deeble institute interim report

date: 26/09/2017

title

Interim Report Briefing:

A Public/Private Collaboration to Reduce the Burden of Preventable Hospitalisations in People Living with Heart Failure in Tasmania

authors

Deeble Institute for Health Policy Research

Australian Healthcare and Hospitals Association

T: 02 6162 0780

E: deeble@ahha.asn.au

Tasmanian heart failure project

This report has been prepared by the Deeble Institute for Health Policy Research to provide an interim evaluation of progress on the Tasmanian Heart Failure project. The report outlines achievements and progress so far, and will support the continued implementation and final evaluation of the project.

The Tasmanian Heart Failure Project is aimed at reducing the burden of preventable hospital admissions for patients with heart failure. The project is a collaboration coordinated by the Australian Healthcare and Hospitals Association (AHHA) led by Primary Health Tasmania and the Heart Foundation with support from Novartis Australia and sponsorship from the Tasmanian Department of Health and Human Services (DHHS).

Purpose

The goal of the project is to reduce preventable hospital re-presentations through improved management of people with chronic heart failure in general practice.

Background

Chronic heart failure remains a major public health issue despite advances in clinical management. Heart failure is the most common cause of hospitalisations in people over 70 years of age internationally. The prevalence of heart failure in Australia is estimated at 1–2%. The rates are higher among Aboriginal and Torres Strait Islander Australians, women, and people living in rural and remote areas. Heart failure is strongly associated with co-morbidity and multi-morbidity leading to increased healthcare utilisation and high mortality. The total annual cost of managing heart failure is estimated to be more than $2.5 billion[1] with recurrent hospitalisations costing more than $1 billion each year[2].

Project scope

The project focuses on improving the management of heart failure in general practice and is being delivered in two initial phases:

Phase 1. Education symposium: improving primary health care workforce capabilities with targeted education (commenced November 2016)

- A 1.5-day symposium held in Hobart on the 11th and 12th of February 2017. The symposium provided information on the management of chronic diseases in general practice, including heart failure, COPD, diabetes and chronic kidney disease and was delivered by Primary Health

[1] National Heart Foundation of Australia 2013, 'A systematic approach to chronic heart failure care: A consensus statement', National Heart Foundation of Australia, Melbourne

[2] Krum H and Abraham WT 2009, 'Heart Failure', *Lancet;* vol 373, no 9667, pp 941–955

Tasmania, in collaboration with the Heart Foundation Tasmanian using a combination of plenary and practical break out sessions. The symposium was available to general practitioners and practice nurses across Tasmania.

Phase 2. General practice collaborative: targeted education and support for general practices to improve the management of patients with heart failure (also described as Heart Failure Collaborative; commenced February 2017)

- providing education and support to targeted practices located in communities identified as having a high rate of potentially preventable hospitalisations due to heart failure, to assist in identifying patient cohorts who would benefit from support and management;
- engaging general practitioners from targeted practices to undertake file audits with independent review and feedback on existing practice;
- engagement and support with targeted practices to use quality improvement methodology, 'plan, do, study act' (PDSA) to monitor and continue to improve care delivery;
- improving linkages with acute care services to support the transfer of care for people moving between acute and primary care through improved utilisation of the Tasmanian HealthPathways and shared transfers of care.

There are 12 general practices in the target area for this project:

- Glenorchy/Claremont/Berridale/Chigwell/Bridgewater/Gagebrook (2–3 practices);
- Sorell/Richmond/Dodges Ferry/Lewisham (3 practices);
- New Norfolk (2 practices).

The second round of target areas will be engaged from July 2017 and will include Huon Valley, Kingborough and New Town.

Progress at 30th June 2017

Outcomes from the symposium

The state-wide chronic conditions symposium provided education around contemporary evidence based guidelines and treatment pathways for Heart Failure, COPD, Diabetes and Chronic Kidney Disease. There were approximately 60 attendees at the symposium.

A particular focus of the education was around the early recognition of deterioration and improving responsiveness including:

- understanding echo-reports;
- maximal medications titrations;
- co-morbidities;
- end-of-life care;
- health literacy;
- discussions with allied health professionals e.g. pharmacists around improved engagement with general practice;
- promotion of the low literacy Heart Foundation Victoria resource booklet for consumers.

There was a significant improvement in attendees' self reported knowledge across all four topic areas heart failure, chronic obstructive pulmonary disease, diabetes and chronic kidney disease post-symposium. Nurse practitioners welcomed the opportunity to engage and 'action plan' with their colleagues and also commented on the opportunity to clarify existing services to improve the care they deliver. In a similar way general practitioners also indicated that they benefited from increased familiarity and confidence accessing resources including HealthPathways for the management of patients with heart failure.

