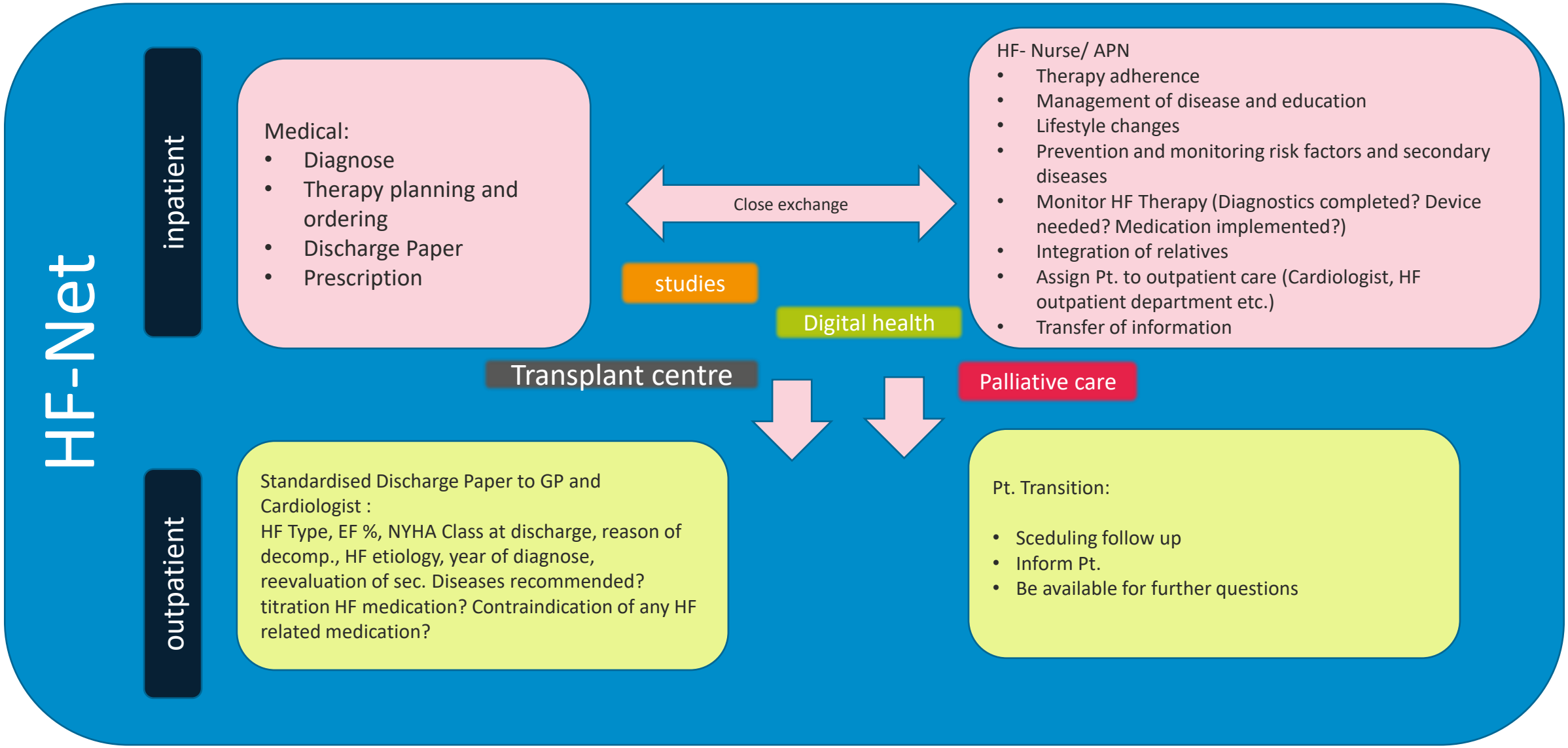
Adding the missing piece

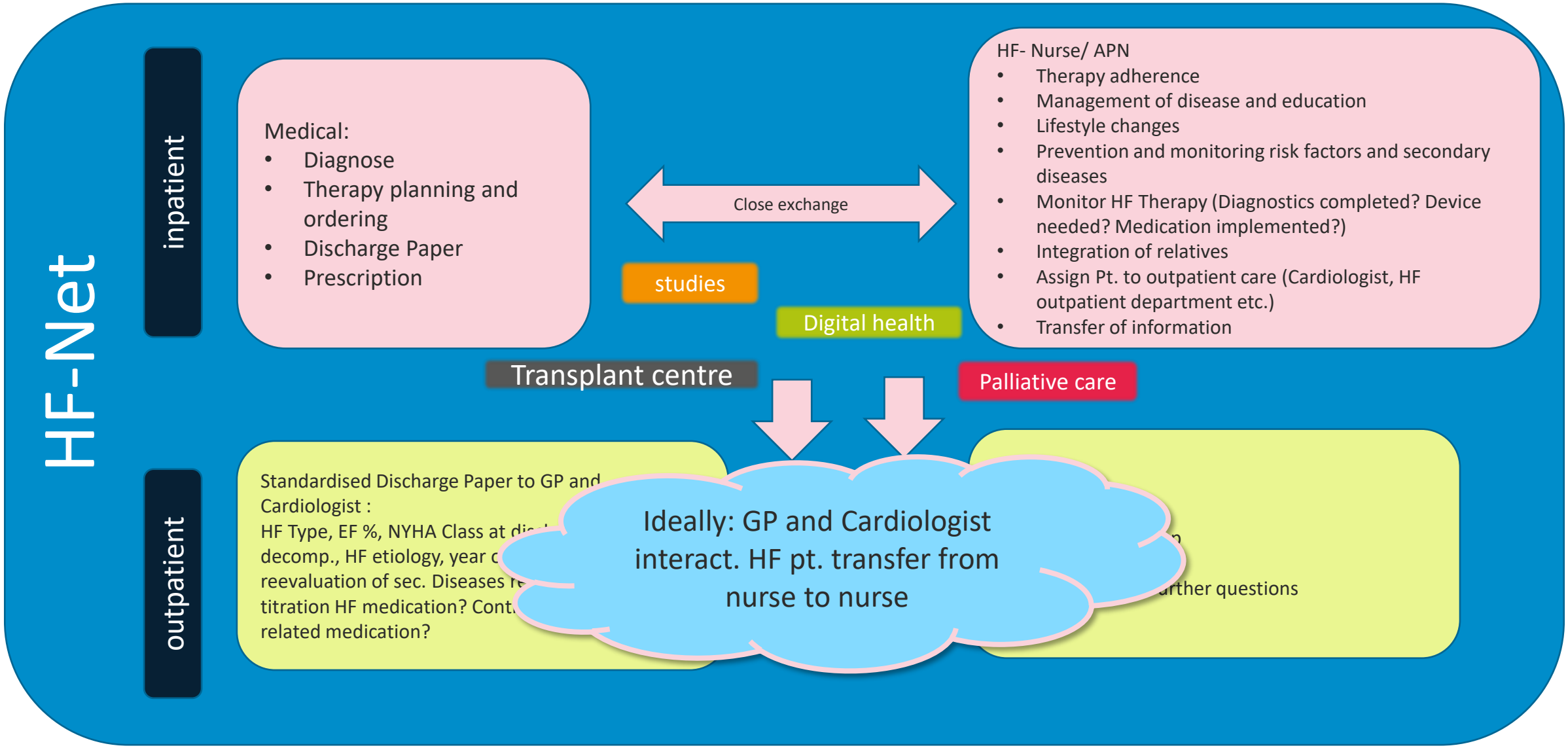
HF Nursing in Germany

- Special Training in several citys
- No political regulation but aknowledgement of DGK
- HF Nurse Network: BAGPH
  - members connect regularly
  - benefit from each other
- Con:
  - often no exemption/ extra time
  - No billing of nursing interventions possible

→ Still, HF nursing is increasing!




