Cardiovascular Ambassador Project

Summary report

From 2022-2024, Safer Care Victoria partnered with 20 Victorian health services to improve the quality of care that cardiac patients receive with the aim of reducing unplanned readmissions to hospital.

Background

Cardiovascular disease is a significant burden on the lives of Victorians, with many experiencing multiple hospital admissions, and challenges with managing their condition after leaving the hospital.

Aim

To improve the quality of cardiac care in patients in and out of hospital, with the overall aim of reducing the rate of avoidable readmissions to hospital by 20%.

Improvement approach

- Twenty health services across Victoria participated in the project.
- We supported these hospitals to recruit a cardiac nurse to design and test locally relevant models of care to support patients with high quality care in hospital and in the early discharge period.
- A number of in-person and virtual learning sessions were held to support the cardiac nurses and their project teams in improvement methodologies, to identify the gaps in their services to guide the design of their interventions.
- Monthly virtual networking sessions were hosted for teams with similar models of care to promote sharing of learnings and cross-collaboration.
- Project sites were also supported as needed either virtually or through site visits.

Results at a glance

Health services

20 hospitals from across Victoria

Duration

January 2022 to April 2024

Project measures

Eleven overall project measures plus several health service specific measures.

Results

Overall, the project helped to reduce the percentage of patients with specific cardiac conditions from returning to hospital within 30 and 90 days after being discharged home. However, not all health services saw this improvement.

Improvements were seen across all sites in quality-of-care processes such as timely follow up, discharge planning, inpatient care coordination and self-management education.

Other outcomes

Increased capability of frontline clinicians to lead a quality improvement project.

Health services have a more in-depth understanding of their cardiac patient cohorts.

Increased collaboration among cardiac nurses across the state.

Key improvements

- 6,545 eligible patients were seen and supported by the cardiac liaison nurse during their inpatient stay, 52% of these patients were from regional Victoria.
- 14% reduction in 30-day all-cause readmissions for patients presenting with Atrial Fibrillation (AF) and 1% for patients presenting with Acute Myocardial Infarction (AMI).
- 6% reduction in 90-day all-cause readmission for patients presenting with Heart Failure (HF).
- 45% reduction in 90-day all-cause readmission for AF, and 14% for AMI.
- 67% of eligible patients were referred for follow up support through chronic disease management programs within 48 hours of being discharged, enhancing patient self-management abilities.
- 58% of eligible patients attended a specialist clinic <30 days of discharge.
- 7 New Nurse led clinics were established as part of this project, improving access to specialist care particularly for those living in regional and rural areas.
- 64% of patients received a follow-up phone call within 48 hours of discharge, enabling the cardiac nurse to support patients with their self-management during the early period of returning home.
- The cardiac nurses have provided patient-centred care and tailored supports to priority populations including Frist Nations and Culturally and Linguistically Diverse to manage their chronic conditions and navigate the complex health services.
- Health service stakeholders reported that the improvements in how patients received education helped to alleviate patient anxiety and better prepare them to return home.

At least 10 out of 20 participating health services have sustained the role of the cardiac nurse after project closure.

Key learnings

- Collect robust and consistent baseline data. Embed a run-in period before project activity commences in circumstances where low quality data is available at baseline.
- Having an in-depth understanding of your area for improvement is key to a successful project.
- Robust governance structures and executive leaders buy-in is essential in promoting improvement work and sustainability of interventions.
- Sharing the workload and allocating tasks to different team members.
- Review data and progress regularly, let go of what's not working and focus efforts into addressing those most at risk.
- Partner with a wide range of consumers including those from priority populations when undertaking improvement work.
- Start testing new ideas on a small scale to iron out any problems before implementing more broadly.

To receive this publication in an accessible format email Safer Care Victoria <info@safercare.vic.gov.au>

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN/ISSN 978-1-76131-652-4
Available at the Safer Care Victoria website <https://www.safercare.vic.gov.au>