Heart Failure Nursing in Australia: Challenges, Strengths, and Opportunities

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AUSTRALIA

Australia has a land mass similar to the United States of America, supporting a population of just over 20 million, which is distributed predominantly across the coastal perimeter. The Australian society is rich in cultural diversity fostered by decades of migration. Both these factors present challenges for health care. First, because resources are scare in rural and remote regions, health outcomes are poorer in these regions, especially among indigenous populations. Second, the cultural diversity of Australians is a challenge to providing evidence-based treatment recommendations.[1] In Australia, in parallel with international trends, there is a strong association between socioeconomic status, chronic conditions, and health outcomes.[2]

THE AUSTRALIAN HEALTH CARE SYSTEM

Australia supports a system of universal health care coverage. The Australian health care system has 3 levels of government—Federal, State, and Local. Australian nursing has an exclusive baccalaureate entry level, although recent workforce shortages and budgetary concerns have threatened this status.[3,4] Overall, acute hospital services and outreach community-based services, such as HF programs, are predominantly administered by the State government system. Community-based services, such as general practice (GP), are funded by the Federal government. Nurses are predominantly funded by government systems, except in private practice settings. However, nurses working in private, specialist cardiology practices are in a minority.

MODELS OF HEART FAILURE (HF) CARE IN AUSTRALIA

Implementation of nurse-directed intervention HF models is variable and there is significant heterogeneity in HF management programs across Australia.[5] Often HF care models are determined by available resources and stakeholder issues or preferences rather than available evidence. The nurse practitioner (NP) role is still in its infancy in Australia, compared with other developed countries.[6] Development of the NP role has been impeded by objections from medical colleagues and regulatory issues.[7] Driscoll et al.[8] undertook a national survey of 56 programs managing HF patients after hospital discharge. Only 22% of potentially eligible patients were represented in these programs and only 8% of these programs were located within rural regions. Hybrid programs were common, with 75% of the programs providing HF outpatient clinics and 77% conducting home visits. States with an enabling policy context for nurse-coordinated models of HF management demonstrated an increased access to services.[9]

Home-Based HF Programs

Some of the seminal work in HF management internationally has been undertaken by Stewart et al.[10,11] A home-based, nurse-led model developed in Australia has shown favorable short-term and long-term outcomes.[12,13] These programs incorporate self-management principles and a treatment plan negotiated with patients, caregivers, and family members. Home-based programs facilitate integrating evidence-based practice principles in the hospital and community and encourage coordination and communication with specialty cardiology providers.

GP Models

Within the Australian health care systems, the general practitioner is the gatekeeper to care. Over 90% of Australians visit a GP each year.[14] Despite the frequency of HF in GP, there is a well-documented treatment gap attributable to lack of: resources, particularly access to echocardiography; knowledge of pharmacological HF management; and communication between the tertiary and primary sectors.[15,16] The role of the Australian practice nurse in HF care is gaining increased attention from new workforce incentives and from the need for nurses to provide chronic disease management.[17] Recently, the numbers of GPs employing a nurse has increased from 40% to 60%.[18] The role of the practice nurse in providing integrated HF management should be an important focus for future development and evaluation of liaison and consultancy models.[19]

Cardiac Rehabilitation (CR)

In Australia, multidisciplinary CR programs are predominantly coordinated by nurses and provided free of charge.[20] These programs provide in-hospital education sessions, supervised ambulatory, and maintenance phases, consisting of group education as well as individualized exercise prescription. In many centers, the CR model has been tailored for individuals with HF. Often programs are increased to 12 weeks, involve systematic disease management, and include exercise programs, known to be safe in stable HF patients.[21] Low participation rates in CR are potentially exaggerated among HF patients, who are more likely to be older and to have comorbidities.[22] In nonmetropolitan regions, generic chronic disease programs (ie, for chronic obstructive pulmonary disease, diabetes, and other chronic conditions) are often in place and accessed by individuals with HF.[23] Although this is not ideal, augmenting these programs with expert consultancy and outreach services is considered potentially cost-effective.

Telephone Monitoring

Telephone monitoring is an important aspect of Australian HF management. Models vary from use of a centralized number for patient use to planned routine calls from a health care worker.[24] Clarke et al.[25] have shown that elderly HF patients can adapt quickly and find telephone monitoring an acceptable part of their health care regimen. Currently, more complex technologically based monitoring programs remain confined to the research setting in Australia.

Integrated Palliative Care Models

A key advantage of the Australian health care system is that HF patients can be comanaged by both cardiology and palliative care teams.[26] As a consequence, patients do not have to choose between hospice and cardiology care. As the importance of palliative and supportive care in HF management increases, many programs have developed collaborative relationships.[27]

Residential Aged Care

Many HF nurses provide outreach and consultancy to residential aged care facilities. Often individuals with HF are admitted to the hospital because the residential facility is no longer able to meet their care needs or because there has not been effective advance care planning. In Australia, a palliative approach within residential aged care facilities is required to care for residents whose condition is not amenable to cure.[28]

RECOMMENDATIONS FOR FOSTERING HF NURSING IN AUSTRALIA

Developing strategies for HF nursing in Australia requires systematic planning in undergraduate and postgraduate education and in professional development. Currently, there is no method of certification or credentialing of nurses working in HF. There is a need to formalize roles and competencies for HF management. Clarification of the unique contribution of the HF nurse, and of potentially shared roles within the multidisciplinary team, is needed to ensure that nurses are adequately prepared and equipped to perform these roles. The valuable contribution of nursing skills to HF management needs to be validated and acknowledged within policy recommendations and funding strategies.

CONCLUSIONS

Refining and scoping the specialization of HF nursing is crucial in preparing a workforce that is able to be responsive of the future needs of people with HF. Achieving consensus of outcome measures, credentialing of HF specialist nurses, promoting independent nursing practice, and developing consultancy models in aged care and GP are important issues for the future.[29] Variability of specialist HF service availability and accessibility—particularly in rural and remote regions—is of concern, particularly within the context of universal coverage. Integrating outreach programs and the use of information technology, supported by the assessment, diagnostic, and therapeutic strategies of the HF nurse, are likely to be the key to ensuring the delivery of optimal evidence-based HF care to all Australians.

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