HF-Net
inpatient
Medical:
• Diagnose
• Therapy planning and ordering
• Discharge Paper
• Prescription
Close exchange
HF- Nurse/ APN
• Therapy adherence
• Management of disease and education
• Lifestyle changes
• Prevention and monitoring risk factors and secondary diseases
• Monitor HF Therapy (Diagnostics completed? Device needed? Medication implemented?)
• Integration of relatives
• Assign Pt. to outpatient care (Cardiologist, HF outpatient department etc.)
• Transfer of information
studies
Digital health
Transplant centre
Palliative care
outpatient
Standardised Discharge Paper to GP and Cardiologist :
HF Type, EF %, NYHA Class at discharge, reason of decomp., HF etiology, year of diagnose, reevaluation of sec. Diseases recommended? titration HF medication? Contraindication of any HF related medication?
Pt. Transition:
• Sceduling follow up
• Inform Pt.
• Be available for further questions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Standardised Discharge Paper to GP and Cardiologist :
HF Type, EF %, NYHA Class at di
decomp., HF etiology, year c
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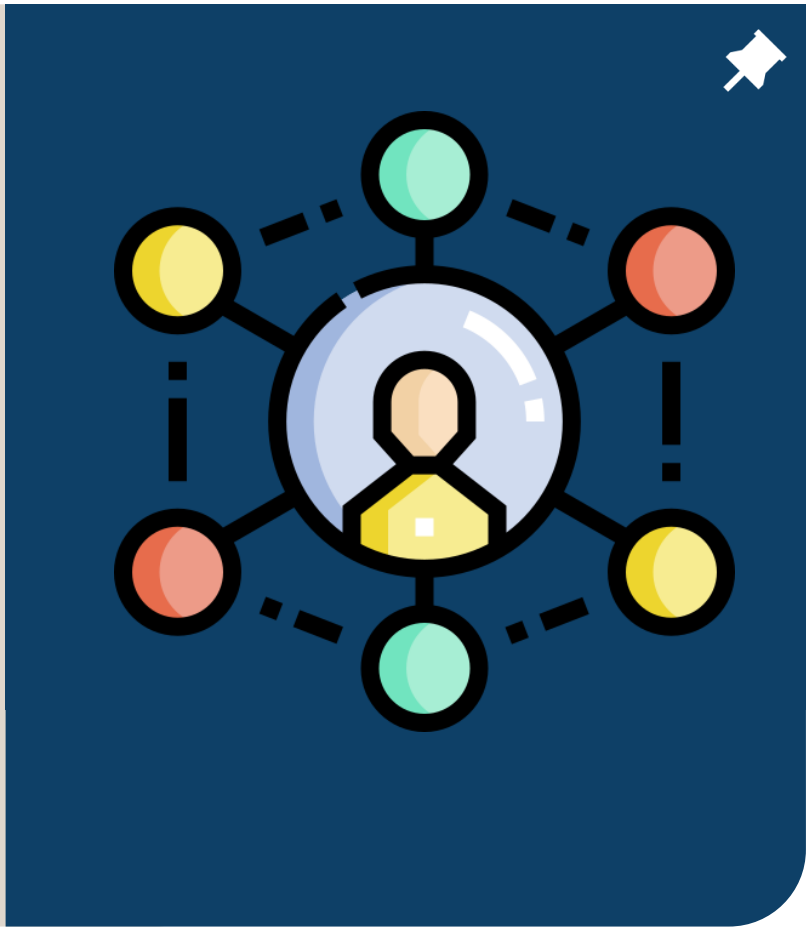
titration HF medication? Cont
related medication?
Ideally: GP and Cardiologist interact. HF pt. transfer from nurse to nurse
rther questions

Additional care provided by HF Nurses

Creating interfaces
- Discharge planning
- Transfer to cardiologist
- Follow up via telephone

Information:
- Pt. education
- Consultation and advive to collegues/ other professions

Networking
- Cooperation
- Improving cross- system structures
  – *E.g. further education for ext. providers*
  – *Generating guidelines / SOPs*



Additional care provided by HF Nurses

Therapy Management

Medication:

- Monitoring implement. of Fantastic Four
  - recommendation
  - tolerance
- Educating Pt. And relatives about medication
  - *regularity*
  - *Effects and side effects*
  - *Monitoring and interpretation of vital signs*
  - *Labs*
  - *Titration of diuretics*

Non- medicinal therapy:

- **Education:**
  - *Lifestyle changes*
  - *Symptom management*
  - *Secondary diseases*

Device therapy:

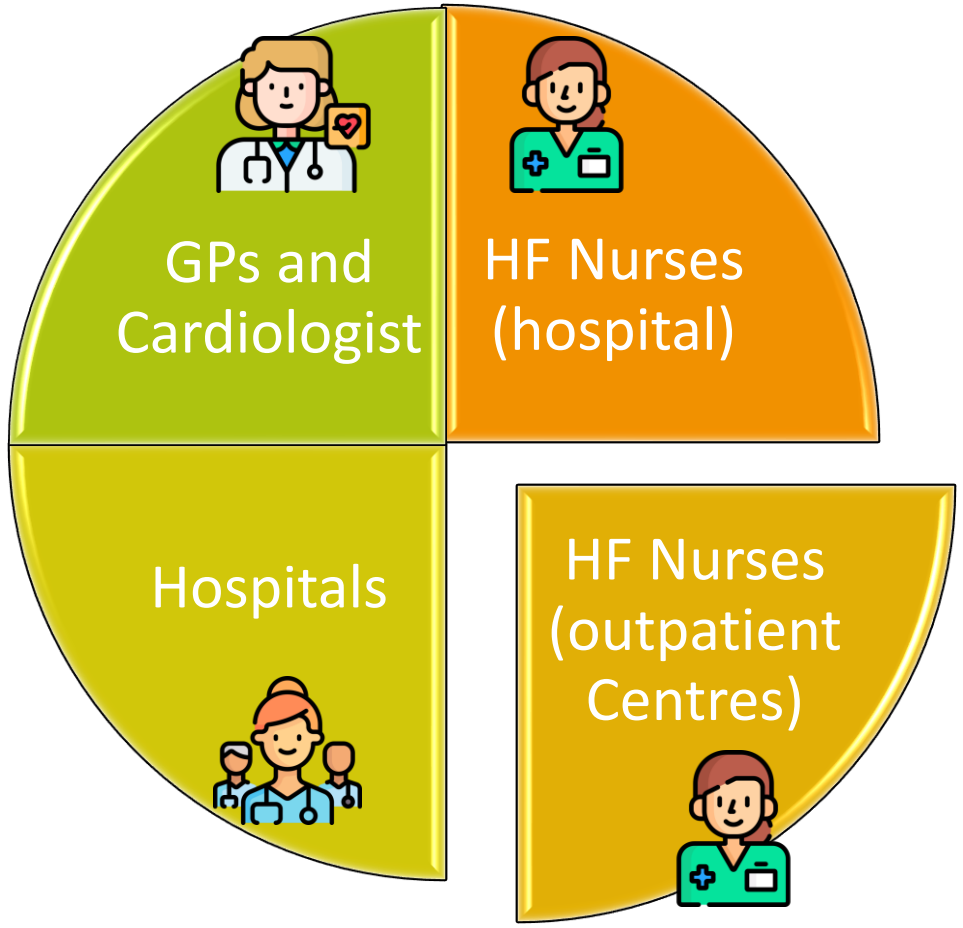
- E.g. defibrillator indication: educating Pt. about particularitys and notable changes in everyday life

HF Discharge Management

Conclusion

- Discharge Management available
- Very aligned to medical regards and basic care needs like housing and maintenance
- Aims to improve are existing, but not billable or legally regulated
- No DMP, treatment diffrent from provider to provider
- HF Nurses try to meet the Pt. Needs
  - Also not billable/ refinanced
- Legal changes may come into force
- Nurse led Case Management in and outpatient
  - great opportunity for german nurses
  - benefit for patients

→ At the moment pt. will always need a doctors appointment for any question or demand regarding their illness



Thank you for your attention!

Contact:
Franziska.Ottenbreit@klinikum-nuernberg.de
Phone: (049) 0911/ 398- 118174

Questions?

Towards a heart failure care path in Belgium

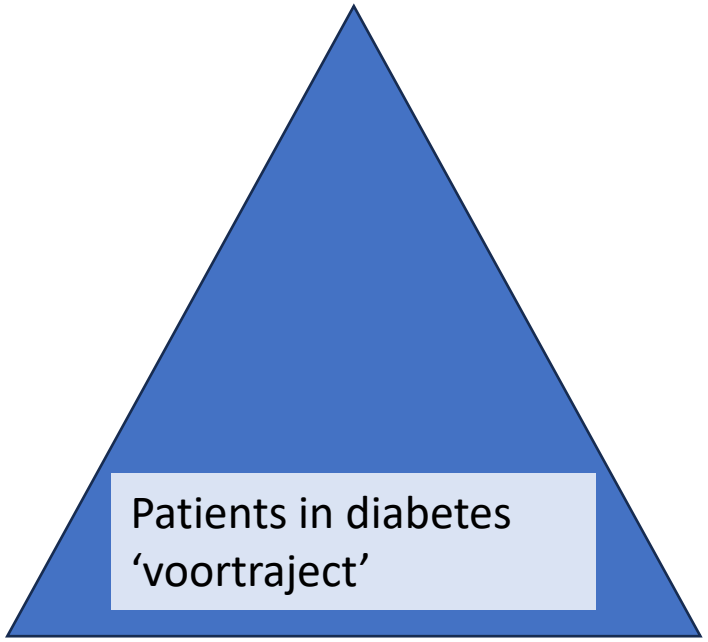
Prof. Dr. Miek Smeets, GP

Background

- There are two integrated care pathways for chronic diseases in Belgium
  - Diabetes
  - Chronic kidney disease

How does this work?

