
Change Champions.

September 2010

Brisbane.

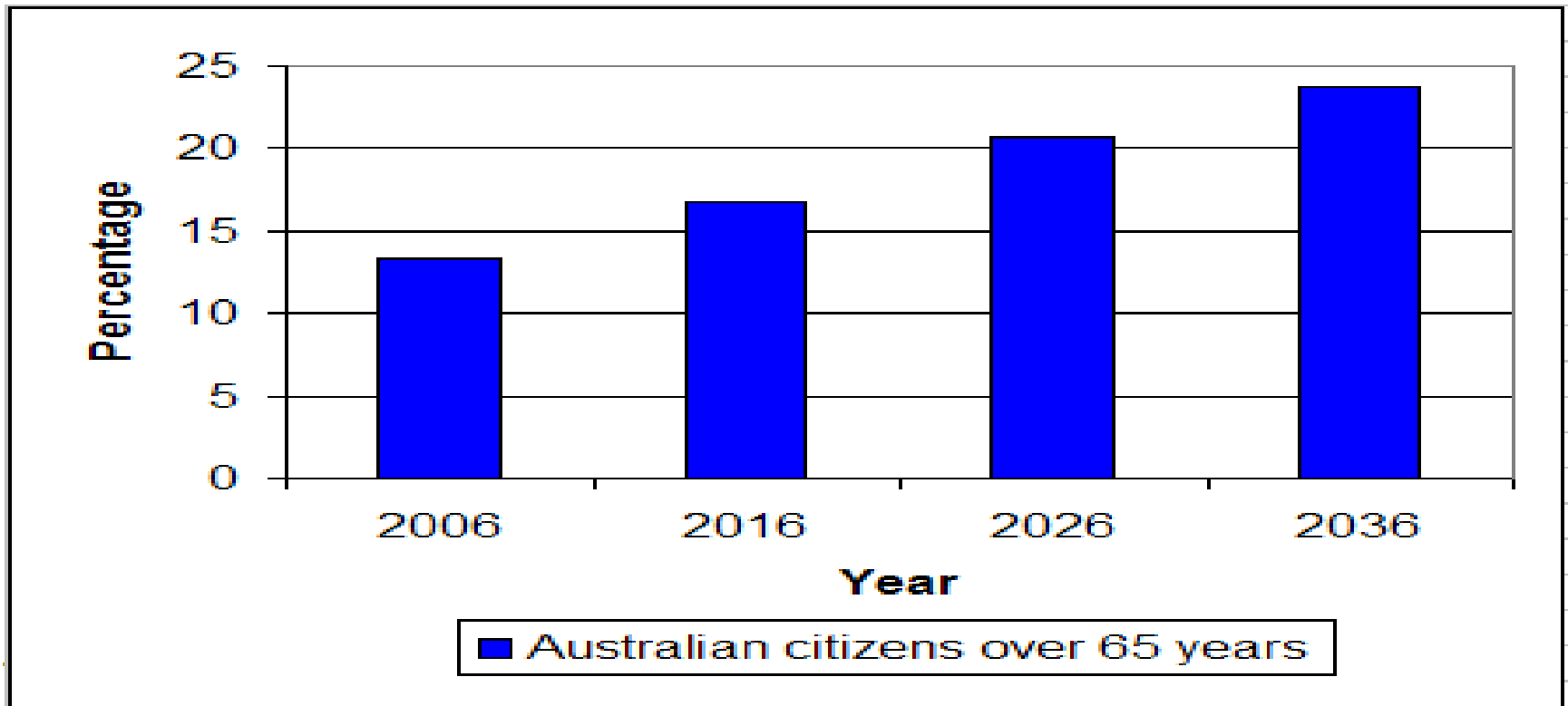
Cardiac Failure Domiciliary Services Reduce Hospital Admissions and Length of Stay.

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Chronic Disease Management

- both a challenge and a reality for all healthcare practitioners providing care for our aging population.



