Change of Heart

Christchurch Hospital

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HRT 1601 Readmissions Special Roundtable

1st / 2nd / 3rd March 2016 , Christchurch NZ

Key Problem

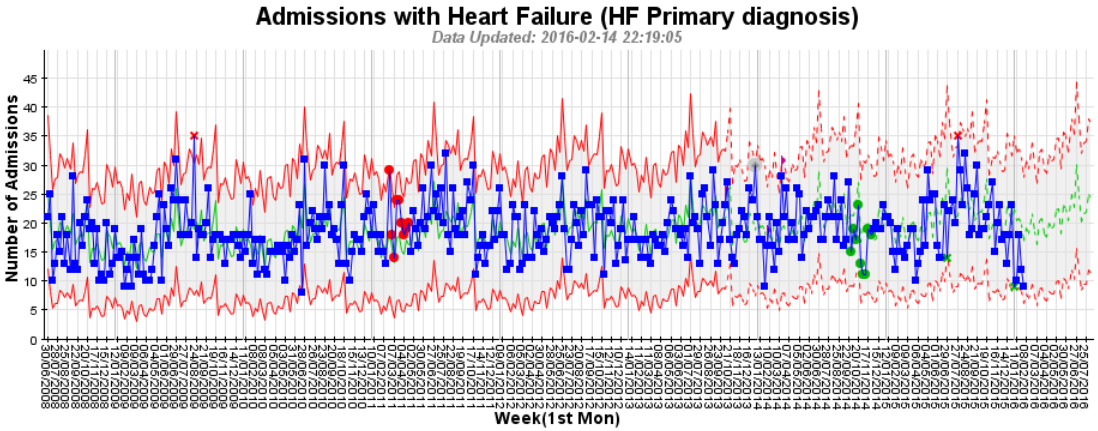
- Heart failure is the leading cause of hospitalisation in the over 65s and has a high readmission rate of around 25%.
- Two thirds of patient admissions for Heart Failure occur in General Medicine.
- For Maori and Pacific people, the event rates are significantly higher with the disease starting 20 years earlier than for those of European descent.
- Patients are predominantly elderly, frail and have a number of additional diagnoses/co-morbidities
- Identified that patient care could be optimised by:
    - improving their pathway through the health care system
    - supporting primary care
    - facilitating increased self-management.

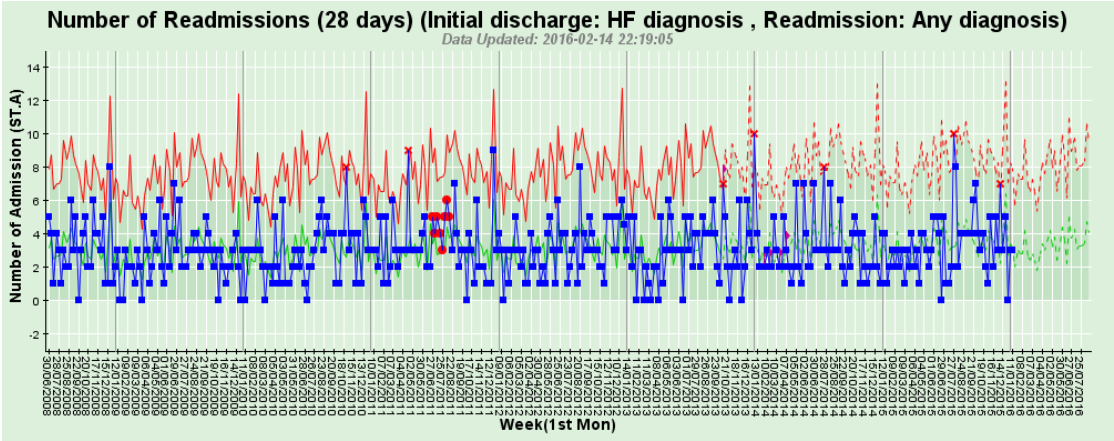
Aim of this innovation

- Our aim is to improve the care of those patients with heart failure across the Canterbury System

  - We want people to be well at home and safe in their community
  - We want people with heart failure to keep well, know what services are available and what to do if they have any problems
  - We want to provide a system that enables 7 day care for patients and their whanau at home
  - We want to improve the way we diagnose, treat and manage this patient group while in hospital and once discharged from hospital
  - We want to reduce overall bed days, reduce readmissions and improve patients' self- management.