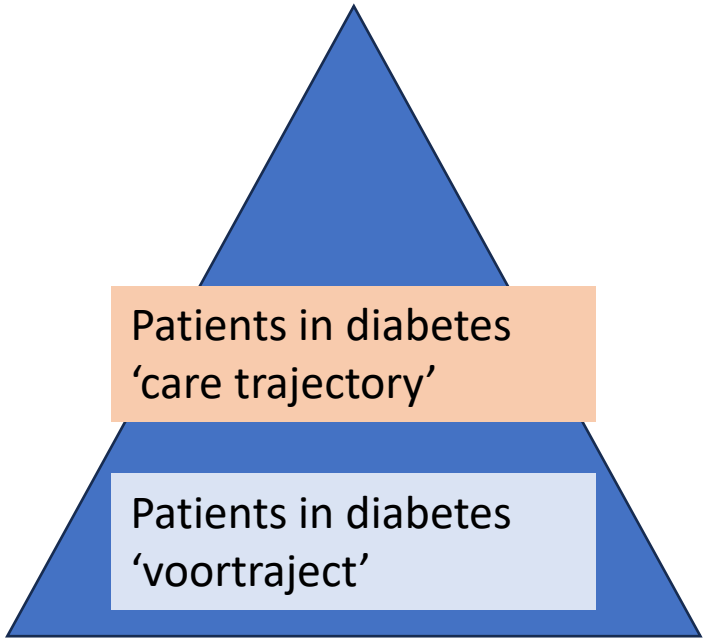
- Contract between patients and health care professionals



Care by GP alone – patients are under control with oral medication
Fee: 24 euro/year for GP (on top of fee for consultations)
Patients can get diabetes education (2 sessions/year) and guidance by a dietician (2 sessions/year) for free

How does this work?

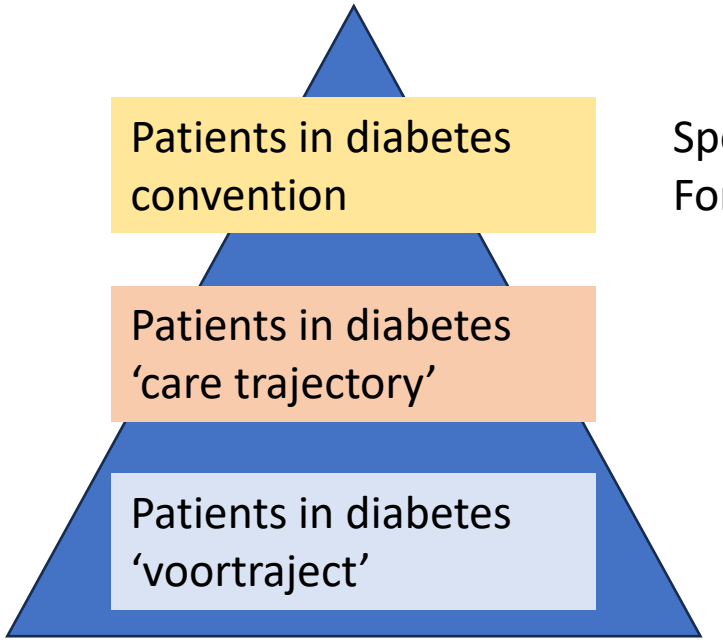
- Contract between patients and health care professionals



Care by GP in collaboration with endocrinologist – patients need more specialized medication (GLP-1, insulin)
Fee: 107 euro/year for GP (on top of fee for consultations) – endocrinologist fee?
Patients can get diabetes education (2 sessions/year) and guidance by a dietician (2 sessions/year) for free, free GP consultations
Have to attend GP’s office at least twice a year, endocrinologist once a year

How does this work?