Heart Failure is a significant burden on all levels of health care.

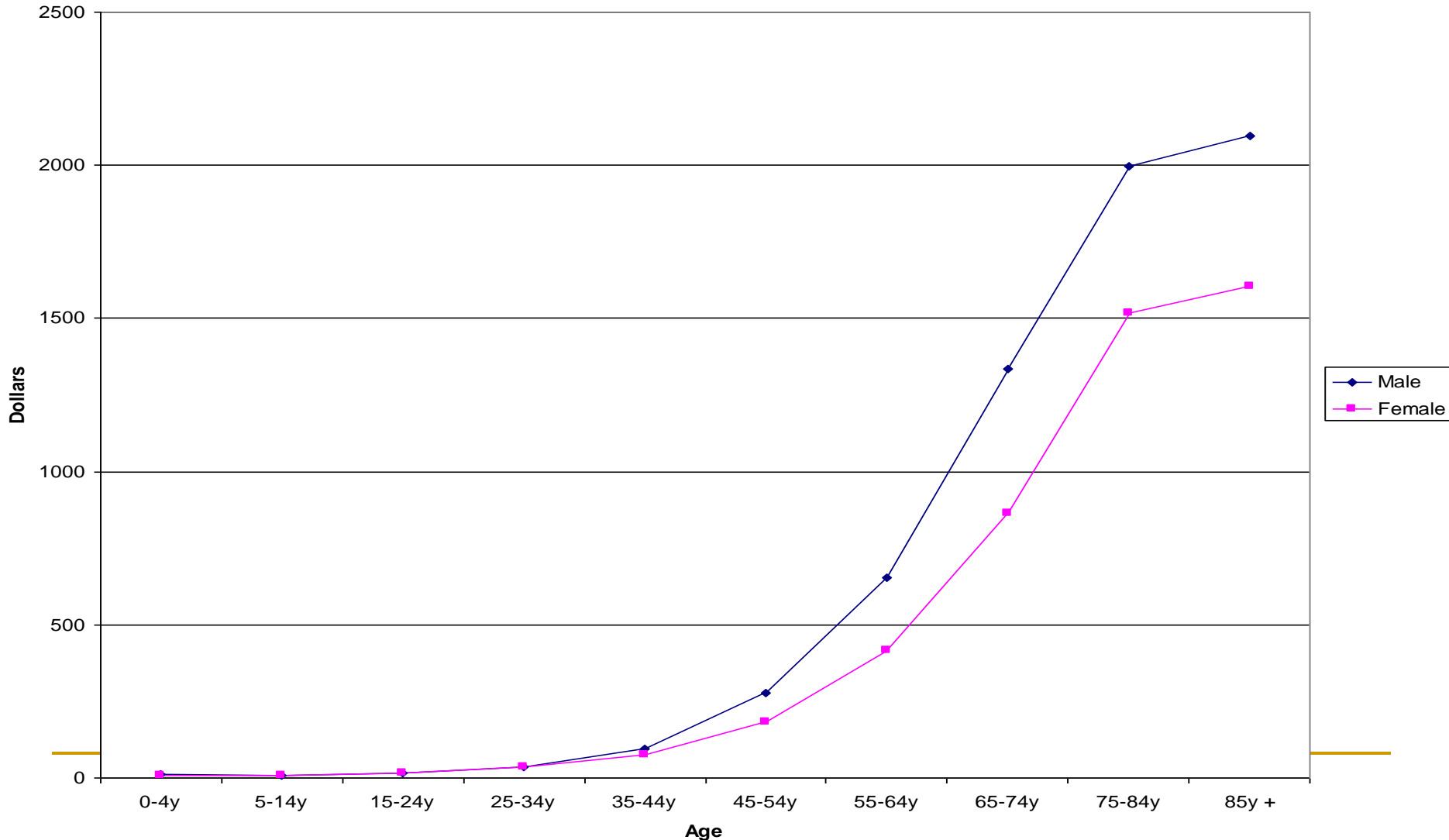
- Cardiovascular disease is the most expensive disease group, accounting for 11.2% of health expenditure 2004-05. *(Ref Australian Institute of health and welfare- Australia's health 2008.)*
 - Multiple hospital admissions.
 - Prolonged length of stay.
 - Polly pharmacy costs.
 - Burden on family and carers.
 - Reduced quality of life.
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Cardiovascular Health expenditure is predicted to increase by greater than 100% in the next 30 years.

