



australian healthcare &  
hospitals association

*the voice of public healthcare®*



## **Tasmanian Heart Failure Project**

**A Public-Private Collaboration aimed at reducing the burden of preventable hospitalisations for people living with heart failure in Tasmania**

**Final Report  
September 2018**



---

## OUR VISION

A healthy Australia, supported by the best possible healthcare system.

## OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

## OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

- Effective
- Accessible
- Equitable
- Sustainable
- Outcomes-focused.

---

## OUR CONTACT DETAILS

Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close  
Deakin ACT 2600

PO Box 78  
Deakin West ACT 2600


P. 02 6162 0780


F. 02 6162 0779

E. [admin@ahha.asn.au](mailto:admin@ahha.asn.au)

W. [ahha.asn.au](http://ahha.asn.au)

 [facebook.com/AusHealthcare](https://facebook.com/AusHealthcare)

 [@AusHealthcare](https://twitter.com/AusHealthcare)

 [linkedin.com/company/australian-healthcare-&-hospitals-association](https://linkedin.com/company/australian-healthcare-&-hospitals-association)

ABN. 49 008 528 470

© Australian Healthcare and Hospitals Association 2017





## ACKNOWLEDGEMENTS

The Tasmanian Heart Failure Project is a joint partnership between Primary Health Tasmania, Heart Foundation Tasmania, Australian Healthcare and Hospitals Association, Novartis Pharmaceuticals Australia and the Tasmanian Department of Health<sup>1</sup>.

Sincere thanks are extended to the general practitioners, practice nurses, practice managers, project working group and the Royal Hobart Hospital heart failure nurse practitioner who gave their time and energy in implementing the project.

### STEERING COMMITTEE

- Sal Bucksey, Health Stream Lead, Primary Health Tasmania
- Phil Edmondson, Chief Executive Officer, Primary Health Tasmania
- Wyman Kwong, Healthcare Program Lead, Novartis Pharmaceuticals Australia
- Graeme Lynch, Chief Executive, Heart Foundation Tasmania
- Paul Macintyre, Director of Cardiology, Royal Hobart Hospital
- Gillian Mangan, Health Director, Heart Foundation Tasmania
- Scott McKeown, Public Health Physician and General Practitioner, Department of Health, Tasmania
- Glenn Montgomery, Director Patient Access and Health Care Solutions, Novartis Pharmaceuticals Australia
- Katharine Silk, Integration and Innovation Manager, Australian Healthcare and Hospitals Association
- Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association

#### *Former members*

- Rosie Beardsley, Primary Health Consultant, Primary Health Tasmania
- Geoff Chin, Head Healthcare Systems, Novartis Pharmaceuticals Australia
- Janelle Cragg, Primary Health Consultant, Primary Health Tasmania
- Martin Haigh, Business Franchise Director, Cardio-Metabolic, Novartis Pharmaceuticals Australia
- Siobhan Harpur, Chief Executive Officer Public Health Services, Department of Health, Tasmania
- Cheryl Maley, Director Patient Access and Healthcare Systems, Novartis Pharmaceuticals Australia
- Susan Powell, General Manager Planning, Design and Evaluation, Primary Health Tasmania

### WORKING GROUP

#### *Co-chair*

- Sal Bucksey, Health Stream Lead, Primary Health Tasmania
- Gillian Mangan, Health Director, Heart Foundation Tasmania

#### *Former co-chair*

- Susan Powell, General Manager Planning, Design and Evaluation, Primary Health Tasmania

#### *Members*

---

<sup>1</sup> As of the 1 July the Department of Health and Human Services was renamed the Tasmanian Department of Health

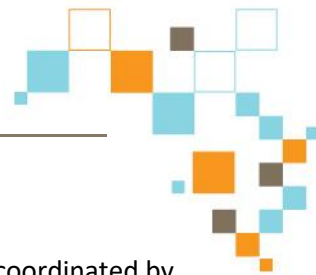


- Glenn Montgomery, Director Patient Access and Health Care Solutions, Novartis Pharmaceuticals Australia
- Katharine Silk, Integration and Innovation Manager, Australian Healthcare and Hospitals Association
- Pip Morris, Primary Health Consultant, Primary Health Tasmania
- Scott McKeown, Public Health Physician and General Practitioner, Department of Health, Tasmania
- Sue Sanderson, Nurse Practitioner Chronic Cardiac Care, Manager Cardiac Rehabilitation Service, Tasmanian Health Organisation South, Royal Hobart Hospital
- Wyman Kwong, Healthcare Program Lead, Novartis Pharmaceuticals Australia



## TABLE OF CONTENTS

- Acknowledgements..... 1**
- Introduction..... 4**
  - Background..... 4
  - Project aims and objectives ..... 4
  - Governance ..... 4
- Methodology ..... 6**
  - Ethics ..... 6
  - Symposium ..... 6
  - Continuous quality improvement activities..... 7
  - Grand round ..... 8
  - Collaborative partnership process ..... 8
- Project findings ..... 9**
  - Symposium ..... 9
  - Continuous quality improvement ..... 9
  - Case study..... 15
  - Collaborative partnership..... 16
- Discussion ..... 18**
- Project publications..... 20**



## INTRODUCTION

The Tasmanian Heart Failure Project was initiated in February 2016 as a collaboration coordinated by the Australian Healthcare and Hospitals Association, led by Primary Health Tasmania and Heart Foundation Tasmania with support from Novartis Pharmaceuticals Australia and sponsorship from the Tasmanian Department of Health. The vision was to conduct a project to reduce preventable heart failure hospitalisations in Tasmania. The main focus of the project was to support optimal management of heart failure in the primary care setting.