- Contract between patients and health care professionals



Specialist care – FU in the hospital
For patients needing more than 3 or 4 insulin injections/day

Diabetes patient education

- Reimbursed
- The title of diabetes educator can be obtained by
  - Dieticians
  - Nurses
  - Physiotherapists
  - Podiatrist
- 20 study points, 40 hours of internship in practice

Do we want this for heart failure?

HF patients have an average of 5 comorbidities

- Care trajectory Diabetes
- Care trajectory CKD
- Care trajectory CHF
- Care trajectory COPD
- Care trajectory depression

Goals

Accurate diagnosis of HF

Appropiate evidence-based therapy

Patient education

Suitable follow-up

By a multidisciplinary HF team

Goals

Patient education

Suitable follow-up

By a multidisciplinary HF team

Fee-for-service

No gatekeeping system

No reimbursement of natriuretic peptides

Specialist HF nurses
1 year full-time educational course
~~No reimbursement~~

Pharmacists
No access to patient data

Cardiologists
Distance and waiting times are acceptable

Primary care nurses
Daily visiting fragile patients for washing, clothing,…
For free

No patient education in HF

General practitioners
Key role
No time for patient education
No tradition of assistent personnel

Ambulatory physiotherapists
Not known enough as an option for cardiac revalidation

Suitable follow-up: transitional care

- Only 10% of the hospitals had an intramural multidisciplinary HF care path
- No systematic care agreements in the transition phase

Nationale bevraging van het college van cardiologen. Data-collectie 2016. BeCareMagazine Sept. 2017

What steps did we take?

- We submitted a reimbursement file for NT-proBNP reimbursement for primary care in January 2024 (3rd time)

Up to date guidelines for primary care

AANBEVELING VOOR
GOEDE MEDISCHE PRAKTIJKVOERING

CHRONISCH HARTFALEN

Gevalideerd door CEBAM in september 2011

P. VAN ROYEN, S. BOULANGER, P. CHEVALIER, G. DEKEULENAER,

M. GOOSSENS, P. KOECK, M. VANHALEWYN, P. VAN DEN HEUVEL

OMSCHRIJVING

Van Royen P, Boulanger S, Chevalier P, Dekeulenaer G, Goossens M, Koeck P, Vanhalewyn M, Van den Heuvel P. Aanbeveling voor goede medische praktijkvoering: Chronisch hartfalen. *Huisarts Nu* 2011;40:S158-S186.

AUTEURS

P. Van Royen, huisarts, verbonden aan de Vakgroep Eerstelijns- en Interdisciplinaire Zorg, Universiteit Antwerpen en aan de Commissie

M. Vanhalewyn, huisarts, verbonden aan de Société Scientifique de Médicine Générale (SSMG);

P. Van den Heuvel, cardioloog, verbonden aan ZNA Middelheim, Antwerpen.

INBRENG VAN DE PATIËNT EN AFWEGING DOOR DE HUISARTS

Aanbevelingen voor goede medische praktijk zijn richtinggevend als ondersteuning en houvast bij het nemen van diagnostische of therapeutische beslissingen in de huisartsgeneeskunde.

Richtlijn chronisch hartfalen

Partiële herziening (2024)

M. Smeets, S. Van Cauwenbergh, S. Mokrane, A. Nonneman, P. Van Royen, M. Goossens, A-C Pouleur, E. Cornelis, D. Derthoo, J. Vandenhoven, K. Baldewijns, L. Hens, D. Vervloet, L. Van der Linden, M. Scherrenberg, M. Hornikx, B. Peeters, P. Nijst, T. Poelman, J. Ooms

In opdracht van de Werkgroep Ontwikkeling Richtlijnen Eerste Lijn (WOREL)

Verkorte versie mei 2024

Worel

Werkgroep Ontwikkeling Richtlijnen Eerste Lijn
Groupe de travail Développement de Guides de pratique de Première ligne
Working group Development of Primary Care Guidelines