Baseline Data

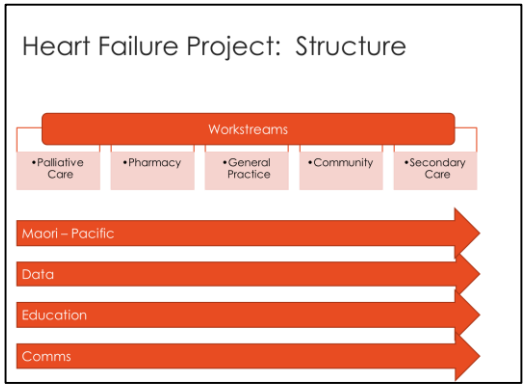




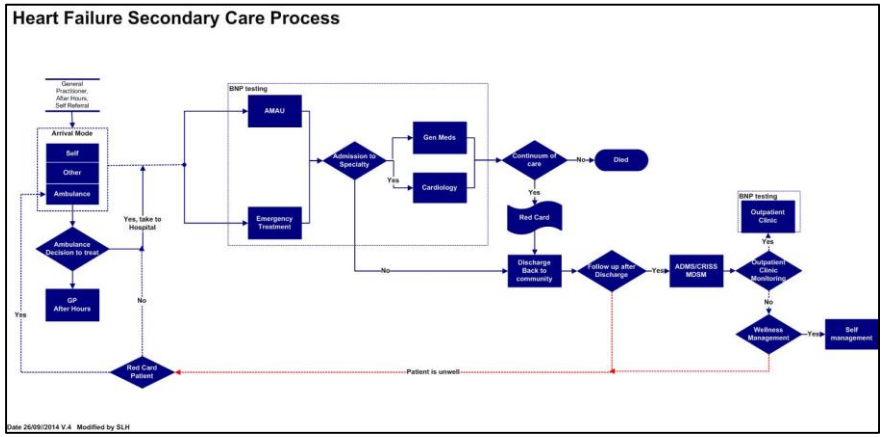
- HF Admissions & Readmissions are cyclical & trended
- 60-100 HF admissions per month (primary diagnosis)
- 20-25% readmission rate within 28 days
- Oct 2014 – initiatives start
- Looking for fewer events than the predicted patterns, reduced variability (runs of green dots)

Key Changes Implemented

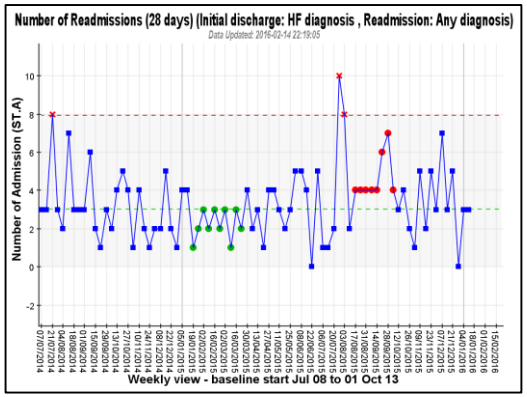
Get everyone on board



Refine the process



Use the data



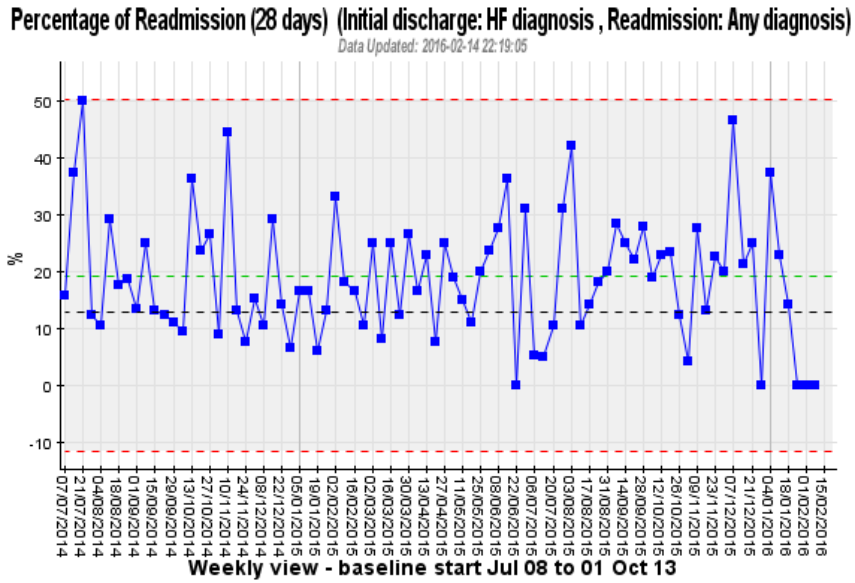
Key Changes Implemented

- Patient Categorisation
  - Using independence and co-morbidity to determine patient management including palliative approach and supported discharge
- Ambulance Triage / ED Turnaround
  - Risk stratification tool provides alternatives to admission
- Community Pharmacy
  - Prompts contained within LTC PMS, ask 3 questions regarding self-management
- Primary Care
  - Education sessions, Health Pathways and HealthInfo updated
- Red Card
  - Magnetic A5 card to support patients with self-management
- Maori / Pacific
  - Improving health literacy of health professionals, targeted initiatives

Outcomes so far

Successes:

- Decreased readmission rate (19%)
- Decreased bed days despite increased patient numbers
- Early supported discharge
- Health Professionals across the system have increased awareness



Refinement Required:

- Ambulance triage / ED Turnaround
- Red Card
- Discharge and patient categorisation – increasing consistency in approach

Further Opportunities:

- Increased engagement and proactive approach in primary care
- Patient voice, understanding and contribution to self-management
- Identification for palliative approach

Lessons Learnt

- Get everyone on board – harness energy and create momentum
- Analyse and understand the data
- Challenge and refine the process


The Health Roundtable