This report has been prepared by the Deeble Institute for Health Policy Research as a final evaluation of the project.

## BACKGROUND

Tasmanians experience the highest rates of heart disease<sup>2</sup>, with heart failure among the top six causes of preventable hospitalisations in Tasmania. In 2014–15 there were 1295 potentially preventable hospital separations for heart failure in Tasmania, with an average length of stay of five days<sup>3</sup>. An unpublished analysis undertaken by Primary Health Tasmania identified that 6.5% of the bed days for potentially preventable hospitalisations were due to heart failure and 99 of the top 500 (20%) individual re-presenters to hospital were heart failure related.

## PROJECT AIMS AND OBJECTIVES

The project aimed to reduce preventable hospital readmissions for people with heart failure. The objectives of the project were to:

- improve the skills of primary care providers—general practitioners and practice nurses—in heart failure management;
- improve patient self-management through education and support; and
- improve transfer of care summaries between acute care and primary care.

These were achieved by:

**Part one – Symposium:** a 1.5-day symposium in Hobart on the management of chronic diseases in general practice, including heart failure, COPD, diabetes and chronic kidney disease.

**Part two – General practice collaborative:** targeted education and support for general practices to improve the management of patients with heart failure.

**Part three – Participation in the Royal Hobart Hospital Grand Round:** presentation focussing on discharge summaries for heart failure patients to improve information provided to general practitioners.

## GOVERNANCE

The project was governed by a Steering Committee and activities were coordinated by a Working Group. In the early stages of project planning, effort was made to obtain agreement from all

<sup>2</sup> ABS 2016, *National Health Survey: First Results, 2014–15: Tasmania*, Cat. no. 4364.0.55.001 Australian Bureau of Statistics, Canberra.

<sup>3</sup> AIHW 2016, *Admitted patient care 2014–2015: Australian hospital statistics*, Health services series no. 68 Cat. no. HSE 172, Australian Institute of Health and Welfare, Canberra.



members of the collaboration to support governance, gain mutual trust and to provide transparency for the project.

### STEERING COMMITTEE

The role of the Steering Committee was to provide overall guidance to the project, including oversight of the project evaluation and to lead strategic communications and engagement.

### WORKING GROUP

The role of the Working Group was to:

- develop a detailed project proposal including an action plan and budget;
- lead implementation and evaluation work associated with development of a ‘community of practice’ approach to heart failure through building workforce capability and capacity; and
- respond to and support client needs and reduce potentially preventable hospital admissions, as directed by the Steering Committee.

Coordination of the project was provided by a Primary Health Consultant from Primary Health Tasmania, with support from the Working Group co-chairs. Secretariat support was provided by the Australian Healthcare and Hospitals Association. Project funds and in-kind partner contributions supported these positions.

### OPEN DISCLOSURE

Collaboration partners and individuals undertook to act with high levels of integrity and a commitment to open and transparent communication. This was formalised through a collaboration agreement with all partners.

Funding for this project was provided by Novartis Pharmaceuticals Australia<sup>4, 5</sup>. The Steering Committee established under the collaboration agreement, and agreed to by all project participants, was responsible for the use of these monies and performed this role using appropriate governance structures underpinned by principles of best practice corporate governance. No funds or resources were used to promote any pharmaceutical products during the project.

---

<sup>4</sup> Novartis Pharmaceuticals Australia adheres to the legislative requirements of the Therapeutic Goods Regulations and the Therapeutic Goods Act, as well as the principles of the Medicines Australia Code of Conduct. The code sets the standards for the ethical marketing and promotion of prescription pharmaceutical products in Australia, providing transparency to the working relationship between industry and healthcare professionals, ensuring ethical and appropriate interaction.

<sup>5</sup> Medicines Australia 2015, *Code of Conduct: Edition 18*, Medicines Australia, viewed 4 July 2018 <https://medicinesaustralia.com.au/wp-content/uploads/sites/52/2010/01/20150617-PUB-Code-Edition-18-FINAL.pdf>



## METHODOLOGY

A quality improvement methodology was chosen for convenience and feasibility, given the budgetary and resource constraints of the project.

## ETHICS

The project was approved by the Tasmania Health and Medical Human Research Ethics Committee. Reference number: H0016354

## SYMPOSIUM

A state-wide chronic conditions symposium held 11–12 February 2017 in Hobart was delivered to an audience of general practitioners, practice nurses and allied health practitioners. The symposium provided education on contemporary evidence-based guidelines and treatment pathways for the diagnosis and treatment of four chronic disease conditions commonly managed in primary care—heart failure, chronic obstructive pulmonary disease, diabetes and chronic kidney disease. A particular focus of the education was early recognition of deterioration and improving clinical responsiveness to changes in patient condition.

Heart failure topics included:

- understanding echocardiogram reports;
- maximal medication titration;
- co-morbidity;
- end-of-life care;
- health literacy;
- interdisciplinary practice with allied health practitioners and general practice; and
- promotion of low literacy heart failure resources such as the Heart Foundation Victoria heart failure booklet for consumers<sup>6</sup>.

Presentations were provided by medical specialists in cardiology, respiratory medicine, endocrinology and nephrology, in addition to a presentation provided by clinical nurse consultants, allied health professionals and medical technology practitioners working in these areas.

Feedback was obtained from symposium participants in the form of a survey.

