A Piece of Your Heart, Who Fits Where in Your Heart Failure Care?

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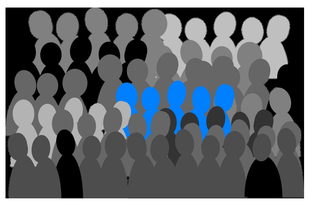
Case for change

There is variation in the way that care is delivered to patients admitted with a primary diagnosis of heart failure in the Greater Newcastle Sector.

Local research within HNELHD discovered a high incidence of readmission and mortality in people with Heart Failure over a 10 year period.(1)



A service review identified opportunities to improve the model of care and improve the outcomes for patients with Heart Failure.(2)

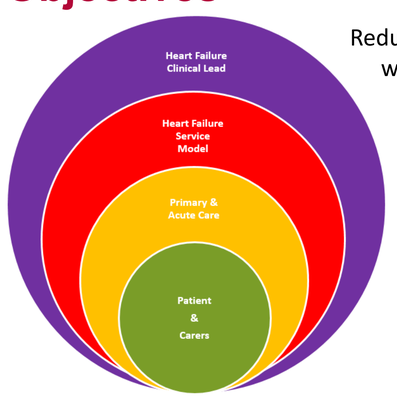
HNELHD strategic plan has a vision "healthy people – now and into the future" - keeping people healthy and in the community providing world class clinical services with timely access and effective infrastructure.(3)

The research, service review and strategic vision for HNELHD showed that there was an opportunity to strengthen the relationship between acute, community and primary care and enable innovation to minimise clinical variation and waste.

Goal

To provide coordinated, equitable access and patient centred Heart Failure (HF) care for people in Greater Newcastle Sector (GNS), transitioning between acute and primary care.

Objectives



Reduce Length of Stay for patients admitted with HF by 10% from 6.2 days to 5.6 days by October 2020

Reduce 28 day readmission rate for HF only primary diagnosis by 10% from 5.6% to 5.0% by October 2020

Improve the experience for Heart Failure patients transitioning from acute facilities to community

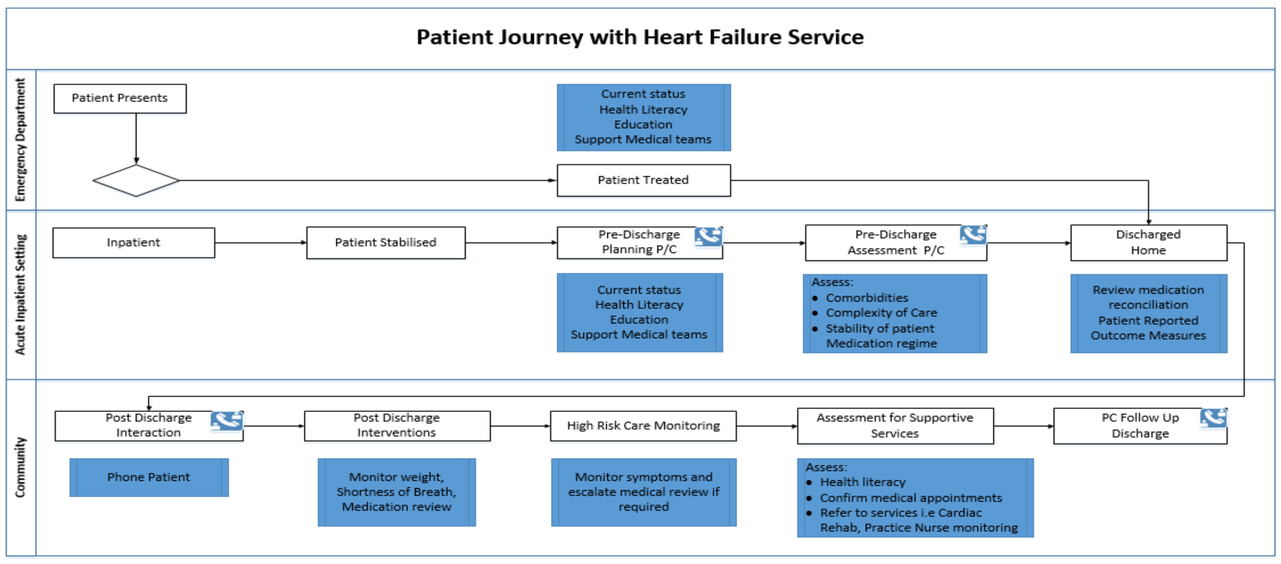
Method

This project is being developed in line with the Centre for Healthcare Redesign Methodology supported by the NSW Agency for Clinical Innovation

