Heart Helper Pilot

Summary report

Over 2022 to 2024, Safer Care Victoria (SCV) partnered with 3 Victorian health services to improve care for people with heart failure with the aim of reducing unplanned readmissions to hospital.

BACKGROUND

Heart failure is a complex, chronic condition. One in four people with heart failure is readmitted to hospital within 30 days of going home.

Heart failure has 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

This Commonwealth funded project aimed to improve patient-reported outcomes and reduce 30-day readmissions for people with heart failure.

This project achieved this by developing and piloting a model that focused on increasing self-management and trialling an innovative **combined workforce** – where staff with and without heart failure specialised experience worked together to support people with heart failure after going home from hospital.

IMPROVEMENT APPROACH

3 Victorian health services participated in the Heart Helper Pilot. This support included Commonwealth funding towards staffing costs of the combined workforce model.

SCV Project Lead and Lived Experience Partner met online weekly with team project leads to provide improvement coaching, share learnings, and discuss challenges. Group meetings and emails encouraged collaboration among health services.

Health service teams provided regular quality improvement reporting including clinical outcomes, service activity data, consumer feedback and case studies.

RESULTS AT A GLANCE

Heart Helper Pilot model

We used a co-design approach to develop a model that provides personalised support and empowers people to self-manage their heart failure.

It trials an innovative 'combined workforce' where healthcare workers with and without heart failure specialised expertise work together to deliver care.

Pilot impact

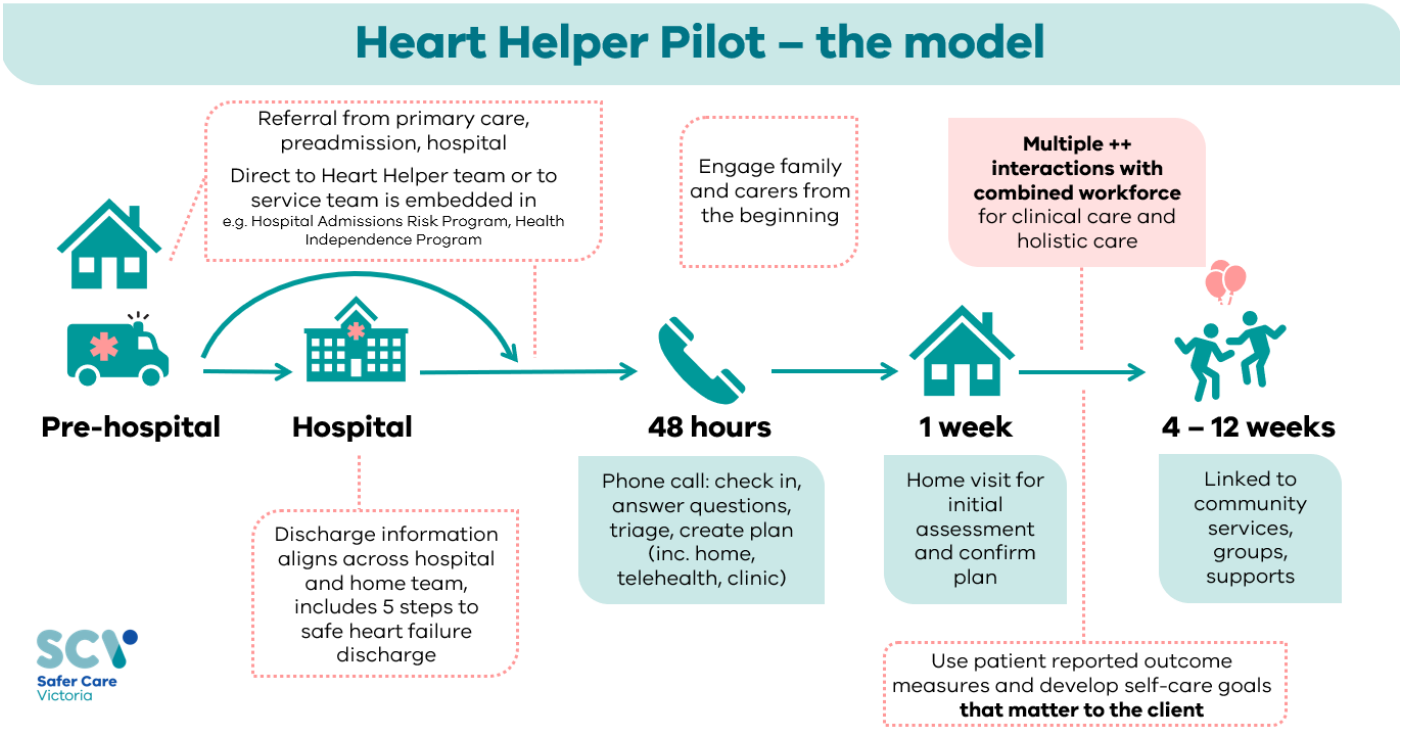
798 people with heart failure received care under this model August 2022 - March 2024.