---

<sup>6</sup> National Heart Foundation of Australia 2016, *Living well with heart failure: Information to help you feel better*, National Heart Foundation of Australia, accessed 28 June 2018, [https://www.heartfoundation.org.au/images/uploads/publications/Living\\_well\\_with\\_heart\\_failure\\_2017.pdf](https://www.heartfoundation.org.au/images/uploads/publications/Living_well_with_heart_failure_2017.pdf)





## CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES

This involved data collection by enrolled general practitioners prior to and following the continuous quality improvement activity within the pre-determined communities with high rates of potentially preventable hospitalisations due to heart failure.

Targeted engagement with general practitioners and practice nurses working in priority communities commenced in March 2017. General practitioners were recruited from general practices in Southern Tasmania. These were selected by identifying geographical areas where there were:

- higher age-standardised rates of potentially preventable hospitalisations due to chronic heart disease as determined by statistics available on the Australian Heart Foundation Heart Map<sup>7</sup>; and
- existing staffing and infrastructure levels adequate to enable appropriate engagement with project activity within project timeframes with minimal impact on everyday work.

General practitioners and practices were recruited from the identified geographical areas through targeted invitations and information provided to clinicians and practices via Primary Health Tasmania communication strategies, including the general practitioner email bulletin and through promotion of the project at the chronic disease symposium.

Participating general practitioners completed an audit on the clinical records of up to five of their current patients with heart failure. Data collected in the audit included patient demographics, clinical information, whether relevant pathology tests had been performed, pharmacological and non-pharmacological management.

General practitioners were then provided with feedback regarding their current practice based on the results of the audits, with the offer made to provide aggregated feedback to general practitioners and practice nurses within the practice if this was preferred. General practitioners were also provided with information on the national heart failure guidelines<sup>8</sup> and the Tasmanian heart failure HealthPathways<sup>9</sup>. General practitioners completed a reflective questionnaire after receiving audit feedback to encourage reflection on, and identification of opportunities for improvement in managing patients with heart failure.

Academic detailing sessions were then delivered to clinicians with continued support as per the general practitioner and practice preferences.

Participating general practitioners, either individually or as a practice group undertook 'Plan, Do, Study, Act' quality improvement cycles focussed on areas of identified need. Promotion of the Heart Foundation's low-literacy heart failure patient resource and the Tasmanian HealthPathways to participants occurred throughout the project.

---

<sup>7</sup> <https://www.heartfoundation.org.au/for-professionals/australian-heart-maps>

<sup>8</sup> National Heart Foundation of Australia & the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel) 2011, *Guidelines for the prevention, detection and management of chronic heart failure in Australia*, National Heart Foundation of Australia.

<sup>9</sup> <https://tasmania.healthpathways.org.au/LoginFiles/Logon.aspx>



A subsequent audit was undertaken approximately six months following the initial audit to identify whether clinical management for patients with heart failure had changed. A second reflective questionnaire was then completed.

Analysis of the project experience from the perspective of the general practitioner was also undertaken through completion of a project evaluation survey after participation. These examined the participant experience, perceived changes in practice and outcomes of the process. In addition, a case study was developed to capture the experience of one of the participating general practitioners. The case study was published and circulated in Primary Health Tasmania's Primary Matters magazine.

Incentive payments were provided to participating practices, and participating general practitioners were supported to receive recognition for continuing professional development.

## GRAND ROUND

An educational activity for staff at the Royal Hobart Hospital was presented in the hour long weekly grand round session held 17 November 2017. This session was dedicated to improved transfers of care for patients living with heart failure when moving from the acute to primary care settings. Presentations specifically focussed on providing general practitioners with better information on titration of heart failure medications. The three speakers were:

- Primary Health Tasmania's Public Health Physician presenting on information general practitioners want to receive on discharge about patients with heart failure;
- a general medical physician presenting on improving management of heart failure patients not admitted under cardiology; and
- a cardiologist promoting the provision of improved information in discharge summaries, with more specific advice about titration of heart failure medication.

## COLLABORATIVE PARTNERSHIP PROCESS

Evaluation of the collaborative process, the mechanisms and the effectiveness of the public-private partnership were also undertaken at the conclusion of the project. These measures were used to identify and examine the benefits, challenges and changes achieved by the organisations working in this manner.

Evaluation surveys were undertaken using a modified version of the Partnership Self-Assessment Tool<sup>10</sup> with 65 questions asked across the themes of synergy, leadership, efficiency, administration and management, resources, decision-making, participation benefits, drawbacks and satisfaction.

---

<sup>10</sup> Centre for the Advancement of Collaborative Strategies in Health 2002, *Partnership self-assessment tool questionnaire*, accessed 7 May 2018, [https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/3129/Partnership\\_Self-Assessment\\_Tool-Questionnaire\\_complete.pdf?sequence=1&isAllowed=y](https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/3129/Partnership_Self-Assessment_Tool-Questionnaire_complete.pdf?sequence=1&isAllowed=y)



## PROJECT FINDINGS

Project findings provide an understanding of how care differed from the national heart failure guidelines, what impacted following the guidelines, and how the activities influenced disease management. The project processes and outcomes have been highlighted via a case study. The evaluation examined the public-private collaborative process to gain insights for successful partnerships.

### SYMPOSIUM

Sixty-four health professionals participated in the symposium.

There was a significant improvement in symposium attendees' self-reported knowledge across all four topic areas—heart failure, chronic obstructive pulmonary disease, diabetes and chronic kidney disease following the symposium.

Practice nurses welcomed the opportunity to engage and 'action plan' with their colleagues. They also commented on the opportunity to identify existing services to improve the care they deliver. Practice nurses found the heart failure workshop improved their confidence in managing patients living with heart failure.

