Guide to implementing a rapid access atrial fibrillation clinic at your health service

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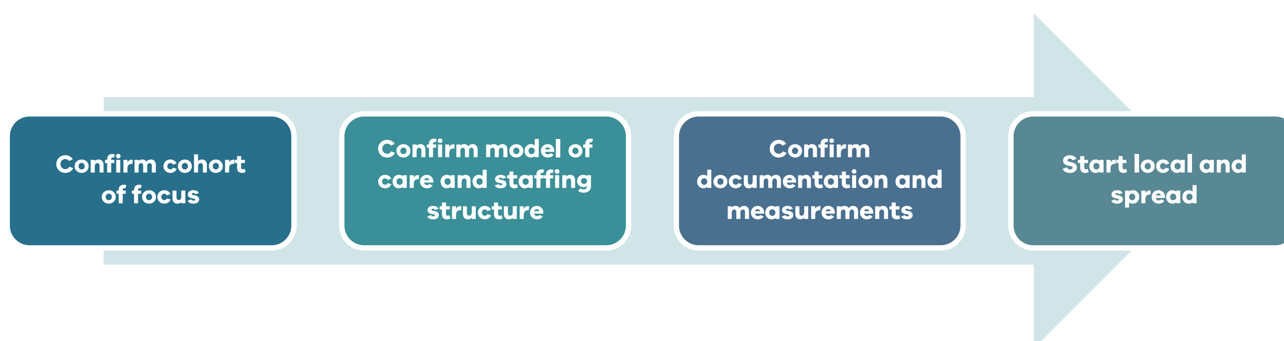
The Rapid Access Atrial Fibrillation (RAAF) Clinic pilot program was implemented at six health services in regional Victoria from 2021-2023, with the aim of referring patients presenting to the emergency department with atrial fibrillation (AF) to a rapid access atrial fibrillation clinic within 14 days from discharge. Better access to specialist clinics in regional Victoria led to improvements in AF management, which in turn reduced AF burden and likely prevented avoidable strokes. For more information, visit the Rapid Access Atrial Fibrillation Clinics Evaluation summary report (accessed here).

To assist in setting up a RAAF Clinic at your health service, we have created a guide based on the pilot. Note that the guide offers suggestions and should be customised to suit your health service's unique circumstances.



Cohort of focus

The target cohort in the RAAF Clinic pilot was AF patients presenting to the emergency department (ED) of the health service. You may elect to focus on patients with newly diagnosed AF, or those with chronic AF. Design the clinic intake criteria to reflect the chosen cohort, and consider incorporating AF referrals from wards, external health services, urgent care centres, and primary care providers such as general practitioners (GPs).

Model of care and staffing structure

Design a model of care that achieves clinical goals and facilitates easy integration with your health service's existing environment.

One example from a health service that participated in the pilot is a **nurse-led clinic** which was effective in shortening patient wait times:

- The clinic coordinator – a registered cardiac liaison nurse – triaged referrals from ED and inpatient units, catchment hospitals, and GPs in the region, ensuring patients who met inclusion criteria were seen at the clinic within 14 days. They coordinated pre-consultation tests for baseline assessments such as TTE and blood tests to optimise use of time during appointments with the cardiologist at the clinic. This approach also reduced the number of appointments required by patients overall.
- Upon presenting to the clinic, patients were seen by the clinic nurse and cardiologist. Assessments conducted included EQ-5D-5L, ECG, CHA2DS2-VASc, and HASBLED. Patients were also screened for co-morbidities, appropriate prescribing of oral anticoagulants, and arrhythmia.
- Patients concluded clinic visits with a better understanding of AF management, a care set (individualised AF action plan), and a follow up appointment (if required). Patients could also be discharged to internal specialty clinics, HITH, HARP, cardiac rehab, or their GP.
- Clerical staff supported clinic operations with assembly of patient information, lodgement of referrals, and collection of measurement data.