Practices recruited

Three practices across the identified regions have enrolled (Derwent Valley Medical Centre, Sorell and Lindisfarne) with 11 general practitioners between the sites. The initial patient file audit utilising the tool has been completed in Derwent Valley Medical Centre (11) and Sorell Family Practice (7). As noted above, a revised audit tool is being rolled out in Lindisfarne. The second round of practices will be recruited in June/July.

Learning needs identified

Early insights from the project team identified: lower than anticipated understanding and interpreting of echocardiogram reports, and an inability to search for patients who have had an echocardiogram in practice software (PenCAT).

Health care providers in primary practice frequently describe current echocardiogram reports as being inadequate in providing information that is interpretative and that easily guides disease management by general practitioners. This concern highlights that not only could the reports be improved to provide clearer results and guidance, but also the skills of primary care clinicians could be enhanced to improve interpretation of echocardiogram reports.

While disease and treatment escalation in primary care has not been comprehensively examined, it has been identified as a potential factor in patient deterioration and hospital representation. Recognition of deterioration and escalation of management, including appropriate titration of diuretics and other medications at disease onset and on disease progression can be challenging.

Three other areas requiring further consideration include:

- practice nurse engagement with this patient cohort is limited and patients tend to only see the general practitioner (despite evidence related to the benefits of increased monitoring of this cohort);
- information about iron studies for patients with heart failure and the beneficial effects of long term intravenous iron therapy;
- variable practice in recording respiration rates identified during early review of the audit data. While the audit tool was amended to reflect this variation, the perceived value of this measure may warrant further investigation.

Data from patient file audits is currently being collated and will then be presented back to practices and will inform discussion of learning and education needs with participating practices. Dr Laura Edwards is facilitating these sessions and will report back the findings from the audits to the working group.

An early recommendation from Phase One is the addition of an echo search function in the PenCAT patient file survey.

Targeted education sessions

Public health physicians from Primary Health Tasmania have completed an introductory session with each practice. This discussion included background to the purpose of the Heart Failure Project and the potentially preventable hospitalisations for heart failure patients in the region. Education also included information about the local health profile, Collaborative—Model for Improvement, PDSA cycles and the clinical audit tool (patient data form).

Practice visits have been undertaken by the Clinical Engagement Coordinator at Heart Foundation Tasmania and the Nurse Practitioner Chronic Cardiac Care Coordinator Cardiac Rehabilitation Service at Tasmanian Health Service (Royal Hobart Hospital) with a third round of visits to be scheduled for July 2017. These visits have recognised the importance of clinical champions within the practice environment to achieve broader engagement.

The project officers are continuing to support general practitioner desktop access and familiarisation with the Tasmanian HealthPathways.

Project impact

The early findings and methodology around the collaborative have been shared at a variety of academic forums during 2017. This has included presentations at:

- ACRA 2017 27th Annual Scientific Meeting, Perth, 7–9 August 2017;
- Tasmanian Health Conference, Hobart, 29 July 2017;
- MyPHN Conference, Cairns 8–9 July 2017;
- APNA National Conference, Hobart 4–6 May 2017.

In addition to a poster presentation at:

- APNA National Conference, Hobart 4–6 May 2017.

Publications have included:

- The Health Advocate article, magazine of the Australian Healthcare and Hospital Association, 1 April 2017 "Integrated care for heart failure patients";
- Heart Foundation article, 13 February 2017, "New heart failure care program";
- Hobart Mercury newspaper article, 11 February 2017; "Heart help for hotspots";
- Tasmanian Times, 10 February 2017, "New heart failure care program";
- symposium media release, 10 February 2017, "New heart failure care program".

Conclusion

Early findings from the Tasmanian heart failure project underscore the reliance on clinical 'champions' to drive uptake of best practice initiatives. However, more systematic approaches to care, including quality improvement focused collaboratives such as the Heart Collaborative, and programs such as HealthPathways and Health Care Homes may potentially offer more sustainable approaches.

The chronic conditions symposium held in February 2017 assisted in improving the confidence of general practitioners and practice nurses in the management of heart failure, as well as building awareness of heart failure resources and services available in Tasmania.

Phase Two will expand the cohort of practices and patients involved in the project, and will provide more intensive education and resources. This combined with a focus on transfer of care will assist in moving towards best-practice management of heart failure via multidisciplinary care across the continuum of acute and primary healthcare.

The evaluation of this project will contribute to our understanding of effective methods for achieving practice change to provide integrated multidisciplinary best practice heart failure care. It is hoped that it will also contribute to better health outcomes for Tasmanians and progress towards achieving the shared goal of a reduction in potentially preventable hospitalisations for heart failure in Tasmania.

Contact

Deeble Institute for Health Policy Research

Australian Healthcare and Hospitals Association

T: 02 6162 0780

E: deeble@ahha.asn.au