(Ref: AIHW.)



Allocated cardiac health expenditure 2004-05. (AIHW.)



Heart failure domiciliary services acknowledges the importance in

- Self management
 - Patient knowledge
 - Empowerment, is as critical to avoiding and/or reducing hospital admission time.
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Patient Domiciliary Program

- reverse an increasing rate of unplanned heart failure readmissions.
- meet an unmet need to better manage heart failure patients.



Eligible Patients.

- Newly diagnosed heart failure patients.
 - Patients with multiple hospital admissions for heart failure.
 - Patients referred by a cardiologist.
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Inpatient education.

- Written and verbal interaction with patient and family in hospital.
- Follow up home visit one week post discharge.



Client Objectives.

- Development of an understanding of cardiac failure.
 - Learn and implement self management strategies.
 - Understanding early warning signs of deterioration in condition.
 - Have an action plan with cues which indicate early nurse contact/intervention is advised.
 - Semi urgent / Emergency action plan.
 - Ability to trouble shoot.
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Organisational Objectives.

- Provide a quality outpatient heart failure service
 - Reduced number of hospital admissions.
 - Reduction in length of inpatient stay.
 - To gain broader private health fund support.
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Outpatient Home Visiting/Telephone Support Service.

- Routine telephone follow up from heart failure nurses.
- Patients or family members initiate contact if they have concerns and a home visit/assessment can be arranged.
- This may be limited by funding arrangements in the private sector.



Benefits.

- Heart failure Nurse accessible to patients, sometimes quicker than their own GP's
 - Thus earlier contact and intervention occurs.
 - Our heart failure nurses have an excellent relationship with our GP's and Cardiologists.
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Benefits.

- Our integrated team approach has been very successful.
- Deteriorating heart failure symptoms can be managed confidently, expediently and often in the community setting.
- Observing patient behaviour in their home setting can alert the nurse to potential problems.



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- Deterioration of chronic heart failure is often the result of poor understanding of the condition and/or poor lifestyle and medication compliance.
 - The importance of which is constantly reinforced by the heart failure nurse.
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Support and ongoing reinforcement empowers patients to be confident and successful in their management of fluid and symptoms.