Similarly, general practitioners identified benefits from increased familiarity and confidence in accessing resources including HealthPathways for the management of individuals living with heart failure. 94% of general practitioners found the heart failure workshop was relevant to their clinical practice, with 79% reporting their learning needs were entirely met.

### CONTINUOUS QUALITY IMPROVEMENT

There were eleven general practitioners involved in the pre-activity audit and ten involved in the post-activity audit from the five enrolled general practices. These practices were located in Sorell, Derwent Valley, New Town, Cygnet and Lindisfarne (pictured below in Figure 1). Eight academic detailing sessions were provided across the five practices. Recruitment took longer than anticipated and was challenging, falling short of the initial intention to recruit ten general practices.

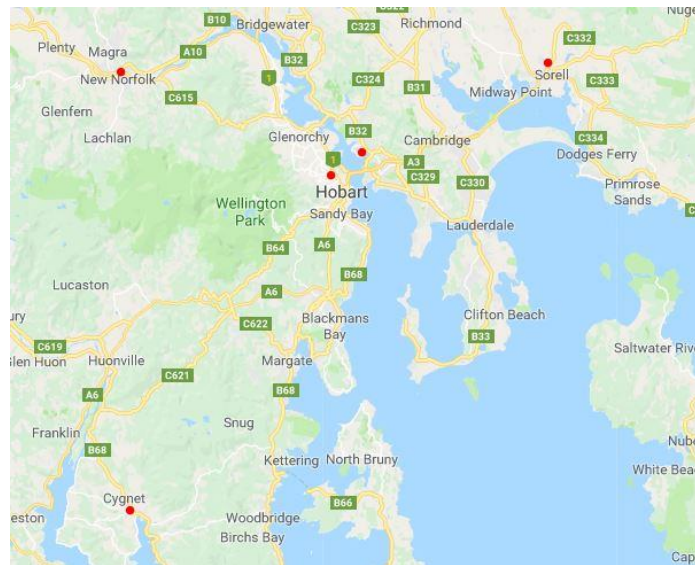


Figure 1 Location of communities with recruited practices.

## PRE-ACTIVITY AUDIT RESULTS

Participating general practitioners undertook audits on twenty-four patient files in the initial audit.

In the initial patient file audit, 9 (38%) of patients were not on ace inhibitors or angiotensin II receptor blockers, and 17 (71%) of patients were not on the maximum tolerated dose of these medicines. One third of patients from the initial audit had blood pressures above the systolic blood pressure target of  $\leq 140$ mmHg.

Only half of all patients 12 (50%) were up to date with clinical pathology testing for iron studies in the last 12 months and 9 (38%) were not up to date with pneumococcal vaccination.

Documentation did not always indicate that lifestyle advice was provided as per the guidelines. Patient files reflected that 10 (42%) of patients had not received advice on nutrition, 12 (50%) had not received advice on fluid management and 7 (29%) had not received advice on physical activity. Patient adherence to these recommendations was also low with 15 (58%) of general practitioners reporting that their patients adhered to nutrition advice, 13 (54%) purporting to adhere to fluid management advice and 12 (50%) purporting to adhere to physical activity advice.



## QUALITY IMPROVEMENT STRATEGIES

The themes of 'Plan, Do, Study, Act' quality improvement cycles undertaken by general practitioners and practices were:

- incorporating Heart Foundation guidelines for the management of patients living with heart failure into the chronic disease management plan template;
- ensuring adequate health outcomes are achieved for patient living with heart failure by recalling patients that require immunisation with pneumococcal vaccination;
- ensuring baseline iron studies are completed and monitored every 6–12 months;
- ensuring patients living with heart failure have regular thyroid stimulating hormone monitoring (every 6–12 months);
- checking and updating the medication lists of patients living with heart failure; and
- ensuring accurate and up-to-date data is correctly coded into appropriate fields in the medical records of patients living with heart failure.

## POST ACTIVITY AUDIT RESULTS

Participating general practitioners undertook audits on twenty-one patient files in the audit following continuous quality improvement activities.

### ***Clinical parameters***

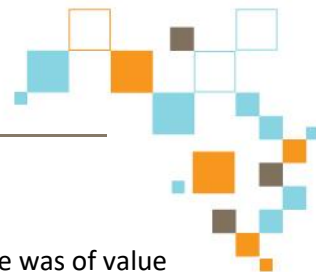
Results from the audit following the quality improvement activity undertaken by general practitioners showed an 18 percentage point increase in the proportion of patients receiving ace inhibitors or angiotensin II receptor blockers, changing from 15 (63%) initially to 17 (81%), with a 19 percentage point increase in the proportion achieving a maximally tolerated dose, changing from 7 (29%) initially to 10 (48%). This coincided with a 9 percentage point reduction in individuals with a systolic blood pressure above the target of  $\leq 140$ mmHg, from 8 (33%) initially to 5 (24%), and a 15 percentage point reduction in the proportion of individuals on frusemide, changing from 16 (67%) initially to 11 (52%).

### ***Pathology and preventive medicine***

The proportion of patients having pathology testing for iron studies increased 21 percentage points, up from 12 (50%) initially to 17 (71%). Similarly, there was a 23 percentage point increase in the proportion of patients who were up-to-date with pneumococcal vaccination, up from 15 (63%) initially to 18 (86%).

