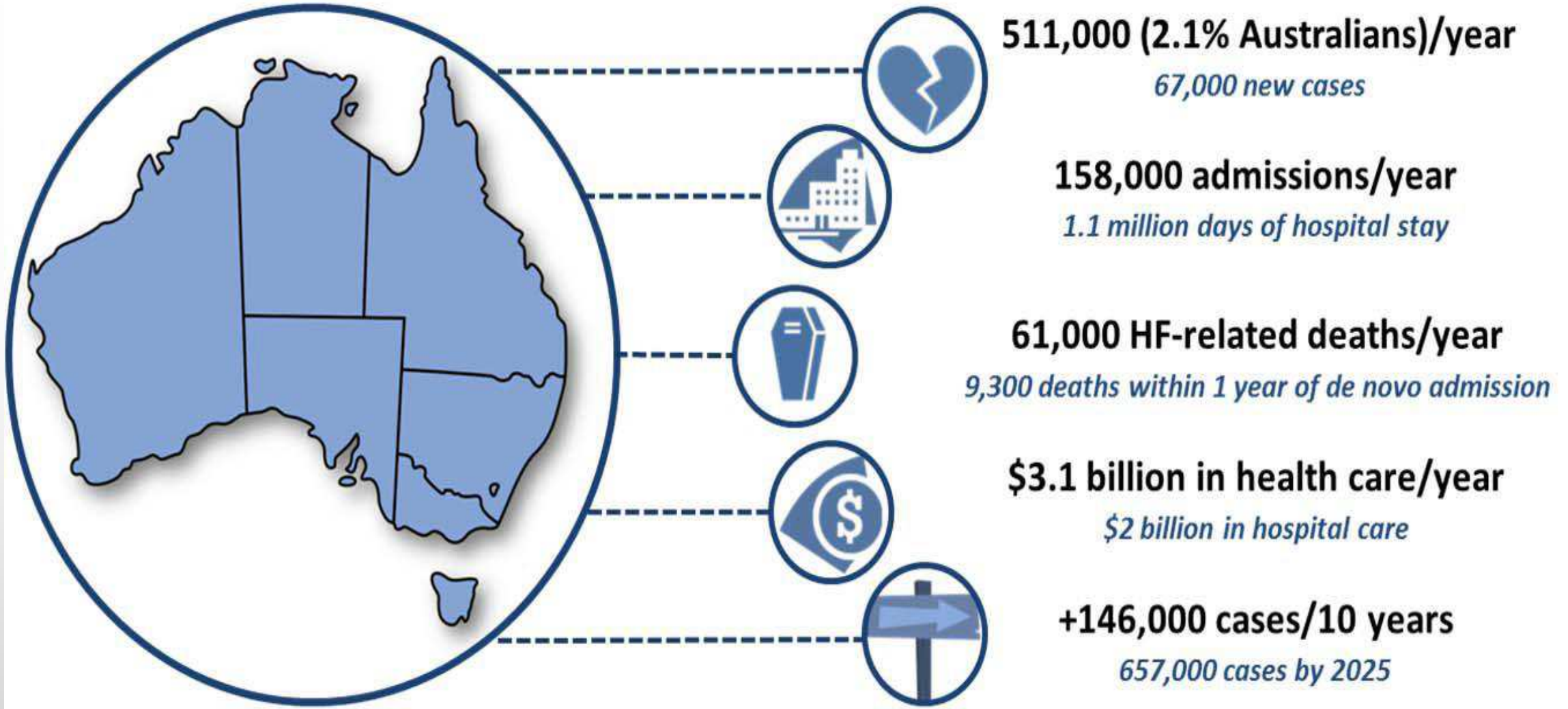
A PUBLIC / PRIVATE COLLABORATION TO REDUCE THE BURDEN OF PREVENTABLE HOSPITALISATIONS IN PATIENTS WITH HEART FAILURE IN TASMANIA

ahha australian healthcare & hospitals association | NOVARTIS | TASMANIAN HEALTH SERVICE | Tasmanian Government | Heart Foundation | primary health TASMANIA | phn TASMANIA An Australian Government Initiative