- 42% from a culturally and linguistically diverse background
- 35% from regional Victoria

Outcomes

- Model adapted to local needs and piloted by 3 participating health services
- 11% reduction in 30-day all-cause hospital readmission
- Improvement in patient-reported outcomes including health, functional ability, psychosocial wellbeing and quality of life
- Helped address unmet psychosocial needs, such as loneliness and lack of agency
- For every $1 invested in the pilot, a return of $2.36 is achieved
- Combined workforce model found to be safe and effective - potential to support people with other chronic conditions
- Increased capability of project teams to partner with consumers, lead quality improvement, and collaborate

Figure 1. The Heart Helper Pilot model



THE HEART HELPER PILOT MODEL

We used a co-design approach to develop the model, shown above in Figure 1. The design process used was a finalist in the 2022 Victorian Premier's Design Awards – Service Design category[1].

We worked closely with people with heart failure, their carers and family members, and healthcare workers in this field. We used a variety of activities to learn about their experiences and understand where there were opportunities to improve care.

Two key themes from this engagement emerged. Consumers and clinicians agreed:

- evidence-based care when provided was useful and effective, such as the Heart Foundation Heart Failure Toolkit[2]
- there is opportunity to spend more time and focus on what matters most to the person with heart failure.

We heard clients would often require more support after hospital discharge if they were frail, over 75 years, living with cognitive impairment, had complex co-morbidities and/or lived alone.

We heard common unmet needs in usual care included social isolation, confusion about medications, anxiety, inadequate referrals to other services, and poor understanding of heart failure.

The model aimed to address these needs by providing personalised support and empowering people to self-manage their heart failure. Key components of care included:

- a support phone call within 48 hours post-discharge
- tailored education around heart failure and self-management
- identifying and working towards self-care goals
- opportunities to engage in social activities
- symptom monitoring and, when necessary, care escalation
- targeted support for priority cohorts
- assistance in navigating the health system.

[1] 2022 Victorian Premier's Design Awards – Service Design category.
https://premiersdesignawards.vic.gov.au/entries/2022/service-design/heart-helper-pilot

[2] National Heart Foundation of Australia, Victorian Government. Heart failure toolkit. a targeted approach to reducing heart failure readmissions. Melbourne: Heart Foundation; 2015

Local models

Participating teams adapted the model to best suit their local needs in ways including:

- combined workforce roles
- client contact frequency and focus
- defining their target population by considering access/eligibility to other programs, social circumstances, and perceived 'urgency' of health follow-up from acute setting
- tailoring their measurement and interventions.

Health services were provided funding towards the staffing costs of the combined workforce. Examples of the combined workforce teams that were trialled:

- care coordinators working with enrolled nurses and nursing students
- clinical nurse consultants working with enrolled nurses
- team approach including allied health, nursing and pharmacy.

