

Improving Service Delivery for Patients with Advanced Liver Disease

Chronic Care

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HNEAHS

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The Team

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- **A/Prof Anne Duggan** Gastroenterologist

Supported by Gastroenterology nursing, medical, allied health and secretarial staff

Liver failure induced fluid accumulation

Ascites



Extent of the problem

HNE alcohol related disease separations 700/100,000 (males)
350/100,000 (women)

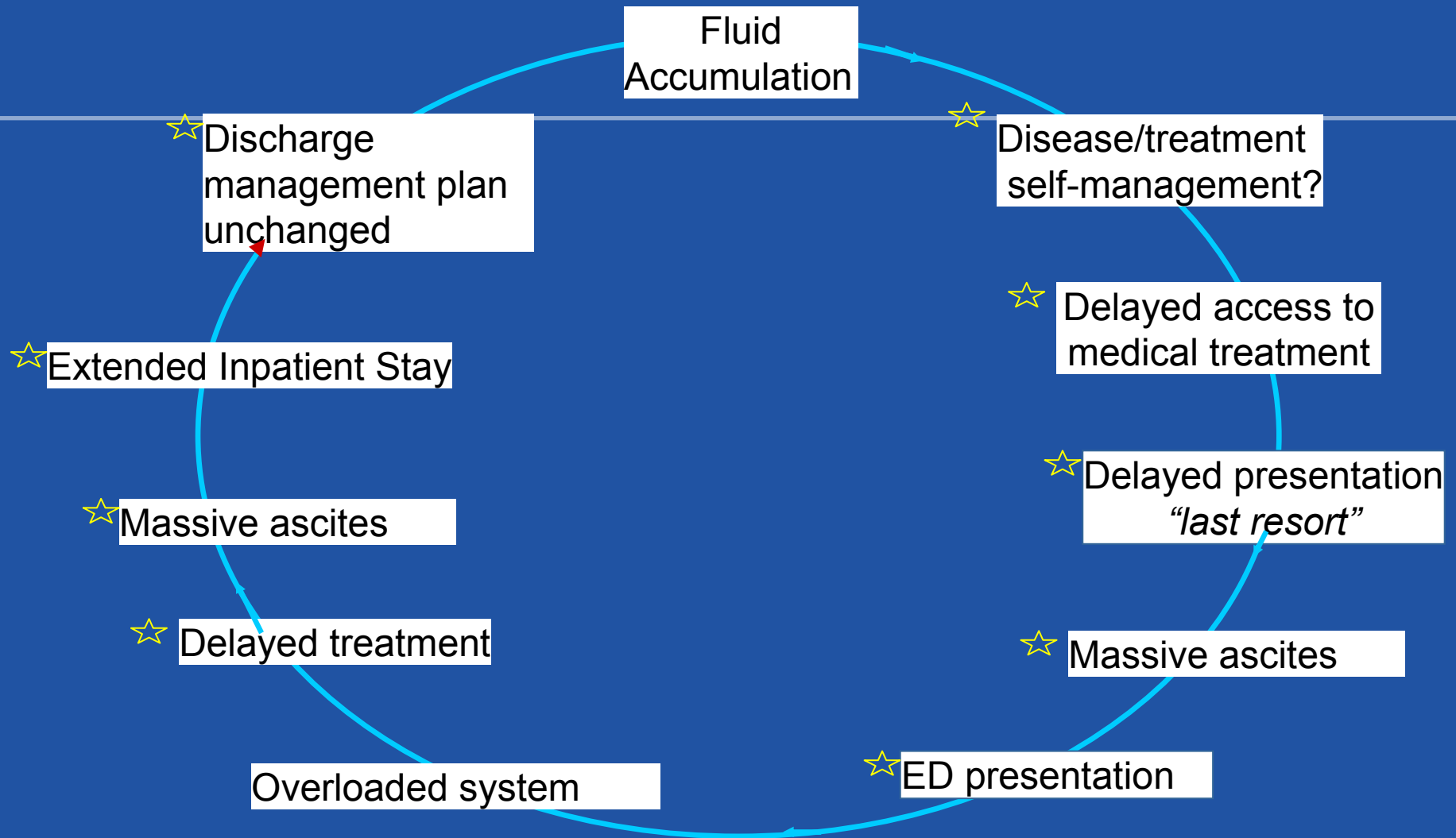
Chronic liver disease:

- frequent clinical presentation – ascites, gastrointestinal haemorrhage, sepsis, confusion (encephalopathy)

The future:

- *over the next few decades will increase markedly due to obesity, alcohol and hepatitis C induced liver disease*

Nature of the problem



★ Problem areas

Aims

For patients with advanced liver disease (resistant ascites)

To avoid:

- Emergency Department (ED) presentations
- Late presentations
- Extended length of stay

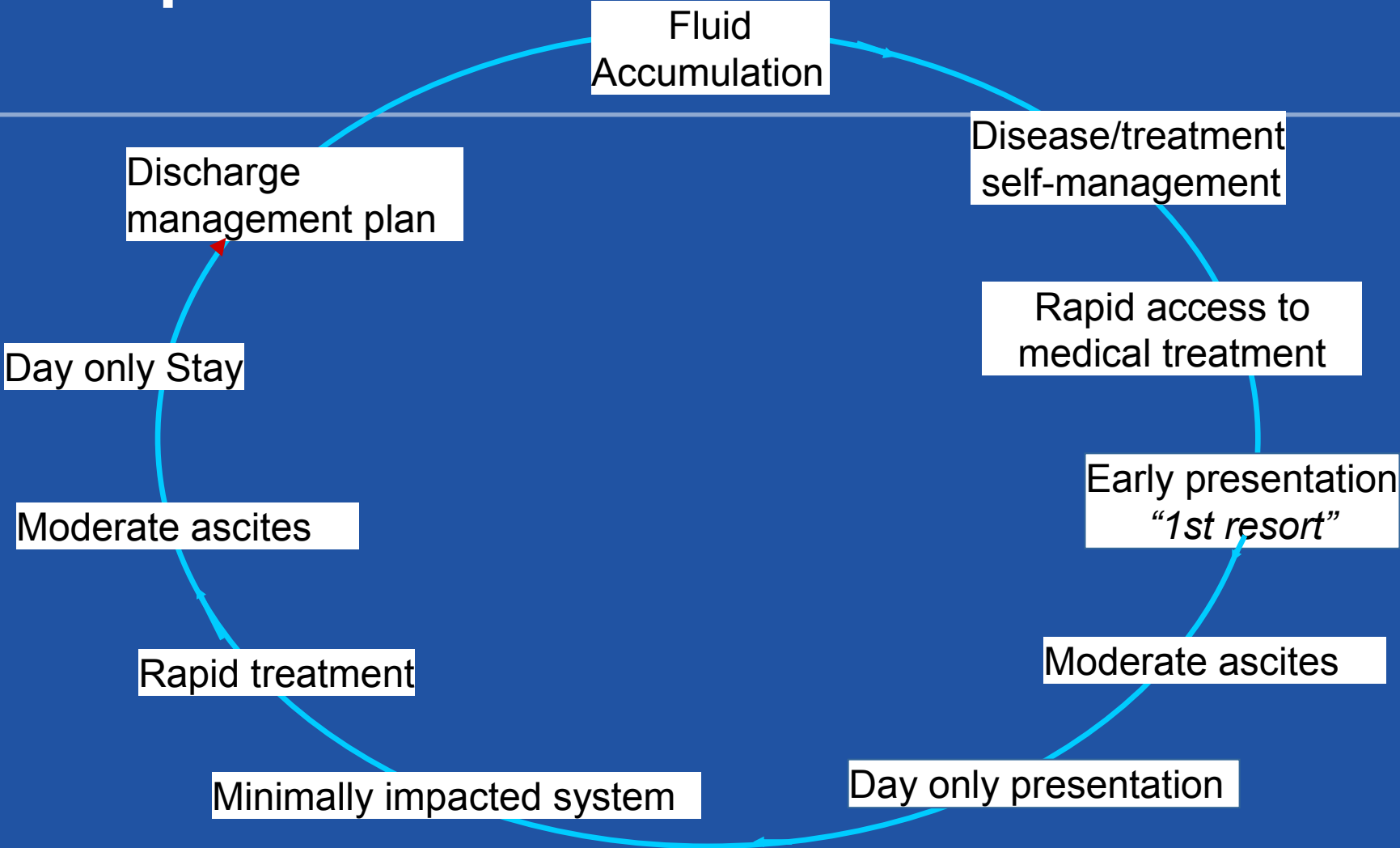
and their associated costs and inefficiencies