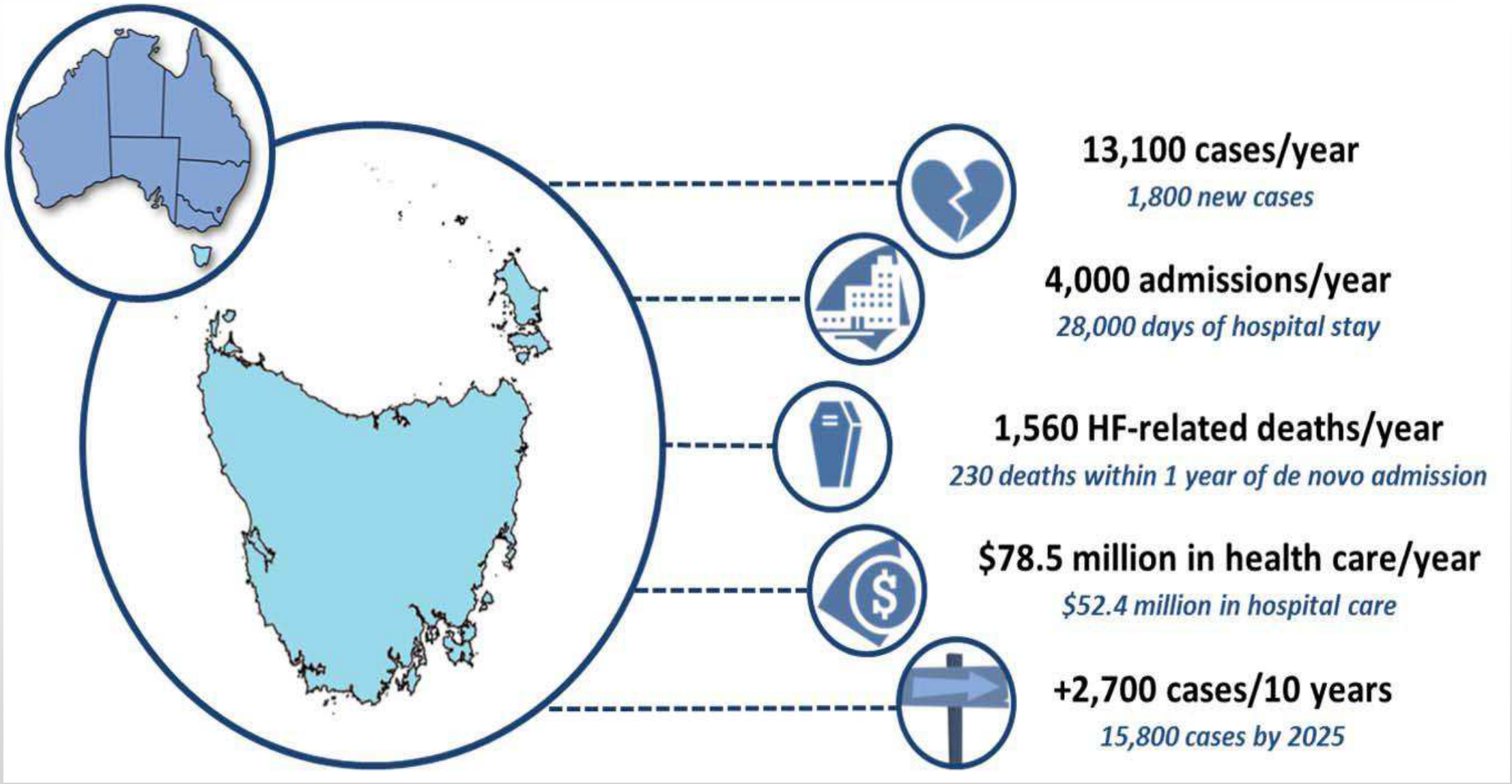
Background

- The Australian Healthcare and Hospitals Association (AHHA), the Tasmanian Primary Health Network (PHN), the Tasmanian Department of Health and Human Services (DHHS), the Heart Foundation Tasmania and Novartis Australia, have developed a collaboration aimed at reducing the burden of preventable hospital admissions in patients with heart failure in Tasmania.