### ***Healthy behaviour advice and behavioural change***

The audit found an improvement in the advice provided on healthy lifestyle behaviours including advice around nutrition, fluid management and physical activity. There was a 28 percentage point increase in the provision of nutrition advice, up from 14 (58%) initially to 18 (86%), a 31 percentage point increase in the provision of fluid management advice, up from 12 (50%) initially to 17 (81), and a 24 percentage point increase in the provision of physical activity advice, up from 17 (71%) initially to 20 (81%). This coincided with a modest increase in the proportion of patients purporting to adhere to nutrition advice up 25 percentage point changing from 11 (46%) initially to 15 (71%) and physical activity advice up 35 percentage point changing from 12 (50%) initially to 18 (86%).



### ***Low health literacy resources***

General practitioners reported that the Heart Foundation heart failure patient resource was of value and was likely to benefit patients with low health literacy. Promotion and provision of the Heart Foundation heart failure resource<sup>11</sup> resulted in a modest increase in usage measured through the patient file audit, with no patients receiving the resources in the initial audit, and 3 of 21 patients (14%) receiving the resource after the activity.

### ***HealthPathways***

There was a 66 percentage point increase in the use of heart failure HealthPathways by general practitioners to support patient care and referrals, from 7 (24%) initially up to 20 (95%).

### ***Other indicators of heart failure disease management***

There were no changes in the patient file audit across the following domains following the activities:

- echocardiograms performed in the past 12 months;
- heart failure symptoms (shortness of breath, peripheral oedema, fatigue);
- NYHA (New York Heart Association) Functional Classification;
- target heart rate 60—70bpm;
- atrial fibrillation;
- electrocardiogram or chest x-ray performed around time of diagnosis;
- cardio selective beta blocker usage, and at maximal tolerated dose;
- influenza vaccine;
- smoking status changes;
- current chronic disease management plan;
- provision and adherence to alcohol consumption advice;
- screening and diagnosis for depression;
- specialist involvement in care if unresponsive to initial medications;
- all hospital admissions and heart failure admissions;
- discharge summary received after hospitalisation; and
- heart failure service contacted by general practitioner for advice.

### **REFLECTIVE QUESTIONNAIRE**

Responses provided by general practitioners after receiving their audit results provided insights into the challenges of providing care that aligns with the national guidelines. Thematic analysis of these responses is presented here.

#### ***Guideline use***

Some general practitioners reported a lack of general awareness of the guidelines, or specific details within guidelines. Some general practitioners suggested that there may not always be adequate time

---

<sup>11</sup> National Heart Foundation of Australia, 2016, *Living well with heart failure: Information to help you feel better*, National Heart Foundation of Australia, accessed 28 June 2018, [https://www.heartfoundation.org.au/images/uploads/publications/Living\\_well\\_with\\_heart\\_failure\\_2017.pdf](https://www.heartfoundation.org.au/images/uploads/publications/Living_well_with_heart_failure_2017.pdf)



to address all components of the guidelines within a consultation, or that if the patient was asymptomatic that they were reluctant to change medications.

### **Communication**

Communication barriers may impact on care aligning with evidence-based guidelines. In heart failure this can include communication between and amongst specialists, hospitals, medical imaging providers, primary care providers and patients.

Some general practitioners perceived this as a significant issue particularly for those patients discharged from hospital after an acute exacerbation. Some general practitioners indicated that discharge summaries and care plan information from hospitals and/or specialists was often slow to be provided, of inadequate detail, or not received at all. This impacted the ability and confidence of some general practitioners to titrate medications, as target parameters were not clear.

Issues were raised around echocardiogram reporting, with some general practitioners reporting that results were not received, or that results failed to provide adequate interpretive information for them to plan care. Interpretation of echocardiogram results and reports are often difficult<sup>12</sup>, with reporting formats and technologies frequently varying across providers and imagers<sup>13</sup>.

### **Patient-centred care**

Some general practitioners reported that patient variation can impact on the ability to follow guidelines, with patient co-morbidity or tolerance of medications limiting use of specific treatments.

### **Care access and patient factors**

Healthcare accessibility was recognised as a challenge to providing guideline-based care for people living with heart failure. General practitioners highlighted the impact of their patient's not being able to access echocardiography within an acceptable timeframe, echocardiography not always being affordable, or patients not recognising the value of investigations, therefore opting to forgo care. Similarly, some general practitioners reported that some patients were reluctant or unable to visit the general practice for ongoing follow-up due to costs, geographic and other barriers. It was suggested that following heart failure management guidelines may not always be consistent with providing patient-centred care.

### **System factors**

Some general practitioners noted that system factors may impact on following guidelines. These included a lack of consultation time for follow-up, poor coding within the practice software, and not being the primary decision-maker for the cardiology management for the patient.

---

<sup>12</sup> McAlister, NH, McAlister, NK & Buttoo, K 2006, 'Understanding cardiac "echo" reports: Practical guide for referring physicians', *Canadian Family Physician*, vol. 52, no. 7, pp. 869–874.

<sup>13</sup> Bansal, M & Sengupta, PP 2017, 'How to interpret an echocardiography report (for the non-imager)?' *Heart*, vol. 103, no. 21, pp. 1733–1744.



### ***Opportunity for improvement***

General practitioners provided a range of recommendations for how they could improve care for patients living with heart failure. These included:

- improving collaboration with specialists;
- setting up systematic recall systems to improve routine management of heart failure, rather than just treating acute symptoms when they arise;
- referring patients to specialist heart failure programs;
- providing better targeted resources for patients with low health literacy;
- seeking additional training in interpretation of echocardiograms;
- developing a practice heart failure clinic;
- increasing general practitioners in practice and bulk billing patients where possible;
- involving practice nurses to support care planning;
- using the HealthPathways to support clinical decision-making;
- increasing echocardiography requesting to include annual review for all patients with heart failure;
- incorporating management guidelines into chronic disease management plans—including echocardiograms, iron studies, thyroid stimulating hormone, immunisations, medication titration;
- developing an iron infusion protocol;
- developing a personal heart failure checklist; and
- reviewing medical records to ensure accuracy of patients' medical history are accurate.