Patient education

Specialized HF nurses

- Setting: hospital
- Education ✓
- Financial support ✗

Primary care nurses

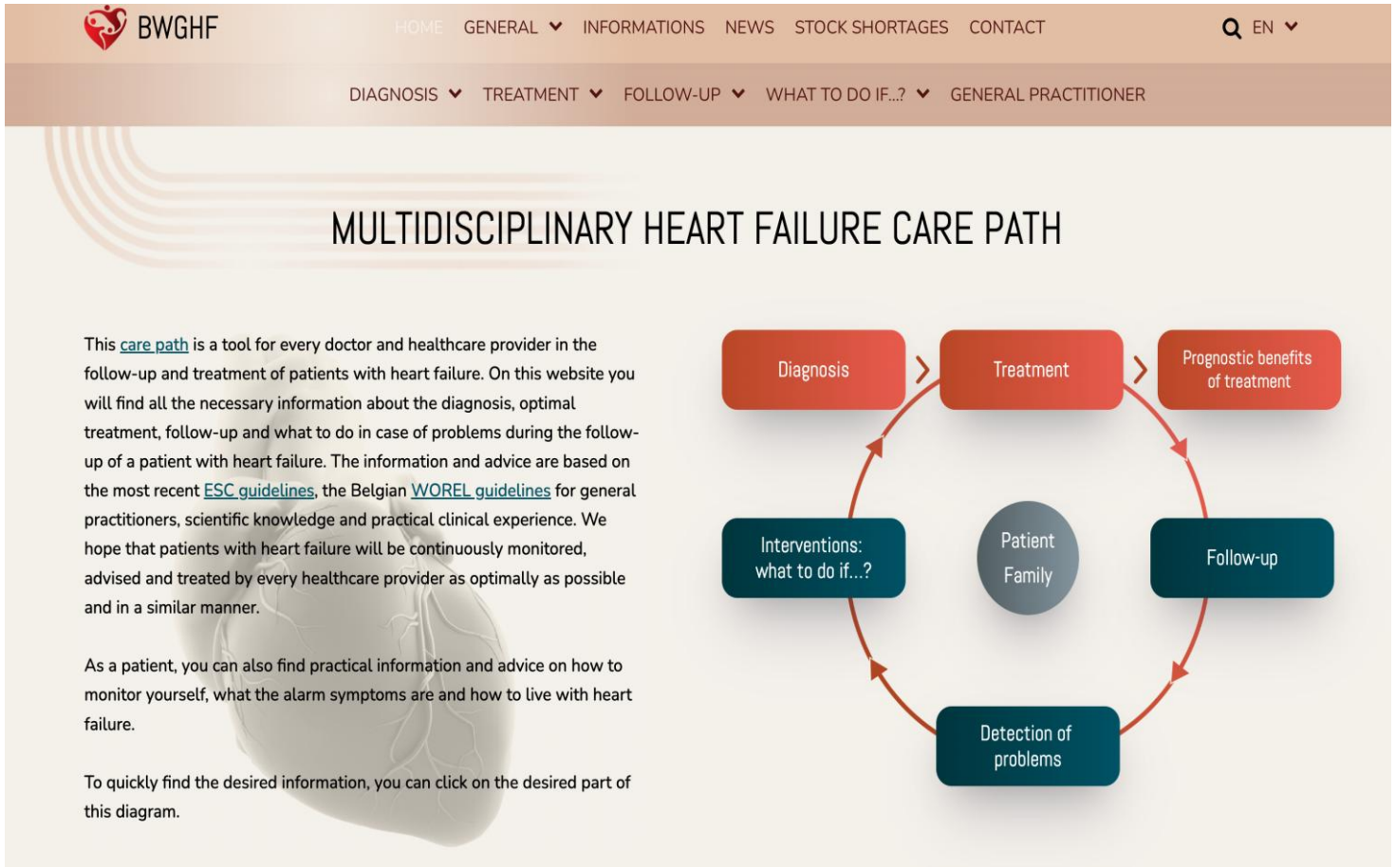
- Setting: primary care
- Education ✓
- Reimbursement ✗

Nurses in general practice

- Setting: primary care
- Education ✓
- Reimbursement ✗

Patient educational materials for primary care

A multidisciplinary HF care path



www.zorgpadhartfalen.be
https://heartfailurepathway.com

In Dutch, French, English

All information about the diagnosis, optimal treatment, follow-up and what to do in case of problems during the follow-up of a patient with HF.