- Collaborative: “a specific method of quality improvement used to distribute and adapt existing knowledge to multiple groups to achieve a common aim” – Improvement Foundation/PHN literature to practices



Chen L, Booley S, Keates AK, Stewart S. Snapshot of heart failure in Australia. May 2017. Mary MacKillop Institute for Health Research, Australian Catholic University, Melbourne, Australia



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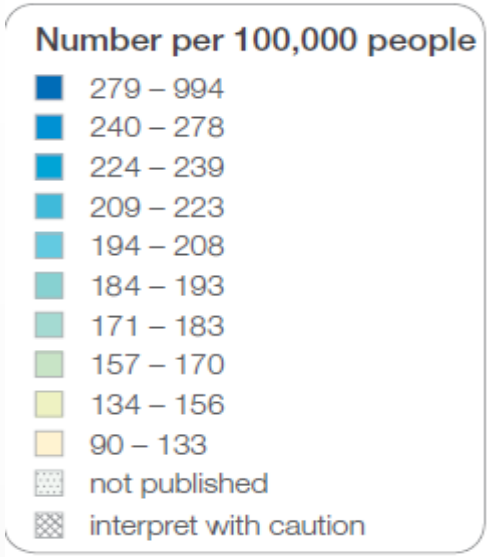


Launceston

Central highlands

Figure 1.11: Number of potentially preventable hospitalisations – heart failure per 100,000 people, age and sex standardised, by Statistical Area Level 3 (SA3), state and territory, 2014–15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Highest rate	437	338	424	632	284	326	259	994*
State/territory	181	201	210	201	187	177	169	344
Lowest rate	90	98	94	117	106	96	134	210
No. hospitalisations	17,394	14,580	10,997	5,355	4,536	1,295	614	572

Establishing the burden of Heart Failure in Tasmania – in 2014-15:

1295

Potentially avoidable hospital admissions

5.3

average length of stay

112 patients admitted **7** times

Source: Tasmanian Health Service

Tasmanians experience high rates of chronic disease, one of these being heart failure.

Primary Health Tasmania - comprehensive needs assessment found that 6.5% of the bed days for potentially preventable hospitalisations are due to heart failure, and up to 20% of top 500 individual re-presenters to hospital have heart failure.

Often these people have multiple co-morbidities.

Source: Tasmanian Health Service

The collaboration will seek to better integrate primary and acute care, using a ‘community of practice’ approach to address gaps in care of patients with heart failure, through better use and coordination of existing resources and services, including those available in the private sector.

Project goal

To reduce preventable hospital re-presentations through improved management of people with chronic heart failure in primary care settings.

Obj.1. Improve the skills of primary care providers, in particular general practitioners and practice nurses, in heart failure management.

Obj.2. Improve patient rehabilitation and self-management through education and support in local communities.

Obj.3. Improve the transfer of care summaries between acute care and primary care to inform care planning and management.

Other aspects include:

