INTRODUCTION | Chronic Heart Failure (CHF) is a complex and disabling disease with increasing prevalence in Australia, affecting 10% of people over the age of 65 and an estimated cost of $1 billion per annum (National Heart Foundation 2011). CHF hospitalisations are potentially preventable when patients have timely access to healthcare services; receive evidence based, co-ordinated care across the continuum of primary, secondary and tertiary services.

Data analysis at Blacktown and Mount Druitt Hospital (BMDH), Western Sydney Local Health District (WSLHD), identified 84% of 2012/13 CHF admissions were Potentially Preventable Admissions (PPA), with a 28 day re-admission rate of 28%. Activity projections for Chronic Heart Failure admissions at Blacktown Hospital suggest a 90% increase from 2010/11 to 2026/27, which will require an additional seven beds per annum.

GOAL | To support patients (and their carers) with Chronic Heart Failure living in Western Sydney to live well at home; and improve their health outcomes and experience of care over the lifetime of their illness.

OBJECTIVE | To reduce potentially preventable admissions of patient with Chronic Heart Failure under the care of a Cardiologist at Blacktown Hospital from 84% to 70% by October 2015

METHOD | The New South Wales Agency for Clinical Innovation (ACI) Healthcare Redesign Methodology was utilised. Five phases including initiation, diagnostics, solution design, implementation and evaluation. This methodology emphasises partnership with patients and stakeholders.

Over 5 months, 35 stakeholders including patients and staff from BMDH, Community, General Practice and Medicare Locals participated in workshops, interviews, forums and data collection.

DIAGNOSTICS | Diagnostic activities undertaken included:
- Process Mapping of current patient journey
- General Practitioner Forum
- Patient and carer interviews
- Staff interviews
- 48 hour follow up calls
- Observational sessions
- Data analysis 2008/09-2012/13

RESULTS | Follow-up calls 48 hours post discharge identified:
- 80% of patients did not have GP appointment
- 80% had changes to medications, but only 40% had a supply
- None had attended to basic self-management post discharge
- Only 1% of discharge summaries were available to GPs electronically.
- Patients have limited understanding of CHF and self-management and experience high levels of anxiety and frustration at limitations.

SOLUTIONS

1. Development of e-documentation and e-referrals for the Chronic Heart Failure service
2. Increasing the number of e-discharge summaries being sent out to GP's from 1% to 80% by October 2015
3. 80% of patients with Chronic Heart Failure to be discharged from Blacktown Hospital with an electronic self-management action plan that is available to patients, carers, community and acute staff and sent with discharge summary to GPs.
4. 80% of patients with CHF to be discharged from Blacktown Hospital referred to Connecting Care
5. 95% of patients to be discharged with CHF from Blacktown Hospital receive a 48 hour follow up call
6. 80% of CHF patients known to Blacktown Hospital to be enrolled on an electronic register
7. Promotions and Communication of Chronic Heart Failure services to staff, community and patients
8. GP Hotline so that GPs can access specialist information and advice to prevent unnecessary Emergency Department presentations

CONCLUSION | There are inherent challenges with multi-sector partnership associated with variable funding models and resistance to change. Through early clinician and patient involvement in the redesign process, development of a shared vision, active sponsorship and a clear case for partnership to improve patient outcomes.

SUSTAINABILITY | A number of strategies have been employed to ensure ongoing sustainability of this work. This includes:
- The use of Accelerative Implementation Methodology, including the training of the project team, sponsors and solution owners.
- Visible, vocal and active sponsorship throughout the Redesign process
- Integration with District Wide initiatives including eHealth, HealthPathways, and the Western Sydney Integrated Care Initiative
- Embed into the Cardiovascular service plan and transition into the expanded Blacktown Hospital
- Significant stakeholder and consumer involvement
- Local ownership and accountability for the solutions
- Role of Implementation Project Officer to support local capability building and ownership of solutions

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