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POSTER ABSTRACT

Shaping the future of Heart Failure Care

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Heart failure (HF) hospitalisations are commonly associated with increased mortality and morbidity. The multi-disciplinary HF workgroup was formed in 2016 comprising Cardiologists, HF Case Managers, Advanced Practice Nurses, Cardiac Pharmacists, Allied Health Professionals and Operations personnel. The group focuses on delivering an end-to-end HF care, that aims to improve clinical and functional outcomes, while keeping cost affordable to patients. Our early initiatives were targeted at the inpatient phase; with current shift towards patient-centred and value-driven care, it presents an opportunity to delve deeper into patients' journey.

Our HF workgroup aims to implement a series of initiatives targeting pre-admission (HF - Extended Diagnostic and Treatment Unit (EDTU)) and post-discharge phases (HF Shared Care (HFSC) and Medical Home (MH)) of the patient's journey, supporting their health needs in the community, thus reducing avoidable hospital readmissions.

Foremost, the team mapped out the patients' journey and adopted a multi-pronged approach to i) manage mild HF patients presented to Emergency Department (ED) under HF-EDTU protocol and support ii) stable HF patients with co-morbidities (HFSC programme) and mild-to-moderately decompensated HF patients (MH programme) in the community.

Under HF-EDTU protocol (commenced Mar' 22), brainstorming sessions were conducted with ED to determine the inclusion criteria to ensure safe discharge from ED. For HFSC programme (commenced Jul' 22), we engaged Shared Care Partnership Office (SCPO) to partner General Practitioners (GPs) to co-manage stable HF patients with co-morbidities in the community. GP focus group discussions were held to gather inputs for effective implementation of HFSC programme. We also worked with Population Health and Community Transformation (PHCT) team to identify patients with haemodynamically stable medical conditions for MH programme (commenced Jun' 22) to reduce unnecessary hospitalisation. Regular meetings were conducted to monitor and evaluate the progress of our initiatives.

Collectively, these initiatives contributed to a decrease in 30D readmission rate from 8.4% to 6.8% (≈19% relative reduction) and a decrease in total bill size from $4,847 to $4,802, when comparing across the pre (Apr 2021 – Mar 2022) and post-implementation of initiatives (Apr 2022 onwards).

To date, of the 11 HF-EDTU patients, 5 were discharged from EDTU, avoiding inpatient admission. This resulted in estimated cost savings of $7,595. Separately, 5 patients were enrolled into HFSC programme.

By adopting a strong value-driven methodology, we were able to assess and identify gaps in existing processes to create more value for our patients. Despite the short period of implementation, the drop in 30D readmission rate is testament to better and safer quality of care received by our patients. By working closely with private primary care providers, patients are able to embark on a lifelong relationship with their GPs to manage different aspects of their health (including preventive care). This is crucial as we tackle the wave of an ageing population and the rising impact of multiple chronic diseases.

With the current promising results, continuous Plan-Do-Study-Act cycles will refine and improve the uptake of our initiatives. Lastly, measurement of patient experience outcomes are underway to truly understand what matters to patients in their care journey.