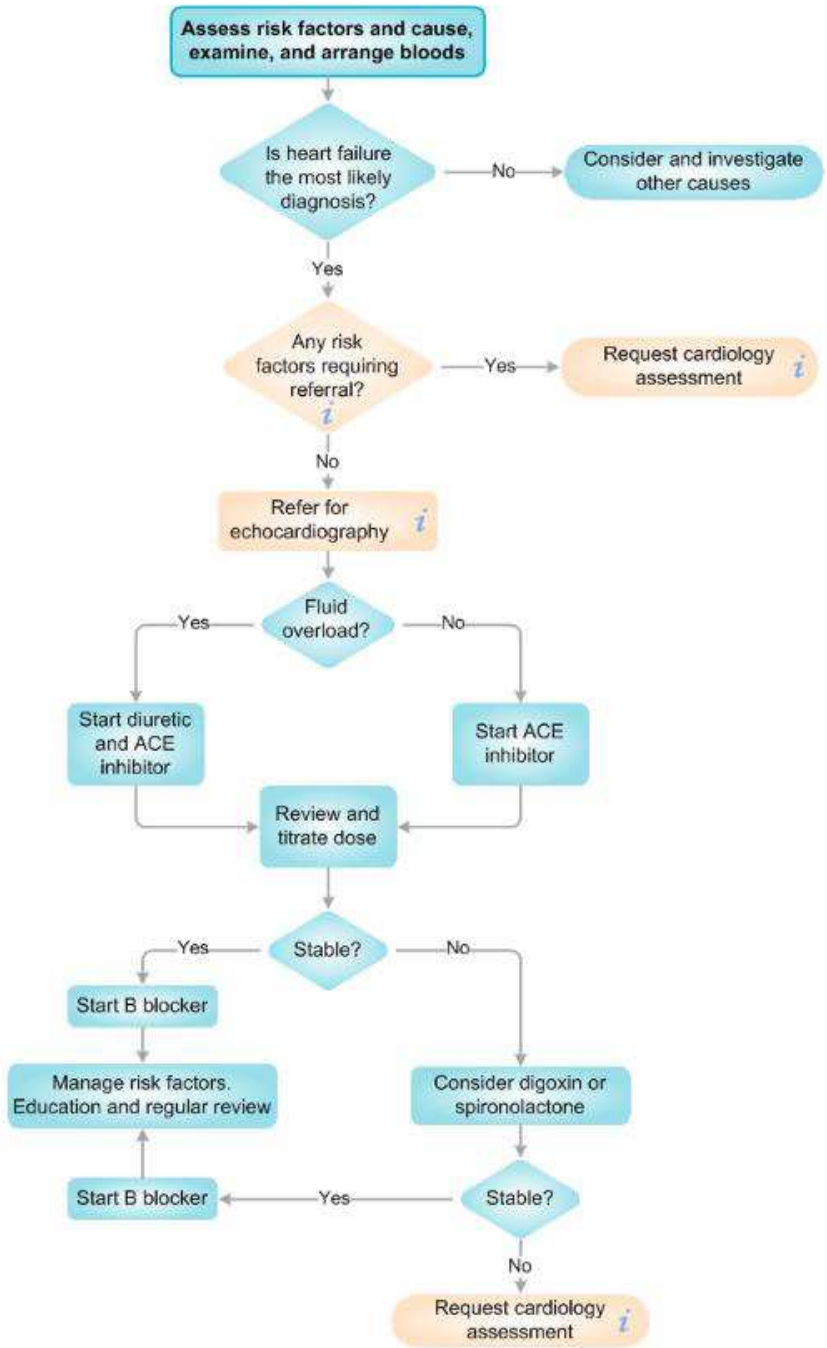
- working with targeted practices located in communities identified as having a high rate of preventable hospitalisations, to assist in identifying patient cohorts who would benefit from heart failure support and management;
- improving linkages also through improved utilisation of the Tasmanian HealthPathways and shared transfers of care.

Tasmanian HealthPathways
Connecting care across Tasmania

Search

- Home
- Acute Services
- Allied Health
- Child Health
- Investigations
- Lifestyle & Preventive Care
- Medical
  - Advance Care Planning
  - Assault or Abuse
  - Cardiology
    - Atrial Fibrillation (AF)
    - Cardiac Catheterisation Complications
    - Cardiac Drugs and Monitoring
    - Cardiovascular (CV) Risk Assessment
    - Chest Pain
    - Funny Turns
    - Heart Failure
      - Heart Failure
        - **Heart Failure Flow Chart**
      - Advanced or End-stage Heart Failure
    - Heart Murmurs in Adults
    - Heart Valves
    - Hyperlipidaemia
    - Infective Endocarditis Prophylaxis
    - Long QT Syndrome
    - Palpitations
    - Percutaneous Coronary Intervention (PC
    - Post-operative Care of Cardiac Patients
    - Warfarin - Starting and Monitoring
    - Cardiology Requests