Care included usual care elements of heart failure education and management (often at a slower pace), symptom monitoring and care escalation when needed. Examples of additional support is shown in figure 2.

Figure 2. Examples of additional types of support provided in the Heart Helper Pilot

RESULTS

Improved outcomes

The Heart Helper Pilot was seen as an improved and more holistic model of care that supported 798 Victorians with heart failure through the use of the innovative combined workforce.

- 11% reduction observed in 30-day all-cause hospital readmissions (from 27% to 16%; range 6-17% across teams).
    - An increase in 30-day ED re-presentations was observed (from 7% to 11%), likely presentations that previously resulted in readmission were now able to be discharged home.
- Teams used a range of patient-reported outcome measures with improvements reported in health, functional ability, psychosocial wellbeing and quality of life.
    - Where measured, physical improvements also reported in gait speed, 6-minute walk tests and sit-to-stand outcome measures.
- Potential to support people with other chronic conditions such as diabetes, renal or respiratory conditions. These conditions share common management strategies including medication adherence and lifestyle modifications.
    - 2 of 3 health services have embedded ongoing additional roles into their Hospital Admission Risk Programs.
- A range of benefits seen in the economic analysis, including a 'social return on investment' evaluation suggesting for every $1 invested in the Heart Helper Pilot, a return of $2.36 is achieved. There are some limitations to this analysis.

Improved access and timeliness of care

Teams reported improved access to heart failure care and some improvement in timeliness of care. Teams noted the model addressed critical gaps in care pathways, including one team supporting clients not eligible for other programs.

- Teams were able to support clients from priority populations:
    - 42% of clients were from culturally and linguistically diverse (CALD) backgrounds

    - 35% of clients were from regional Victoria
    - First Nations clients were connected with support workers to provide culturally appropriate care
- Model enabled improved access to heart failure care by providing home visits and remote monitoring to overcome technology access issues or support client preferences.
    - Teams acquired and established lending programs for remote monitoring equipment and digital tablets.

'There is no place like my home'
– Heart Helper Pilot client

- Half of clients and/or their carers were contacted within 48-hours of hospital discharge (compared to 37% at baseline).
    - Teams noted this was especially helpful for clients who were confused, needed medication guidance, lived alone or required additional referrals.

'Another gap in service filled by this Pilot was providing immediate support post-discharge from acute care through a 48-hr phone call…. Clients really appreciated having this support.'
- Heart Helper Team member

- One team able to consistently provide a home visit within 7 days of hospital discharge.

More personalised care that met client needs

Teams achieved positive outcomes by delivering more personalised support and empowering clients to self-manage their heart failure. In particular, the model helped address unmet psychosocial needs commonly experienced by people with heart failure, such as loneliness and lack of agency.

- 82% of clients set self-care goals (compared to 20% at baseline).
- Heart failure education was tailored to client communication needs and health literacy - including repetition, slower pace, 'real life' ways of practicing self-management principles, engaging family, and use of cultural workers or interpreters.
- Teams were flexible and creative in fostering social connection including social prescribing, supporting client interests, linking with community groups, and organising social events with other local heart failure clients.

'The program made me feel that you can go back into the world'
-Heart Helper Pilot client

- Teams reported high client satisfaction with care provided through avenues such as surveys, interviews, informal feedback and focus groups.

'… Treated me like I'm a person again, not a number… You do not get this in a hospital. It is a very professional service but doesn't feel clinical at all'
-Heart Helper Pilot client

Safe and effective workforce model

The combined workforce model was safe and effective, with potential to support people with other chronic conditions.

- Teams defined roles and responsibilities across their Heart Helper Teams; service referral and discharge criteria; and developed position descriptions including scopes of practice, documentation tools, care / escalation pathways.
- Only one clinical incident was reported throughout the pilot period.
- Teams reported detecting and escalating multiple occasions of clinical deterioration earlier due to more frequent client contact. At times staff supported the client to self-recognise and escalate as per their health plan (e.g. heart failure nurse, GP, Virtual ED, ambulance), and other times staff directly escalated care.
- Clinical workflows were more efficient with more senior staff involved in initial assessments and supervising less experienced staff to provide more frequent client contacts. This allowed faster allocation and triaging of new clients.