Diagnostics Activities		
GP/Primary Health: GPs, Practice Nurse- Nurse Practitioner, Community Nurse Care Coordinator, Community Pharmacist Process Mapping Workshop (n=9)	General Medicine and Cardiology Staff Specialist Process Mapping Workshop (n=7)	Inpatient Multidisciplinary Staff: Pharmacist, Dietician, NUM, HITH Assessment Nurse, End of Life Nurse Practitioner, Physiotherapist Process Mapping Workshop (n=10)
Patient Interviews (n=10)	Staff Interviews (n=10)	Root cause analysis workshop (n=4)
GP HF PENCAT data extraction	Baseline data collection (LOS and 28 day readmission)	Medical File Audits (n=30)
HNELHD research publication December 2017: 'Outcomes following Heart Failure Hospitalisation in a regional Australian setting between 2005 and 2014' [1]		HNELHD Heart Failure Service Review 2017

Solution Design	
Solution *'Brain Storming'* Workshop	Staff interviews
Team Workshop	Literature Review
Benchmarking	Patient Consultations

The New Journey for People with Heart Failure in Greater Newcastle Sector



Heart Failure Service providing:

Care coordination

Patient education and post discharge follow up via telehealth

Contact point for primary care providers

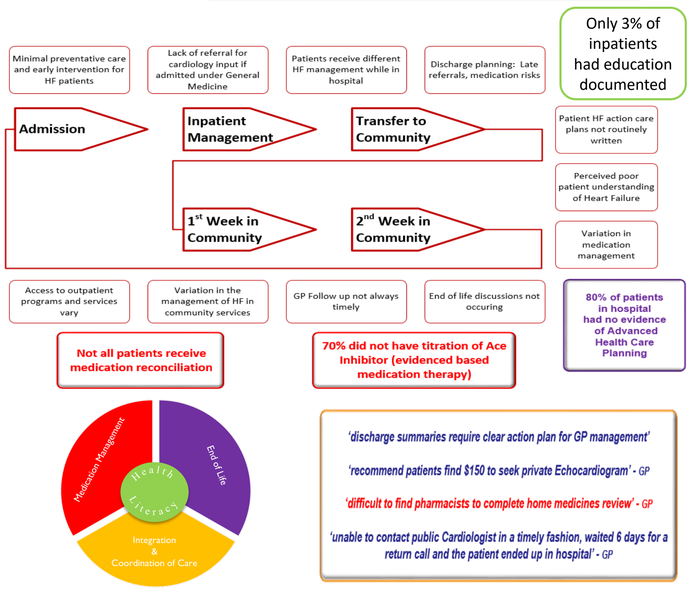
Education strategies for acute and community staff

Diagnostics

In 2017 **1008** patients were admitted with *primary diagnosis* of Heart Failure.

Only 26% of these patients were managed by the current Heart Failure Service provided by Hospital in The Home.

"No one told me I'm dying"
"I wasn't sure so I took my old and new pills"
"I'm waiting to hear about my appointment with the specialist" (7 weeks post D/C)
"I didn't know I was in hospital for my heart, I thought it was a kidney infection"



'discharge summaries require clear action plan for GP management'

'recommend patients find $150 to seek private Echocardiogram' - GP

'difficult to find pharmacists to complete home medicines review' - GP

'unable to contact public Cardiologist in a timely fashion, waited 6 days for a return call and the patient ended up in hospital' - GP