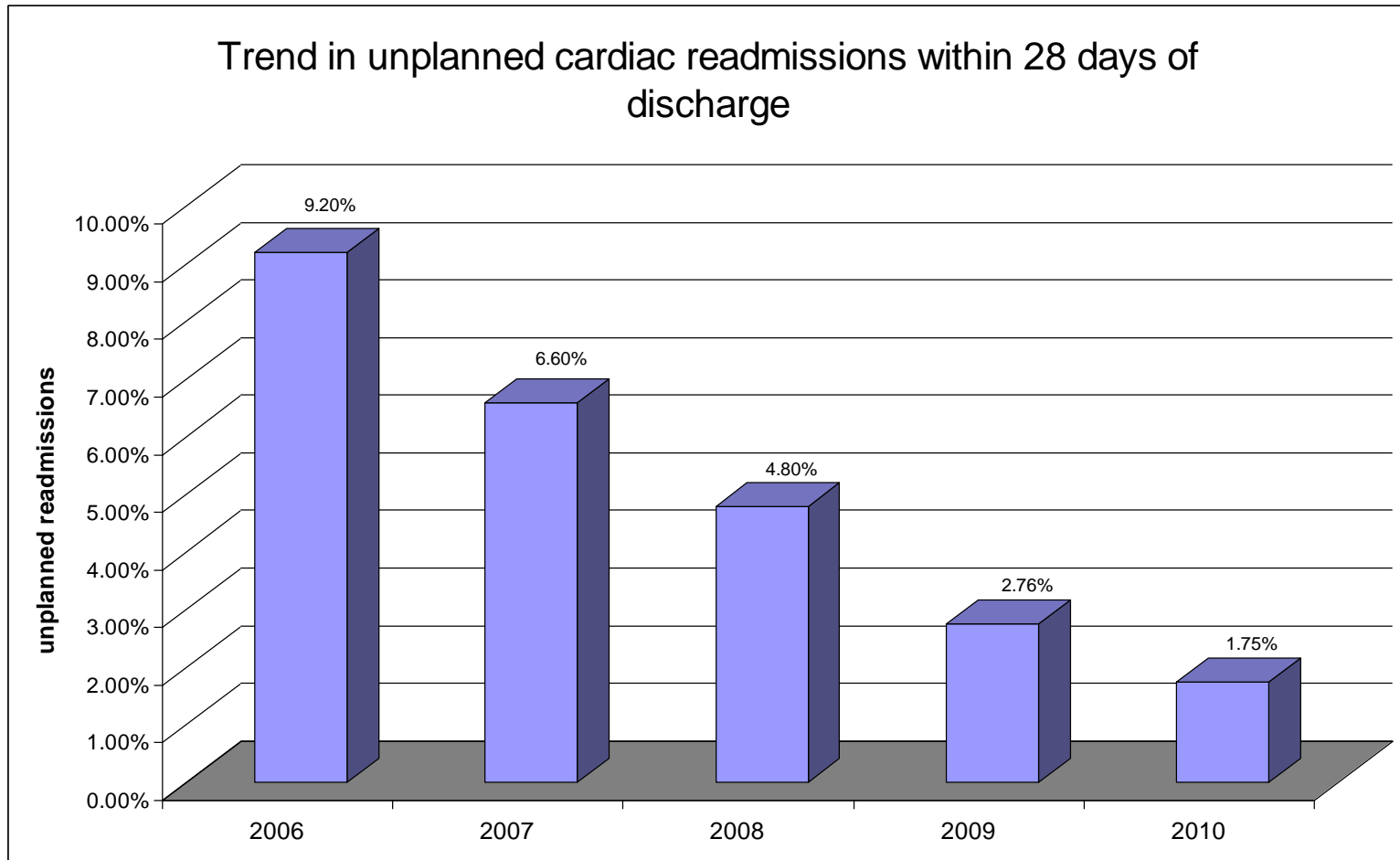
Financial Advantages.

