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Poster

Heart to Heart: Partnership to improve outcomes for Chronic Heart Failure Patients in Western Sydney

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Abstract

Introduction: Chronic Heart Failure (CHF) is a complex and disabling disease with increasing prevalence in Australia, affecting 10% of people over the age of 65 and estimated cost of $1 billion per annum. CHF hospitalisations are potentially preventable when patients have timely access to healthcare services; receive evidence based, co-ordinated care across the continuum of primary, secondary and tertiary services.

Background: Data analysis at Blacktown and Mount Druitt Hospital (BMDH) Western Sydney Local Health District (WSLHD), identified 84% of 2012/13 CHF admissions were Potentially Preventable Admissions (PPA), including 28 day re-admission rate of 28%. A team was established in February 2014 with the goal to reduce PPA from 84% to 70% by October 2015, developing strategies to support patients to live well at home, improve their health outcomes and experience of care over the lifetime of their disease.

Methodology: The New South Wales Agency for Clinical Innovation (ACI) Healthcare Redesign Methodology was utilised. Five phases including initiation, diagnostics, solution design, implementation and evaluation; the methodology emphasises partnership with patients and stakeholders. Over 5 months, 35 stakeholders including patients and staff from BMDH, Community, General Practice and Medicare Locals participated in workshops, interviews, forums and data collection.

Diagnostic results:

- Follow up calls 48 hours post discharge identified 80% of patients did not have GP appointment; 80% had changes to medications, but only 40% had a supply; none had attended to basic self-management post discharge

- Only 1% of discharge summaries were available to GPs electronically.

- Patients have limited understanding of CHF and self-management and experience high levels of anxiety and frustration at limitations.

- Communication between healthcare services is fragmented and the system is difficult to navigate; care is poorly co-ordinated; and patients are inadequately supported in self-management.

Solution: The system of care was redesigned to improve transition from acute sector to primary and community care:

- Development of electronic documentation visible to all healthcare partners, including a self-management action plan

- 48 hour follow up calls to mitigate risk of re-admission, conduct a service needs assessment and coordinate connection with local chronic disease services and telephonic self-management program

- High risk patients jointly managed between acute, community health services and GP

- Patient register to facilitate discharge planning and care co-ordination

These local solutions are potentially transferable to other chronic disease specialties in WSLHD.

Outcomes: Early evaluation has identified clinician and patient involvement in the redesign process has facilitated local networking, development of capability in change management and redesign of clinical roles to facilitate transition of patients from hospital to primary care including increased home visits from two to nine a week. Organisational commitment of a project officer facilitates ongoing solution implementation and evaluation.

Discussion: There are inherent challenges with multi-sector partnership associated with variable funding models and resistance to change. Through early clinician and patient involvement in the redesign process, development of a shared vision, active sponsorship and a clear case for change connected to local priorities, we demonstrated the gains to be made through working in partnership to improve patient outcomes.

Keywords

partnership; redesign; capability; transition; chronic disease

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PowerPoint presentation

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