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22nd September 2020

Deputy Louise O'Reilly, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 21591/20

To ask the Minister for Health his plans to standardise referral pathways nationwide using existing IT infrastructure such as Healthlink to aid improved communication between the community and hospital services for heart failure; his views on whether heart failure virtual consultations between general practitioners and cardiologists are particularly useful in rural areas or areas geographically removed from heart failure units or those with multimorbidity; his plans to develop the services to deliver more effective and cost-effective care; and if he will make a statement on the matter.

Dear Deputy O'Reilly,

The Health Service Executive has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the National Heart Programme (NHP) on your question and have been informed that the following outlines the position.

General practitioners refer patients to the heart failure virtual consultation service using Healthlink, Healthmail referral letter or fax. The use of Healthlink and Healthmail as secure methods of communication is part of the Heart Failure Virtual Consultation (HFVC) protocol. GPs can use the HSE standardized referral template, virtual consult referral tool or letter at their preference.

The National Heart Programme (NHP), as part of the Integrated Care Programme for the Prevention and Management of Chronic Disease (ICP CD) advocates working with Healthlink to use their existing platform to enable rapid and effective communication between GP and specialist services for standard clinics, urgent clinic, virtual consult, diagnostics or clinical queries. This would allow attachment of files and two way communication, while also tracking all referrals in the system.

The NHP believes the HFVC service is useful for all patients but particularly those patients living remote from services or those that suffer with chronic co-morbidities limiting their capacity to travel. Delivering heart failure and other cardiovascular disease services in a COVID-19 environment further underlines the need for, and roll-out of the HFVC model in order to avoid actively inviting individuals with heart failure and co-morbidities into the higher-risk congregate setting that is the acute hospital, when this can be avoided.

Implementation of the HFVC service commenced as a pilot project in the Heart Failure Unit at St

Vincent's University Hospital and was subsequently extended to the Carlow- Kilkenny area, at the end of 2016. It involved providing a new model of care for heart failure patients where GPs, Consultants and CNS worked collaboratively in a team approach, using web-based technology and access to diagnostics, to deliver comprehensive, coordinated and integrated care to patients in the community. This project was consistent with Sláintecare and national health policy in moving appropriate heart failure care out of hospitals and providing it close to where the patient lives. From 2020 the HFVC Service has been mainstreamed in the Carlow/ Kilkenny area.

Overall the outcomes of this project demonstrated:

- Significant hospital avoidance / particularly emergency department avoidance
- More proactive care in the community
- Effective provision of coordinated/comprehensive/accessible care in the community to a vulnerable, frail, at-risk population who are high users of health care and hospital beds
- Travel avoided for patient and families
- Use of technology to enhance access to care
- Better outcomes through quality service provision and value-based care for patients, families and providers: in essence, patients are cared for at home and avoid unnecessary hospitalisations
- GPs enabled/supported to provide comprehensive management of a chronic disease as part of an integrated system
- A new model of care that shifts care into the community in an agreed and resourced manner with service providers working as a team (GP/CNS/Consultant) - each to the top of their license – and with care provided close to the patient's home
- Knowledge transfer from hospital to community providers
- A template for managing at-risk populations with other chronic diseases/ frailty using technology and through partnerships between GPs, hospital and CHO
- Value to state from cost savings and efficiencies of scale

In 2019, the NHP successfully secured funding from the Slaintecare Integration Fund (SIF). SIF Project 237: Heart Failure Virtual Consultation Services with Integrated Care Clinical Nurse Specialist supports in the community. The project commenced in January 2020 and builds on the concepts proven in the Carlow/ Kilkenny evaluation project and expands the service along the East Coast/ South Dublin/ North Wicklow area and in the Mater/ Dublin North area. The project which was granted an exception to the stay on SIF projects during the COVID-19 pandemic is on-going with a current commitment of funding to March 2021. A final report will be developed as part of the grant agreement; this will include results on outputs and outcomes of the project.

I trust this information is of assistance to you but should you have any further queries please do not hesitate to contact me.

Yours sincerely

Patricia Gilsenan O'Neill
General Manager