Use of case management to reduce unplanned heart failure admissions

Case management that is initiated in hospital and led by specialist nurses may reduce unplanned hospital readmissions and length of hospital stay for adults with heart failure. Case management is specific, intensive one-to-one care that involves many components to do with planning, coordinating and reviewing the care of people with long-term conditions.

This National Institute for Health Research (NIHR) Review of organisational type research featured 17 trials and five other studies, including three from the UK. The interventions used by the individual studies varied widely, which highlights some need for caution in interpreting the pooled findings.

There was limited evidence that hospital-initiated case management is cost effective - particularly in relation to the NHS. A few studies examined case management that was started in the community. However, the findings are promising in different settings.

Most studies reviewed specified specialist nurses, but some were part of a multidisciplinary team. Competency frameworks have been developed for heart failure nurses in the UK, but the scope of practice for specialist nurses may be different for other studies included in this review.

We do not know exactly which components are most effective or cost-effective, or how differences in team and skill mix affect outcomes. Well-designed studies are needed in community settings.

Implications for practice

- Hospital-initiated case management can reduce emergency admissions and length of stay for people with heart failure. As well as care coordination, it includes elements of patient education, symptom management and medication review.
- Patients may be referred for specialist nurse case management from cardiology wards and clinics, general medical wards, medical admission units and care of older people wards.
- Care is now based in the community and includes many complex activities in different settings.
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- Competency frameworks have been developed for heart failure nurses in the UK, but the scope of practice for specialist nurses may be different for other studies included in this review.
- We do not know exactly which components are most effective or cost-effective, or how differences in team and skill mix affect outcomes.
- Well-designed studies are needed in community settings.

Expert commentary

Caroline Golder, cardiac rehabilitation nurse, Wirral Community Foundation Trust, Birkenhead

I see many patients with heart failure who have benefited from our community heart failure specialist nurse (HFSN) service. The HFSNs do home visits or see patients at their local health centre, titrate medication and educate patients about their condition. Patients are followed up until the HFSNs are satisfied that they are stable and their medications are at optimal levels. Our nurses monitor patients regularly, ensure they see a cardiologist when required and liaise with other professionals such as community matrons and local GPs. This cuts admissions to acute care and helps patients both physically and psychologically.

Part of my role is to work alongside the HFSNs to educate patients and their families. We help them to monitor for warning signs of a worsening in their condition and liaise with the heart failure team when we are concerned about patients.

This study demonstrates how hospital-initiated case management can reduce pressure on acute care, but more research is needed into how community heart failure teams can help to reduce hospital admissions.