To increase:

- patient engagement in their disease management
- patient satisfaction with their care

through the introduction of a Gastroenterology Liaison Nurse (GLN) Service

Proposed solutions



Proposed Solutions

Service reconfiguration 2004

Establishment of a Gastroenterology Liaison Nurse Service

(shared position, 2 gastroenterology trained nurses, allied health and medical support)

Key responsibilities:

- Be available by phone for information, advice, and assistance to patients
- Communicate with GPs, consultants and the healthcare team about problems and promote appropriate advice, intervention and therapy
- Organize community based pathology tests for monitoring
- Arrange outpatient review, short stay or inpatient admission as needed
- Monitor medication changes
- Monitor and respond to patient satisfaction information

Proposed Solution

Gastroenterology Liaison Nurse (GLN) Led Service

1-referral process

- GI team consult to GLN service
- Progress plan: Ideal weight, diuretic regime
- GLN consult pre discharge/OPD appointment
- Registered with GLN Service (database)
- GLN contact card

2-Implementation Process

- Patient & carer education
- Patient information handouts
- Bathroom scales_(Patient Purchased)
- Patient weight self-record sheet
- Patient initiated GLN contact
- GLN initiated backup contact
- Database documentation of contact

Business card provided to patients

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Outcomes & Evaluation

Pre Service

Reactive

Fragmented

Less compliance

Extended bed days

Disease anxiety

Post Service

Proactive

Cohesive

More Compliance

Day only admissions

Disease understanding

Outcomes before and after GLN (6 months prior and 6 months post GLN): *Hospital Admissions*

Patient ID	Pre-program admissions	On-program admissions
1	1	1
2	2	8
3	3	0
4	0	3
5	1	0
6	1	0
7	1	0
8	2	2
9	1	0
10	1	0
Total	13	14
Total excluding patient 2	11	6

Outcomes before and after GLN (6 months prior and 6 months post GLN) (n=10)

	<u>Pre-program</u>	<u>On-program</u>
Admissions %:		
-Planned	46%	71%
-via ED	54%	29%
Mean Length of stay in ED (hours)	9	7.8

- *Subsequent promotion of the GLN service to the Emergency Department, to increase identification of new patients and fast tracking*

Outcomes before and after GLN: Pathology ordered and associated costs

	Pre-program (6months)	On-program (6months)
Number of ascitic taps	9	13
FBC	106	78
EUC	124	88
LFT	110	46
Cost of FBC/EUC/LFT (AUD)	\$6805.42	\$4218.02

Lessons Learned

- The system's sustainability is promoted by:
 - it's cost effectiveness
 - high degree of patient and family satisfaction
 - patient appreciation of a sense of control and understanding of their disease
- 2007 patient satisfaction survey data indicates liver disease monitoring programs are highly acceptable to liver patients
- A liaison nurse service is a **service redesign** with wide applicability to chronic disease groups with monitoring needs

Future Scope

- Holistic care for advanced liver disease patients *Advanced care directives

JHH ICU audit of 3 months activity:

- 11 patients with chronic liver failure to ICU
- 1 survived, returned to ICU, died 2 months later
- 1 survived and discharged

patient - focused? initiated? quality life/death?

- Other chronic disease groups with indications for intermittent need for hospital services
 - Patient triggered
 - Problem orientated
 - Efficient and effective