Heart Failure Flow Chart



Heart Foundation

PRACTICE RECRUITMENT

- Education symposium advertised through PHT – GP's, PN's
- Chronic disease focus – HF, COPD, DM, CKD – plenary and workshop format – 1.5 days
- Expression of interest Heart Failure Collaborative – "Improving the management of heart failure in general practice"
- Project officer follow-up
- Practice visits
- Use of low literacy Heart Foundation resource
- Targeted education and support to practices engaged

Selected communities with high burden of potentially preventable hospital readmissions to build on their local existing resources & health care infrastructure (approx. 50km radius)

Metro	Outer Metro	Regional	Regional/rural	Rural
• Glenorchy Goal x2-3 with B'water/G'book 	• Bridgewater • Gagebrook  	• Sorell • Richmond Goal x2-3  	• New Norfolk Goal x2 	• Cygnet  Practices engaged: 1 New Norfolk 1 Sorell 1 Lindisfarne Others pending in 2nd round

ACTIONS

- Pre- and post-audit of practice data re HF management
- Issues in identifying patients fitting criteria
- Modification audit tool
- Feedback to practices
- Reflective questionnaire
- PDSA quality improvement activity
- CPD points
- Practice incentive payment

AUDIT

- Pre and post
- Targeting
  - Echo
  - d/c summary from hospital
  - last known patient stats eg SBP/DBP, rhythm, smoking status
  - medications – MTD/up-titration
  - monitoring eg renal function etc
  - non-pharmacological interventions targeting RF; depression screen; action plan
  - unplanned admission
  - HF service awareness
- Peer review

PRACTICE VISITS

- Project officer – assisting identification patients for audit process
- Project officer, GP and HFNP – support, guidelines, raise HF service awareness
- Feedback from practices re audit tool – subsequently modified
- Identified issues with practice databases – capacity to readily identify appropriate patients for project eg no easy way to search ‘echo’
- What is best method of providing information hospital → GP practice?
  - written eg HF plan separate to d/c summary or ensuring hospital doctors accurately relay specific instructions re management?
  - medication titration plan?

REFLECTIVE QUESTIONNAIRE

- What changes will or have you implemented in your practice as a result of your participation in this audit?
- How do you plan to monitor these changes?
- What evaluation process will you use to monitor these changes?