- Reduced Burden on the Community
 - Reduced Burden on the Hospital System
 - Reduced Burden on the Health Funds
 - Heart failure nurse home visit \$65 compared with
 - Medical bed per day \$700
 - Coronary care bed per day \$1447
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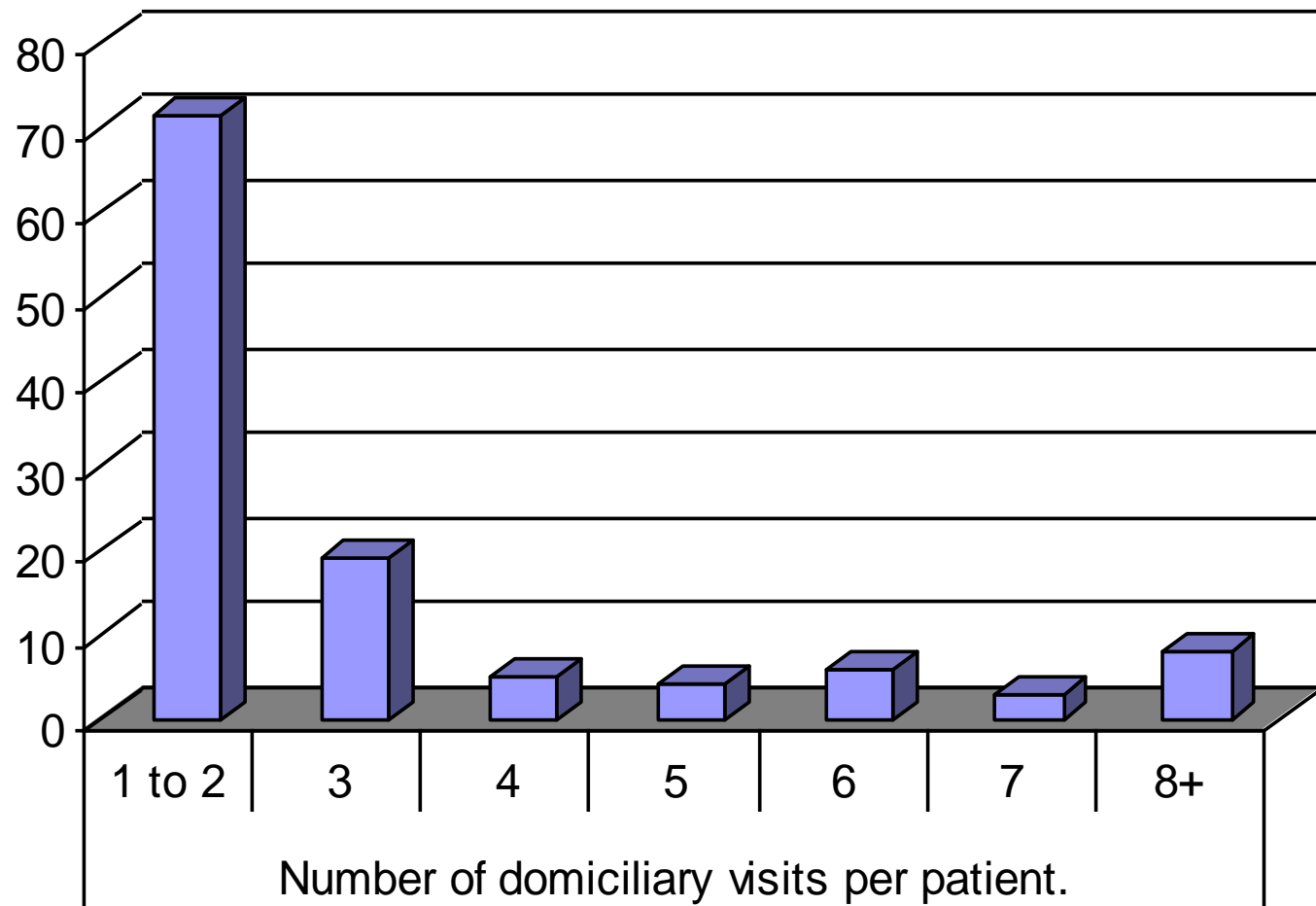
How do we know this program works?

- Reduction in length of stay.
 - Reduction in separations for heart failure.
 - Reduction in unplanned readmissions within 28 days of discharge.
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Average unplanned cardiac readmissions rates within 28 days, 2006-2010.