### **GENERAL PRACTITIONER FEEDBACK ON PROJECT**

Seven of the eleven participating general practitioners completed project evaluation surveys at the end of the project. All those who responded found that their participation in the project had improved their confidence in managing heart failure patients, while also providing the opportunity to reflect on their practice. General practitioners reported that they had taken steps to ensure patients had all appropriate investigations, such as routinely ordering echocardiograms, and applying non-pharmacological strategies as part of a comprehensive management plan. Steps to improve heart failure management were also reported for prescribing and reviewing appropriate heart failure medications tailored to each patient 6 (86%) using clinical guidelines to assess patients' heart failure symptoms and degree of control 5 (71%) and identifying any medications that may exacerbate heart failure 4 (57%). One general practitioner reported providing patients with the Heart Foundation low literacy heart failure resource.





## CASE STUDY

### CHRONIC CONDITIONS: HEART FAILURE



# Supporting heart failure care in general practice

**DR Chris Hilton, a Derwent Valley GP with almost 30 years' experience, comes face-to-face with the reality of heart failure on a regular basis.**

"I'd say every week I encounter a patient who comes into the Derwent Valley Medical Centre with signs of heart failure," he says.

"There is a high incidence of the disease in the Tasmanian population, especially in less affluent areas and where a patient is a smoker or has diabetes.

"And in addition to the effect on the patient and the significant suffering in the community, heart failure can lead to increased emergency department admissions, placing an extra load on our hospitals' resources."

Heart failure is a chronic condition whereby the heart muscles are damaged by a heart attack, heart disease, high blood pressure, or diabetes, and become too weak to pump properly. Heart failure leads to fluid build-up in the body, which can cause weakness, weight gain, breathlessness, and dizziness, and make everyday activities exhausting.

Hospitalisation from heart failure costs our national healthcare system more than \$1 billion each year. It is one of the top five conditions in Tasmania where people are re-hospitalised regularly when their condition deteriorates.

In response to this, Primary Health Tasmania teamed up with the Australian Healthcare and Hospitals Association, the Heart Foundation, the Tasmanian Department of Health and Human Services and Novartis Australia on a project to improve the management of heart failure in general practice to reduce hospital admissions and improve health outcomes for people living with heart failure.

The Heart Failure Collaborative has involved a symposium for GPs and practice nurses, as well as education and quality improvement activities for general practices in regions where there are higher rates of heart failure.

The project will be evaluated to understand what impact it has had on heart failure patients at participating practices.

The Derwent Valley Medical Centre is one of the general practices participating in the project.

Chris says the Heart Failure Collaborative has reminded staff of the key actions that need to be taken to improve the best-practice management of heart failure.

He says it has also increased awareness of local hospital services.

"Following the audit process, we decided to implement a number of changes to our practice, including reviewing the medication and dosage we give to patients who present with heart failure, as well as looking into thyroid function and iron studies," Chris says.

"What also came out of the process was the idea of iron infusions for patients presenting with low iron saturation levels, which was based on a study that looked into the benefits of infusion versus oral treatment. Infusions showed a significant benefit whereas oral iron did not.

"This has by far been the biggest change for our practice and based on our research, we expect this will be very helpful and make a big difference for our patients." ■

**For more information, contact Catherine Spiller at [cspiller@primaryhealthtas.com.au](mailto:cspiller@primaryhealthtas.com.au) or on 6213 8200**



## COLLABORATIVE PARTNERSHIP

The results of the collaborative partnership survey are summarised by theme below.

### SYNERGY

Questions were asked to illuminate how well the partnership was able to work together to solve problems in new ways, include others' views, develop shared goals, work together to respond to the needs of the community and communicate how their actions will address problems that are important to those communities.

Most questions had positive responses. Barriers to the partnership working synergistically included time, competing priorities and lack of general practitioner participation. Enablers included having common objectives, having a facilitator to coax people to contribute and the contribution of a broad reaching group of collaborators and stakeholders.

### LEADERSHIP

Questions were asked that described attributes of leadership including taking responsibility for the partnership, empowering people, fostering respect, trust and openness, combining the perspectives and skills of partners and creating an environment where differences of opinion can be voiced.

The majority provided good to excellent responses. Barriers identified included lack of clear goals, organisations being busy and having competing priorities that made it challenging to sustain engagement, and leadership changes throughout the project. Enablers included continuous single leadership and alignment of objectives, formal and informal leadership.

### EFFICIENCY

Questions were asked to elucidate how well the partnership used financial resources, in-kind resources and partners' time. Most respondents answered positively to varying degrees.

### ADMINISTRATION AND MANAGEMENT

Questions were asked about coordinating communication among partners and those outside the partnership, organising meetings, applying for ethics approval, preparing materials to help partners make timely decisions, performing secretarial duties, evaluating progress and minimising barriers to participation.

This theme had varied responses. Most responses were positive, but there were split responses to coordination of communication with people and organisations outside the partnership. About half provided positive responses with the other half not knowing or thinking this was poor. Two people responded that the process for applying for ethics approval was poor.

### RESOURCES NON-FINANCIAL

Questions were asked about skills and expertise, data and information, connections to target populations, connections to political decision-makers and other organisations, legitimacy and credibility, influence and ability to bring people together for activities and meetings.



