Improving access to psychological therapy for people with heart failure

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Our model for learning and change
Background

MDD 21.5%
Depression in heart failure
Elevated Sx 35.5%

“Depression increases all-cause mortality risk in HF patients”

Source: Gathright EC et al., J Psychosom Research, 94:82-89, 2017
Impact of depression

- Worse prognosis
- Functional decline
- Re-hospitalisation
- Increased risk of mortality

Responding regional NHS boards…
Does your NHS board have a defined clinical pathway for people with heart failure to access psychological support?
In your NHS board, are people with heart failure routinely assessed or screened for emotional distress or behavioural disturbance?
How many people with heart failure were referred for psychological support from your local service in 2013?
How many people with heart failure were referred for psychological support from your local service in 2013?

~50
What are we trying to accomplish?

“To improve psychological care for people with heart failure in Scotland”
What are we trying to accomplish?

1. Increase the number of people with HF recognised as being ‘depressed’ or ‘distressed’
2. Increase the number of people with HF accessing psychological therapy
3. Increase the number of HF staff trained to provide psychological support for people with HF
4. Improve patients’ experience and satisfaction of their HF management
“To improve psychological care for people with heart failure in Scotland”

- Increase the number of people with HF recognised as being ‘depressed’ or ‘distressed’
- Increase the number of people with HF accessing psychological therapy
- Increase the number of HF staff trained to provide psychological support for people with HF
- Improve patients’ experience and satisfaction of their HF management
- Routine screening
  - Increase awareness
  - Staff training
  - Adopt models of self-management
  - Encourage self-referral
  - Monitor patient flow
  - Establish defined clinical pathways
  - Embed psychol care within documentation
  - Online learning options
  - Adopt standards for service
  - Support with continuous mentoring
  - Change nomenclature
  - Increase peer support
  - Improve staff communication
What you do not measure, you cannot improve.”
“The diagnosis of depression should be considered in all patients with heart failure.”

Source: NICE Guideline 108, Chronic Heart Failure, 2010
Recognition and management of psychological distress in heart failure

Abstract

Background: There is evidence that psychological distress is common in people with heart failure, and associated with increased hospitalization and mortality. The aim of this study was to examine the prevalence of psychological distress in a sample of patients with heart failure, and to investigate associations between psychological distress and clinical characteristics.

Methods: A cross-sectional study was conducted in patients with heart failure (n=100) attending a tertiary care centre. Psychological distress was assessed using the Hospital Anxiety and Depression Scale (HADS). Demographic and clinical characteristics were also collected.

Results: The prevalence of psychological distress was 46%. There was a significant association between psychological distress and age, with older patients reporting higher levels of distress. Moreover, patients with higher New York Heart Association (NYHA) class also showed higher levels of psychological distress.

Conclusion: Psychological distress is common in people with heart failure and is associated with negative outcomes. Early identification and management of psychological distress are crucial to improve patient outcomes.
1. Lack of knowledge and skills, and systems, to routinely monitor and identify depression in people with HF
2. Lack of ability and confidence in directly delivering low-intensity psychological therapy
3. Unreliable systems to direct patients to psychological services as appropriate
1. HF services should have a clearly defined clinical pathway detailing the provision of psychological assessment and care for people with HF including systematic, routine monitoring of psychological well-being and ready access to psychological therapy as appropriate.
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2. Healthcare professionals working within HF services should complete an appropriate training programme to enhance their knowledge and skills of psychological care.
Improving psychological care in heart failure: what training works for whom?

Recommendations to increase access to psychological skills training for healthcare professionals

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2. Healthcare professionals working within HF services should complete an appropriate training programme to enhance their knowledge and skills of psychological care.

3. Healthcare professionals working within HF services delivering psychological interventions should have regular and routine access to consultation and/or supervision with a suitable practitioner psychologist/psychiatrist to optimise the competency and delivery of interventions.
Level 1
Sub-threshold problems

Level 2
Mild/moderate symptoms

Level 3
Severe & persistent
1. People with HF should have their psychological well-being monitored at every contact with their HF health care professional, assessing for the presence and symptoms of psychological distress.
“During the last month, have you often been bothered by feeling down, depressed or hopeless?”

“During the last month, have you often been bothered by having little interest or pleasure in doing things?”