PDSA

Improvement Foundation

What are we trying to achieve? → goal

How will we know that a change is an improvement? → measures

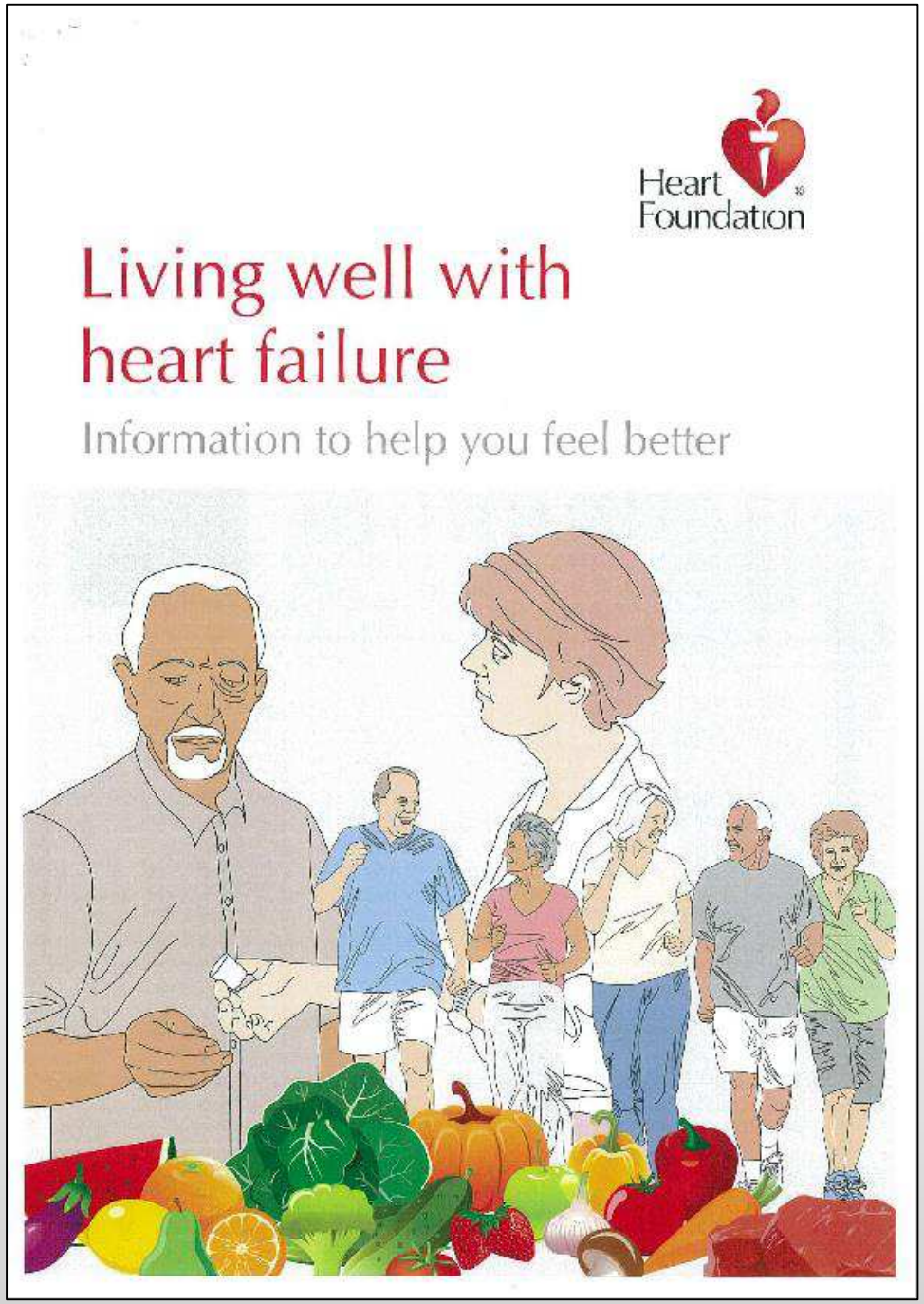
What changes can we make that will lead to an improvement? → ideas → PDSA

<u>Plans:</u>

- Smoking status recorded in patient file/record
- Maximum tolerated dose – up-titration plan
- Iron studies
- Medications – guideline recommended/MTD
- Document/record the diagnosis of heart failure in the patient file/record

PRELIMINARY PRE-AUDIT RESULTS

- No. patients = 16 No. GP's = 6 (3 practices)
- Echo last 12/12 = 14 (6 LVEF ≤ 40%)
- NHYA I-II = 8; NHYA III-IV = 7 S/R = 6; AF = 8
- On ACE/ARB = 11; MTD = 6; up-titrate = 2
- On BB = 14; MTD = 10; up-titrate = 1
- Fe studies = 7 FBE = 4 **UEC = 1** TSH = 10
- Screened depression = 7
- D/C summary = 9 received; 5 adequate
- Unplanned hospital admission = 6
- Contacted HF service for advice = 5



Heart Foundation

- Used as low literacy resource to practices
- No feedback to date
- Provided in acute setting Cardiology

Reflections

- HF ‘dilute’ in primary care – acute care ‘crisis’
- Role of PN
- Issues with identification patients through Practice electronic records
- Initial use of echo results for eligibility
- Slow recruitment practices
- Medication titration plan – perceived ambivalence re use
- No specific cardiac rehabilitation support resourcing
- Majority patients admitted General physicians – no specific heart failure care plan

THANK YOU