Most responses indicated that the group had most of what it needed in terms of data and information, connections to target populations and skills and expertise. In relation to legitimacy and credibility, connections to political decision-makers and government agencies, and influence and ability to bring people together for meetings and activities, there were a few responses that indicated the group did not have enough of these attributes.

## FINANCIAL AND OTHER RESOURCES

Questions were asked about money, physical resources and the strength and limitations of these on the project. Most respondents thought that the partnership had most or all of what it needed.

Responses indicated that more funding might have made it easier to design a project with more impact and of higher priority. However, scope management was good and there were adequate resources to fulfil project goals.

## DECISION-MAKING

Questions were asked to ascertain comfort levels with the way decisions were made, how often they supported the decisions, how often they felt left out of the process and how improvements could be made in the decision-making process.

Most respondents reported being comfortable with how decisions were made. Suggestions for how improvements could be made included ensuring clear governance and shared goals from the outset and ensuring key people attend meetings.

## PARTICIPATION BENEFITS, DRAWBACKS, SATISFACTION

Questions were asked about the process, impacts, influence and perceptions of being involved in the project, drawbacks of being involved and levels of satisfaction.

Participation benefits included an enhanced ability to address an important issue, heightened public profile, increased utilisation of expertise, enhanced ability to affect public policy, meeting the needs of clients and have a greater impact than working alone.

Most respondents reported an enhanced ability to affect public policy, but a few respondents did not feel this way.

In terms of drawbacks, half of respondents indicated that the project was a diversion of time and resources away from other priorities and experienced some frustration or aggravation. Most said the benefits exceeded the drawbacks and were satisfied with the process.

## SUMMARY

The questionnaire was long and detailed but provided insights into how the collaboration functioned overall and identified some strengths and weaknesses. Based on the responses, the partnership functioned well with strengths identified in the themes of synergy, leadership, resourcing and management of the group. Decision-making, participation benefits, drawbacks and satisfaction had largely positive responses, but the turnover of partners in the group, the perceived diversion of time away from other priorities, the small scale of the project and make-up of the partnership group negatively affected the impact and satisfaction of some partners.



## DISCUSSION

Findings are discussed in the context of the original research questions.

### ***Can we improve the knowledge and confidence of the general practitioners who are participating in the project to better manage individuals living with heart failure?***

A significant improvement was achieved in symposium attendees' self-reported heart failure knowledge. General practitioners indicated that they benefited from increased familiarity and confidence in accessing resources including HealthPathways for the management heart failure. Whether these improvements persisted after the symposium was not measured. Despite this, there were indications that continuous professional development is important to general practitioners remaining current with contemporary guidelines for disease management.

General practitioners who completed the project evaluation reported improved confidence in their management of heart failure. They noted taking steps to improve use of appropriate investigations, such as routinely ordering echocardiograms, and applying non-pharmacological strategies as part of a comprehensive management plan. There were also changes seen in steps to improve prescribing and review of heart failure medications for each patient, use of clinical guidelines to assess heart failure symptoms and degree of disease control, and identification of medications that may exacerbate heart failure. There were several domains of management that did not change during the project. Overall, reported changes in heart failure management were modest.

### ***Can collaboration between acute care and primary care be improved in the management of individuals living with heart failure?***

The project undertook three activities to improve collaboration between acute and primary care in heart failure.

First, by facilitating heart failure sessions at the symposium, where a cardiologist from the acute care setting outlined their perspectives, providing information to primary care practitioners on improving heart failure management.

Second, by facilitating a heart failure grand round at the Royal Hobart Hospital, where a primary care general practitioner outlined their perspectives, providing information to acute care providers on issues they face and what information is useful for general practitioners to receive at discharge to improve heart failure management.

Perhaps the most ambitious activity attempted were efforts to influence the patient discharge summary document to provide additional guidance for general practitioners on medication titration and care planning after hospital discharge. System level barriers prevented these changes from being successfully implemented during the project timeframes, with changes to the discharge summary currently not being supported. There was also difficulty influencing non-cardiology teams with rotating junior medical officers to adopt the practice of consistently providing specific medication titration instructions in their discharge summaries.

Whilst it was disappointing that the partnership was unable to influence this during the project timeframes—as a lack of comprehensive hospital discharge information and clinical guidance was a



key concern of general practitioners—it is hoped that the cardiologist championing these changes may have success in the longer term.

In Southern Tasmania the Royal Hobart Hospital heart failure outpatient clinic already offers an opportunity for collaboration between acute care and primary care for referred patients. A Heart failure nurse practitioner provides support and advice to general practitioners for these patients. Whilst promotion of this clinic during the project did not appear to increase usage of the service, this might have been due to the recruited general practitioners already being aware of the services available.

***How does a collaborative public-private partnership work? And what is required for it to be successful?***

The collaborative partnership functioned well with strengths identified in the themes of synergy, leadership, resourcing and management of the group. Decision-making, participation benefits, drawbacks and satisfaction had largely positive responses, but the turnover of partners in the group, the perceived diversion of time away from other priorities, the small scale of the project and make-up of the partnership group negatively affected the impact and satisfaction of some partners.

#### LIMITATIONS

A major limitation of the project was the low number of participants recruited to the study, both general practitioners and practices. Despite extensive efforts, recruitment was difficult. Similarly, identifying adequate numbers of patients with heart failure proved more difficult than anticipated. The project's small scale made it difficult to draw definitive conclusions on the impacts of using this approach. It is possible that a scaled-up version of the project using a larger cohort of both practitioners and patients could yield more meaningful results.