Quick Wins

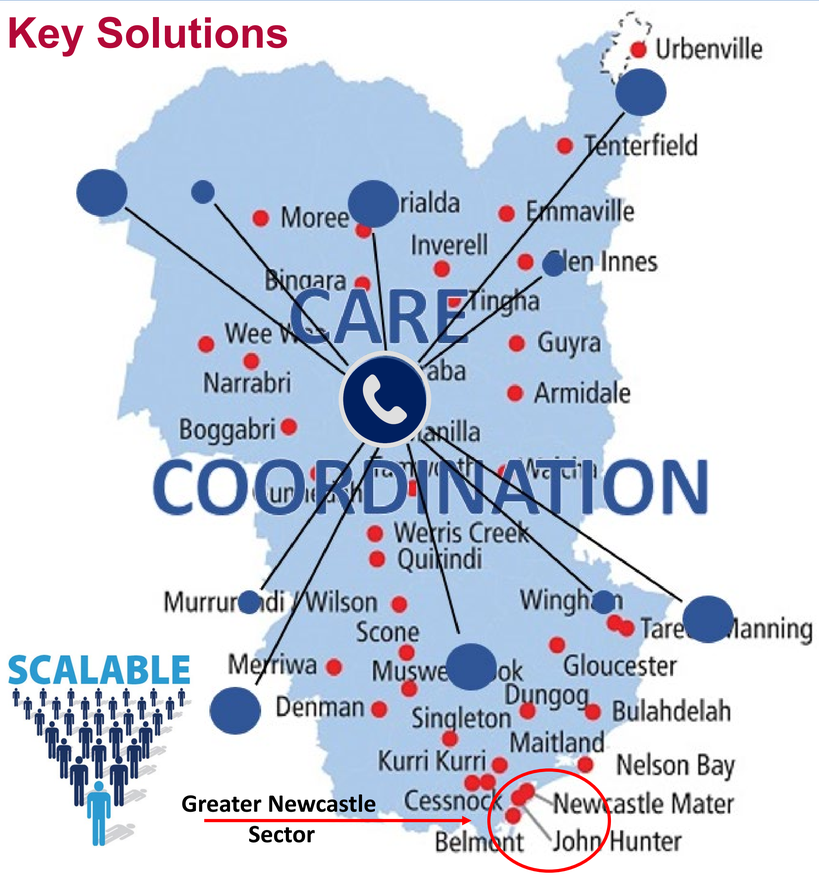
patient info
CENTRAL COAST & HUNTER NEW ENGLAND

PatientInfo public website providing patients with consistent information

Fostering relationships between primary and acute care services

Cardiovascular Investigation form changed to pink on Community HealthPathways as this is how it is recognised in Acute Facility

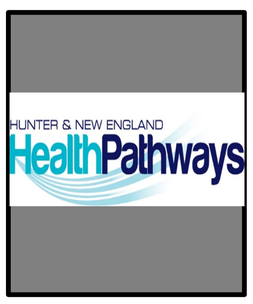
Key Solutions



DESIGNED FOR SCALABILITY AND TRANSFER TO OTHER SECTORS

Heart Failure Service Model
Telephone support service

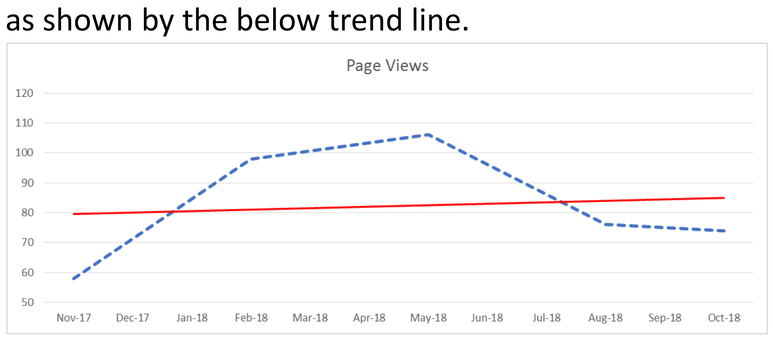
Heart Failure Discharge Plan
Development & Integration



Health Pathways
Community and Hospital HealthPathway

Results

Integration: Increasing use of the Community Heart Failure HealthPathway at start of the project then sustained over time following the revision in July 2018 as shown by the below trend line.



Improvement in utilisation for Heart Failure Community HealthPathways

Length of Stay, readmission rate and patient reported outcome measures will be monitored by new Heart Failure service as full implementation occurs.

Sustaining Change

- Key relationships built
- New way of working is clearly documented and agreed by stakeholders
- Processes to monitor outcomes
- New Position Description developed and recruitment completed for Heart Failure nursing position

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Conclusion

This project resulted in a redesign of the existing HF services to provide coordination of care access across both acute and community using a telehealth model. The approach aims to optimise the patients care in hospital and provide navigation on discharge to ensure the patient is connected to appropriate services in the community.

Acknowledgment

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