Source: NICE Guideline 91, Depression in adults with a chronic physical health problem, 2009
“The use of depression screening or case finding instruments has little or no impact on the recognition, management or outcome of depression in primary care or the general hospital.”

Source: Gilbody S, House A, Sheldon T: Screening and case finding instruments for depression (review). The Cochrane Library, 2009
### Psychology

Over the past 2 weeks how often have you been bothered by any of the following problems:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than ½ of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total**

**PHQ Total Score**

Score ≥ 4  □  Ask Risk Question (below)

**Score of ≥ 1 - Further Risk Assessment Required - Ask Suicide Risk Follow-Up Questions**

<table>
<thead>
<tr>
<th>Thought</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Referral for further support?**

- GP
- Mental Health Services
- Psychology
- Voluntary Sector
- Other

**Advice/Signposting/Resources provided**

□

**Give details:**

**Daily Review/Clinic Review**

**Date**
1. People with HF should have their psychological well-being monitored at every contact with their HF health care professional, assessing for the presence and symptoms of psychological distress.

2. People with HF, recognised as experiencing psychological distress, should be offered access to evidence-based psychological interventions appropriate to their needs and preferences.

3. People with HF, receiving a psychological intervention, should have their response to treatment monitored at each appointment using validated outcome measures and the delivery of their treatment adjusted in response to such outcomes.
Percentage of patients screened identified as ‘distressed’
1. People with HF should have their psychological well-being monitored at every contact with their HF health care professional, assessing for the presence and symptoms of psychological distress.

2. People with HF, recognised as experiencing psychological distress, should be offered access to evidence-based psychological interventions appropriate to their needs and preferences.
Percentage of patients accessing psychological care

Before
- No access: 76
- Access to care: 24

After
- No access: 28.2
- Access to care: 71.8
2.2 EMOTIONAL WELLBEING AND HEALTH BEHAVIOUR CHANGE

- Patients with heart failure should be screened for depression using a validated measure and within the context of a collaborative, stepped-care model which includes a locally-defined clinical care pathway.

- Cognitive behaviour therapy should be considered for patients with heart failure and clinical depression.
PDSA cycles

**Agree Next Steps**
- To roll out pilot to Wishaw for 3 months
- Have portable folder with spare questionnaires and signposting information
- Ensure front sheet visible for audit
- Have information leaflets on anxiety/depression
- Get on distribution list for updates on Stress Control dates
- Remember that not able to ‘fix’ psychological issues
- Meet up next Feb/March
PDSA Improvement Cycle

**Act**
- Results justify adopting new method
- Document the new standard practice
- Implement new standard

**Plan**
- Objective for this experiment (this turning of the PD cycle)
- Plan the experiment
- Set operational definitions
- Prediction: What would various results mean?

**Study**
- Review the results
- Compare to predictions
- What did you learn?
- Was the turn of the cycle warranted?

**Do**
- Do the experiment
- Collect results

**Aims of Pilot Study**
- To improve recognition and management of psychological distress in NHSL CHF patients
  - Process
    - Outpatient clinics only — 2 sessions
    - PHQ4 and GAD12 to be sent with appointment
    - Scores reviewed in clinic; post and outcome discussed and recorded
    - Separate recording sheet at front of book
  - Start March 2017

**Summary of Data**
- Front sheet completed (38 male/16 female)
- 22/3/17 to 18/1/17
- 19 not returned (empty data sheet)
- Summary of scores (n=52)

<table>
<thead>
<tr>
<th>Score</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Low</td>
<td>11</td>
<td>21%</td>
</tr>
<tr>
<td>Medium</td>
<td>15</td>
<td>29%</td>
</tr>
<tr>
<td>High</td>
<td>10</td>
<td>19%</td>
</tr>
<tr>
<td>Very high</td>
<td>6</td>
<td>11%</td>
</tr>
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Outcome recorded (n=52)
• Increasing access to psychological therapies
• Enhancing HF care through psychologically-informed practice
Introducing Teach-Back into an Advanced Heart Failure Clinic - A Case Study

Introduction

Heart Failure (HF) affects approximately 800,000 people in the UK. Teach-back focuses on symptom management and strengthening the link to improve outcomes for clinical interventions. National guidelines specify effective communication between healthcare professionals, patients, and carers as essential for the best management of HF.