Other models of care represented in the pilot involved **pharmacist-led clinics**, **geriatrician consultants**, and **telehealth services**.

Confirm documentation and measurements

Appropriate documentation is pivotal in streamlining clinic operations. Customised templates designed by health services included:

- clinic referral form
- appointment booking form
- assessment forms e.g. EQ-5D-5L
- discharge form to maintain transitions of care (may be combined with a follow-up plan)
- care sets containing educational material for patients to bring home which may include an individualised AF management plan and lifestyle management advice

A measurement strategy outlines key performance indicators of success and is essential in tracking progress of the clinic. It may include additional objectives that lead to improved AF patient care, such as:

- increasing stroke risk assessment and bleeding risk screening
- increasing prescribing of appropriate oral anticoagulants for stroke prevention
- ensuring patients have follow up appointments

Please refer to the Rapid Access AF clinics measurement strategy template and data master spreadsheet template. These have been modified from documents used in the RAAF Clinic pilot program and can be accessed here.

Start local and spread

At the start, test clinic operations on a small scale, e.g. the referral pathway with your health service's ED. After several referrals, assess via the collected data and staff/patient feedback: Does the process function as intended, or does it require optimisations? Repeat small scale testing until you are confident that the pathway is running smoothly. Once established, gradually scale up by testing referral pathways with other wards within your health service, eventually expanding to external sources such as catchment hospitals and GPs.

At all stages of operation, identify barriers and implement changes for improvement – a risk register can assist in mitigation planning. In the pilot, a common barrier found at multiple health services at clinic initiation was low referral numbers. One health service addressed this by introducing the clinic referral form to ED physicians and educating administrative staff to coordinate appointments.

Best practice recommendations

Here are some learnings from the RAAF Clinic pilot:

- **Advertise the RAAF Clinic** to ensure a stream of referrals from clinic launch. Some health services achieved this through use of promotional emails, newsletters, website updates, and directly approaching staff where gaps in referral sources were identified.
- **Streamlined referral pathways** are fundamental for the clinic's success. One health service set up a line of direct communication between the ED nurse and RAAF Clinic nurse and trained administrative staff to process referrals daily.
- A robust **discharge pathway** ensures patients receive appropriate transitions of care. One health service established a system to refer low-risk patients back to their GPs for ongoing management, which reduced the burden on the general cardiology wait list and encouraged patients' return to community.
- **Collaborate with regional health services**. In addition to observed improvement in patient outcomes, clinic coordinators enjoyed the social links and knowledge exchange networks that resulted from partnering with other health services.
- **Workforce shortage** was a common barrier across multiple health services. Involve junior medical, nursing, and allied health staff to establish a deployable workforce and promote sustainability of the clinic.
- **Measure and monitor clinic engagement numbers and wait time to first clinic appointment** to keep track that your clinic maintains its responsiveness and does not become a routine clinic with extended wait times.

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Glossary

CHA2DS2-VASc: Tool for calculating stroke risk in patients with atrial fibrillation.

Electrocardiogram (ECG): A test used to evaluate heartbeat.

EuroQol-5 Dimension (EQ-5D-5L): A questionnaire used to assess health-related quality of life by measuring individuals' overall health status across five dimensions.

HASBLED: Scoring system to estimate bleeding risk for patients with atrial fibrillation on anticoagulation.

Hospital Admission Risk Program (HARP): A suite of services to manage people with chronic disease, aged and/or complex needs who present frequently or are at imminent risk of presenting to hospital.

Hospital in the Home (HITH): Program designed provide acute admitted care to public hospital patients in the comfort of their home, or other suitable location.

Transthoracic echocardiogram (TTE): An ultrasound test to create images of the heart.

Resources

Rapid Access Atrial Fibrillation Clinics summary report (accessed here)

Rapid Access Atrial Fibrillation Clinics measurement strategy template (accessed here)

Rapid Access Atrial Fibrillation Clinics data master spreadsheet template (accessed here)