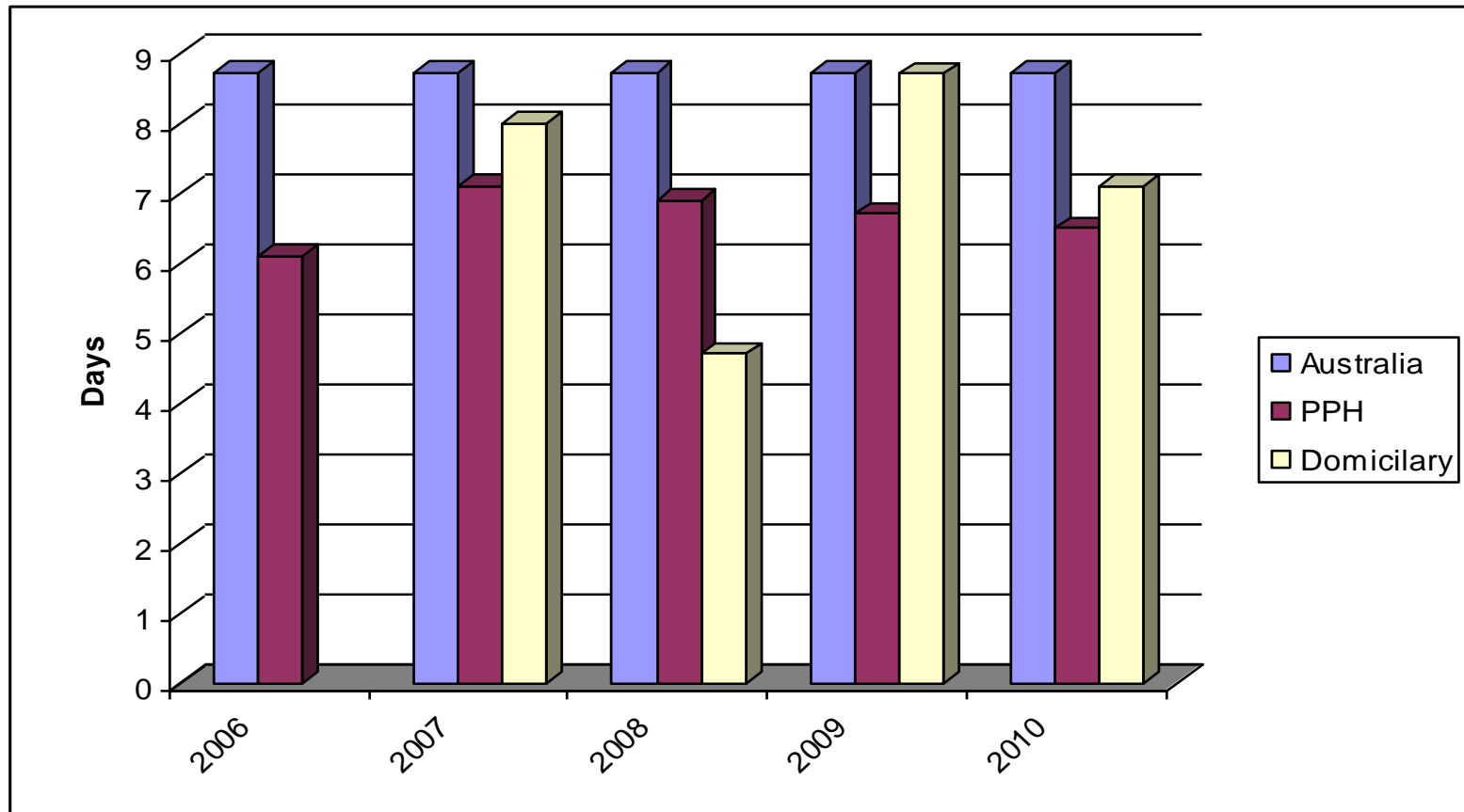


Number of domiciliary visits per patient.