Teach-back is an interactive teaching method that focuses on key learning outcomes and asks patients to restate information in their own words. This allows the educator to evaluate patient understanding and reinforces and personalises concepts in an open interaction with the patient.

The Teach-back cycle

Aims

The project aimed to evaluate the feasibility of introducing teach-back as a means of ensuring quality communication and patient education during a cardiologist-led Advanced HF clinic, specifically to determine if changes:

- the quality of staff communication;
- patient experience of the consultation;
- patient knowledge, and
- staff confidence in their communication.

Methods

Pre-training - Clinical psychology and cardiology staff collaborators to obtain baseline descriptive and self-reported measures of use of teach-back skills, patient experience, patient knowledge, and staff confidence. This was taken from 15 patient consultations over three cardiologist-led Advanced HF clinics.

Training - The participating cardiologist completed the online teach-back training module.

Post-training - Measures continued at 14 further patient consultations over two clinics. The cardiologist then completed a semi-structured debriefing interview.

Results

Introducing teach-back increased staff confidence and use of good communication indicators (Figure 1). Patient knowledge also improved without significantly impacting patient experience (Figure 2).

Conclusion

In addition to teaching and enhancing existing communication skills, the element of patient re-stating information in their own words was the most beneficial aspect of teach-back for both practitioners and patients.

By demonstrating that teach-back is a simple and cost-effective means of achieving improvements in patient knowledge, staff confidence, and communication, we hope that NHS colleagues will be encouraged to embark on similar improvement projects.

References

1. NICE, Chronic Heart Failure, Clinical Guidelines CG86, (2016), Available at: https://www.nice.org.uk/guidance/cg86.
2. NICE, Heart Failure: Management of Patients with Heart Failure, (2012), Available at: https://www.nice.org.uk/guidance/cg169.
3. ...
<table>
<thead>
<tr>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
</tr>
</thead>
</table>
| Position of peer support | - Establish Learning Cafe  
- Develop HfP relationship programme |
| Access to peer support | - Increase number of people with HfP to receive peer support (e.g., advance Learning Cafe, start of mentors)  
- Create a patient registry (database) to monitor those receiving formal peer support  
- Check what services to be used within HfP. Climate and demonstrate after  
- Improve (or improve documentation and increase likelihood of actualisation)** |
| Raise awareness of value of peer support among staff and patient population | - Mind shift to be identified/invited to participate in the group  
- Dissemination of outcomes from Learning Cafe |

*HfP: Heart Failure Patients
National online survey of HF service users (n=174)

Gathered views on term ‘heart failure’ and potential other terms (e.g. cardiac dysfunction, heart pump impairment)

Term ‘heart failure’ distressing for 1 in 2

Term ‘heart failure’ associated with negative beliefs about illness and poor quality of life
Impact

REALISTIC MEDICINE

CAN WE:

BUILD A PERSONALISED APPROACH TO CARE?

CHANGE OUR STYLE TO SHARED DECISION-MAKING?

REDUCE HARM AND WASTE?

REDUCE UNNECESSARY VARIATION IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

Australia

1. Being adaptable
2. Becoming informed
3. Being dedicated

NHS Scotland

Chief Medical Officer's Annual Report 2013-14

REALISTIC MEDICINE

The Scottish Government

Health Improvement

August 2013

The Scottish Government
“Small easily implemented changes will result in the assessment and documentation plus intervention as required now being offered to a significantly higher proportion of patients than previous. Our cardiac rehab team are also going to implement some of the recommendations so just in Tayside in one year, 2000 patients will have been assessed who previously might have been overlooked. I am so chuffed!”

Email correspondence from HF nurse specialist, May 2016
“I have shared our learning and draft pathway with other long term condition teams - Diabetes in particular are very interested, as are the Stroke team.

So my own feedback is very positive. I have found the tools easy to use and to be an appropriate addition to our standard assessment.”

Email correspondence from Lead Nurse Cardiac Services, June 2016
Key learning points

1. Small changes, not major paradigm shifts
2. All good ideas come from employees
3. Change is cheap
4. Ownership and accountability
5. Reflective
6. Measureable and repeatable
“Simple ain’t easy”