#### CONCLUSION

The Tasmanian Heart Failure Project aimed to reduce preventable hospital readmissions for people living with heart failure. While project activities improved the confidence of primary care providers in heart failure management, facilitated general practitioners and practices to undertake quality improvement activities, provided patient resources to improve self-management and provided opportunities for collaboration between acute care and primary care practitioners, this original aim was likely too ambitious.

This project has illustrated that with proper governance, mutual trust and transparency public-private partnerships have the potential to contribute to the improved management of heart failure in primary care. Continuity of membership and support of the project aims and approach are essential to making the partnership successful.



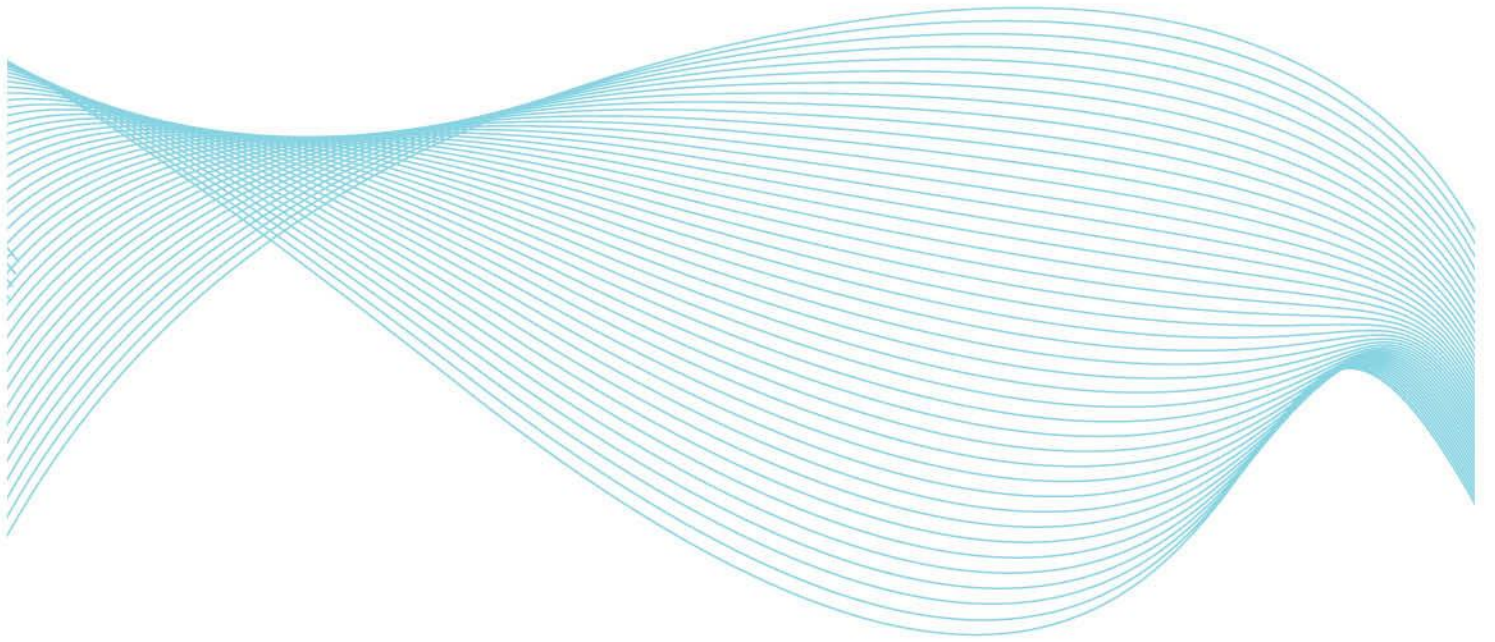
## PROJECT PUBLICATIONS

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

- APNA National Conference, Hobart 4–6 May 2017 (presentation and poster presentation);
- MyPHN Conference, Cairns 8–9 July 2017;
- Tasmanian Health Conference, Hobart, 29 July 2017;
- ACRA 2017 27th Annual Scientific Meeting, Perth, 7–9 August 2017;
- International Hospitals Federations 41<sup>st</sup> World Hospitals Congress, Taipei Taiwan 7–9 November 2017.

Publications have included:

- Tasmanian Times, 10 February 2017, “New heart failure care program”;
- Symposium media release, 10 February 2017, “New heart failure care program”;
- Hobart Mercury newspaper article, 11 February 2017; “Heart help for hotspots”;
- Heart Foundation article, 13 February 2017, “New heart failure care program”;
- The Health Advocate article, magazine of the Australian Healthcare and Hospital Association, 1 April 2017 “Integrated care for heart failure patients”;
- Primary Health Matters, Issue 7–December 2017, “Supporting heart failure care in general practice”.



#### OUR CONTACT DETAILS

Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close  
Deakin ACT 2600

PO Box 78  
Deakin West ACT 2600


P. 02 6162 0780


F. 02 6162 0779

E. [admin@ahha.asn.au](mailto:admin@ahha.asn.au)

W. [ahha.asn.au](http://ahha.asn.au)

 [facebook.com/AusHealthcare](https://facebook.com/AusHealthcare)

 [@AusHealthcare](https://twitter.com/AusHealthcare)

 [linkedin.com/company/australian-healthcare-&-hospitals-association](https://linkedin.com/company/australian-healthcare-&-hospitals-association)

ABN. 49 008 528 470

© Australian Healthcare and Hospitals Association 2017