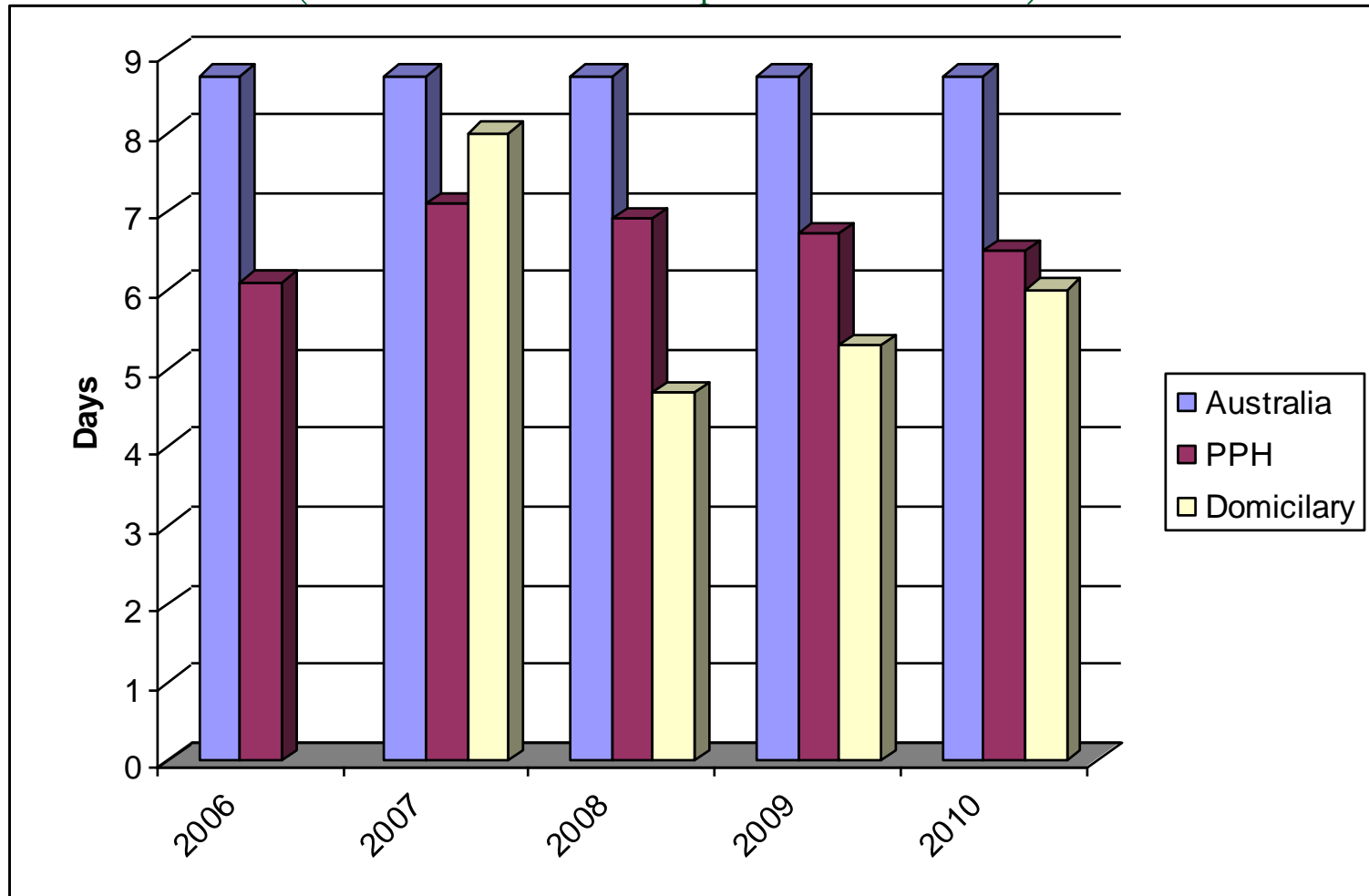
Reduction in the average length of stay for domiciliary program participants.

