Cardiovascular ambassador project

Model of care explainer

This fact sheet aims to support health services apply to join the Cardiovascular ambassador project. It is not a comprehensive summary of models of care in heart disease.

What is meant by a model of care?

A model of care can be defined as 'best practice care and services within a health care system for a person or population group as they progress through the stages of a condition, injury or event'. (ACI,2013, p 3)

In the context of the Cardiovascular ambassador project, model of care refers to multiple interventions across a patient's care journey with the purpose of improving service delivery and patient and community outcomes.

Multifaceted interventions are most likely to be successful and hospitals will compile a series of interventions into a model of care to improve cardiac care and transitions. In addition, the interventions that constitute a model of care should be introduced in numerous settings where a patient or carer interacts with the health system, including but not limited to inpatient, outpatient clinics, sub-acute and home visit care services, and primary care settings. The role of the cardiac liaison nurse will be to deliver, coordinate or facilitate the designed model of care with a multidisciplinary care team.

Examples of interventions that have been included in successful readmission reduction models of care

Inpatient	Bundles of care that streamline and standardise care processes for patients admitted with cardiovascular disease. Inpatient cardiac coordinator who provides inpatient cardiac education, coordination of specialist care and discharge support, coordinates follow up with GP within seven days. Multidisciplinary case conferences for readmitted patients to identify and discuss reasons for readmission and develop a management plan.
Outpatient	Nurse led or coordinated post discharge or titration clinics to ensure uptitration and monitoring of evidence-based pharmacotherapy. Telehealth cardiac specialist clinics that provide telemedicine support to regional health services. Follow-up phone call service for recently discharged patients deemed medium- to high-risk of readmission.
Community	Home visiting specialist nurses to improve cardiovascular care in the community. Chronic disease management and exercise rehabilitation programs. Collaborating with primary care settings to improve transitions and cardiac care in GP clinics. Advanced care planning and shared decision-making improvement initiatives. Improved timely palliative care referral and end of life support in a cardiovascular patient's preferred setting.

Consider reviewing the following supporting resources as you prepare your model of care proposal:

- Agency for Clinical Innovation, 2013. Understanding the process to develop a Model of Care An ACI Framework. ACI, NSW. Access here
- Agency for Clinical Innovation, 2019. Chronic Heart Failure Organisational Models. ACI, NSW. Access here
- National Heart Foundation of Australia, 2016. Heart Failure Toolkit. NHFA. Access here

What are some examples of a CV ambassador model of care?

Example 1

A small regional hospital identifies that many cardiac patients leave hospital unaware of their diagnosis and management, with a high proportion lost to follow up. The hospital does not have a high volume of admissions for one individual cardiac diagnosis. However, by focussing on atrial fibrillation, heart failure, and acute coronary syndrome admissions, there is a significant number of patients who will benefit from the cardiac liaison nurse support.

The hospital decides to focus on an inpatient cardiac coordinator to support access to evidence-based cardiac care, patient education and safe discharge, with an early discharge clinic that is nurse led with general medicine physician support offering follow up for all discharged cardiac patients within two weeks of discharge.

Example 2

A metro hospital has a mature outpatient post discharge heart failure clinic and inpatient nurse led heart failure service. They identify that improving the care of heart failure patients at end of life will be the focus of their CV Ambassador program. The cardiac liaison nurse will test a model of providing inpatient, clinic and at home support to advanced heart failure patients improving transitions between hospital and the community, with a focus on shared care between palliative care, cardiology, and community services.