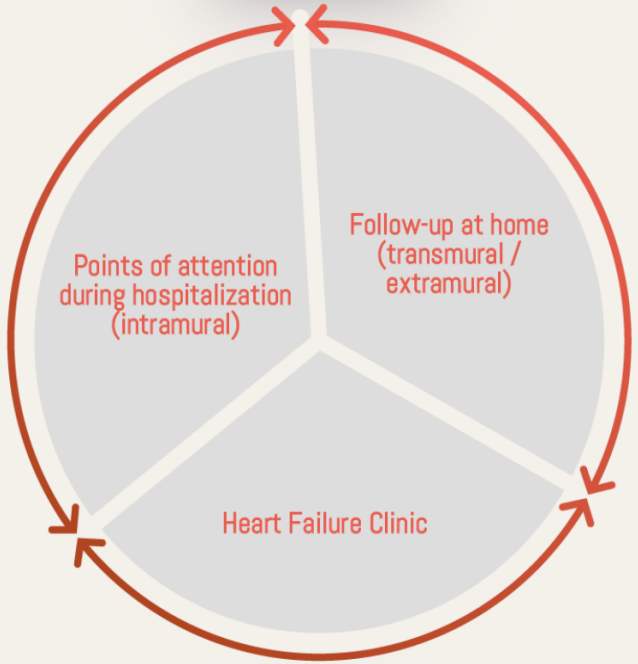
Points to consider upon discharge

- Hospitalization due to heart failure
- Hospitalization in a non-cardiology department

DURING HOSPITALIZATION

- Nurse
- Heart failure nurse
- Cardiac rehabilitation: physiotherapist
- Dietitian
- Pharmacy
- Social support
- Psychological support

General Practitioner



What is a heart failure clinic?

Follow-up of a heart failure patient

AT HOME

- Home nurse / Home care
- Pharmacy
- Cardiac rehabilitation: physiotherapist
- Dietitian
- Psychological support

TRANSMURAL FOLLOW-UP

- Heart failure nurse
- Telemonitoring

What steps did the government take?

- In November 2024 a RIZIV consensus meeting was held were expert opinions on how care should be organized were presented. Will they take action?
- Non-invasive telemonitoring is reimbursed since January 2025
  - Initiated by a specialist HF center after a HF hospitalization
  - Collaboration with the GP is obliged
  - The center is paid a lump sum per patient for 6 months FU
  - GP is paid a forfait of 24 euro to take their role in the FU of patients that are telemonitored
  - Patient education (at the hospital) is included in this telemonitoring care trajectory

Where should we go next?

- In the updated guidelines:
  - Patients with HFrEF, especially those with frequent rehospitalizations, should be included in a multidisciplinary care trajectory
- At first we always envisioned a more holistic approach
- All building blocks for evidence-based HF care accessible and reimbursed without an overarching care trajectory
  - NTproBNP reimbursement
  - Reimbursement of primary care HF educators
  - Reimbursement of specialist HF nurses in the hospital who provide patient education and coordinate transitional care
- But maybe in the Belgian system we also need a care trajectory to get an integrated approach and incentives for health care providers and patients??

Your opinions?

Questions?

Wrapping up

What’s in a name?!

- Do you have an idea of suggestion? Let Karolien know before 15/5/25
- @karolien.baldewijns@thomasmore.be


Heart2Heart
multidisciplinairsymposiumhartfalen
Uitnodiging
26 april 2025 van 9u tot 13u30
Programma:
• De nieuwe richtlijn hartfalen - Dr. Miek Smeets
• De nieuwe pallialine richtlijn hartfalen - Dr. Anneleen Janssen
• Het multidisciplinaire zorgpad hartfalen - Dr. David Derthoo
• Nieuwe educatiematerialen - Dr. Karolien Baldewijns
• Resultaten van de hospitalisatiecijfers in Vlaanderen en lessen uit het werkveld - Dr. Willem Raat
• Keynote: Toekomstvisie op hartfalenzorg - Prof. Dr. Hans-Peter Brunner-La Rocca
• Interdisciplinaire, hands-on workshop
• Netwerklunch en posterbeurs
Voor patiënten met hartfalen, mantelzorgers, huisartsen, verpleegkundigen (eerste en tweede lijn), apothekers, kinesitherapeuten, cardiologen en geriaters.
Accreditering voor artsen en apothekers wordt aangevraagd.
Inschrijven voor 1 april op witgelekruis.be/heart_heart
Wit-Gele Kruis van Antwerpen
Nonnenvest 10
2200 Herentals
Deze uitnodiging gaat uit van HeartsConnect,
Wit-Gele Kruis van Antwerpen, Thomas More Hogeschool en Universiteit Antwerpen
in samenwerking met Domus Medica, BWGHF en KFK
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Thomas More
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Faculteit Geneeskunde en Gezondheidswetenschappen
Domus Medica
BWGHF
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Wrapping up

- Input for next symposia