(Ref PPH case mix reports DRG F62B)

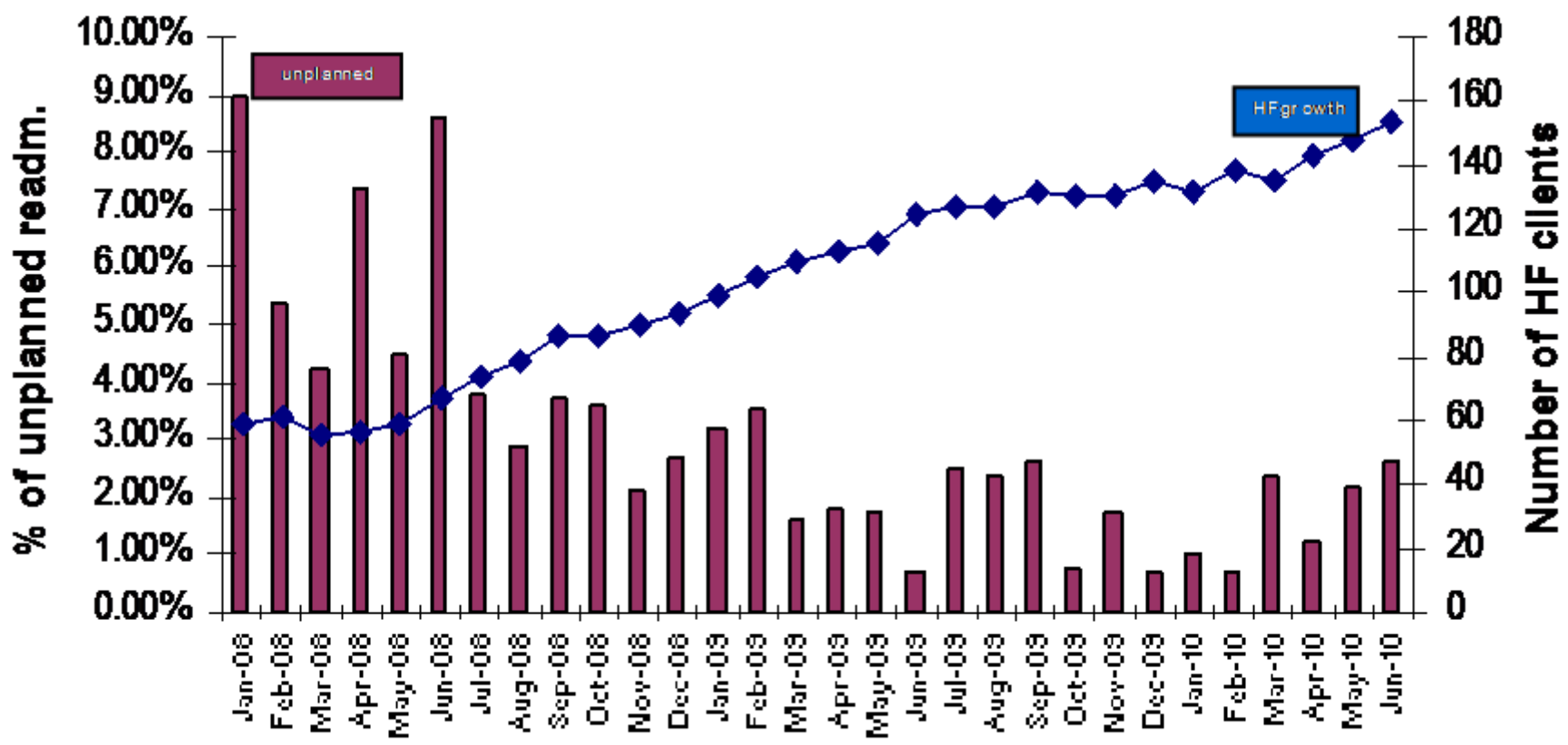


Reduction in the average length of stay for domiciliary program participants, excluding palliative admissions.

(Ref PPH case mix reports DRG F62B).



Unplanned cardiac readmissions & growth in number of heart failure clients



Conclusion.

- Domiciliary heart failure services provides efficient, cost effective, proactive health care.
 - Achieves the goal of reducing length of hospital stay and number of admissions.
 - Improved quality of life for patients and their family members.
 - Reduced costs to the health care purchasers.
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