'This way of working is really efficient, we can all spend more time with the clients that need us'
- Heart Helper Team member

Collaboration and upskilling for project teams

The pilot supported increased capability of teams to partner with consumers, lead quality improvement work and collaborate across health services.

REASONS FOR SUCCESS

- Using a co-design approach ensured the model focused on meeting a gap in current care and being able to tailor care to consumer needs.
    - Embedding a Lived Experience Partner in the SCV project team enabled ongoing consumer input and support to the project.
    - We used a variety of ways to engage with consumers, even when challenged by pandemic restrictions.

Health services were successful by partnering with consumers, collaborating with each other, and being open and flexible to change the way they did things based on what they learnt.
- SCV Project Lead

- Teams dedicated time to partnering with consumers by including consumer members in their project teams, regularly gathering and acting on client feedback about their service (using surveys, focus groups and case studies).
- Teams were willing to collaborate and share with each other their learnings, challenges and successes. There was high attendance at optional weekly meetings facilitated by SCV.
- Teams were willing to be open and flexible to adapt and tweak their model based on data and consumer feedback. This included pivoting to address client psychosocial needs more directly and 'finding a way' to support every client.

All 3 health services also participated in another project 'Cardiovascular Nurse Ambassador', and this project likely benefited from broader organisational interest and improvement in cardiovascular care.

FUTURE MODEL RECOMMENDATIONS

For health services looking to implement something similar to the Heart Helper Pilot model, please consider the following lessons and recommendations. The model should be part of a holistic, person-centred and multidisciplinary model of care to maximise client experience.

Define and understand your target population

Explore and consider how to address any known local needs such as technology access and literacy, health literacy, and cultural needs:

- plan for how to provide and support use of telehealth and remote monitoring equipment
- identify spoken languages and adopt cultural support practices, including having timely access to interpreters – avoid assuming clients will understand health matters in English
- teams attributed high success and ability to build strong connections with CALD clients when their team also had diverse cultural backgrounds and spoke languages other than English.

Clearly define the scope and role of the service from other programs

Teams saw most success when the combined workforce model was embedded in an existing service such as Hospital Admission Risk Program or Health Independence Program that had pre-existing access to home-visiting resources and specialist escalation care. Be specific:

- define referral and discharge criteria
- set performance indicators of responsiveness (e.g. 48-hour phone call, home visit within 7 days)
- measure and address low referral rates or wait times to better support clients in the vulnerable early discharge period
- develop clear care pathways, escalation pathways, and ways to upskill in heart failure management and managing complexity in the community setting
- proactively plan for staff leave
- have access to appropriate equipment and set up support for clients (e.g. loan/buy monitoring equipment, weight scales, or exercise equipment)
- have access to appropriate equipment for staff (e.g. office space, vehicles for home visits, monitoring equipment such as blood pressure)
- consider how to coordinate care with primary care sector – as both referral into service, and transitioning care back to primary care.

Outline roles, responsibilities and ways of working for the combined workforce team

Plan who will be in the team, how they will communicate, provide supervision, and discuss client care needs. Consider the most appropriate skillset, qualifications and scope of practice for any new roles.

Teams from Heart Helper Pilot recommend the following staff attributes:

- understanding of health and how to navigate the healthcare system
- reflect diversity of local population, with benefits of having cultural and spoken language diversity across the team
- capable of effective communication
- able to practice under direction but not direct supervision
- able to build strong rapport with clients, but also able to help 'let go' and discharge from program.

Build and leverage relationships with referrers

Raise awareness and support referrals with key stakeholders including ward, outpatient, and specialist staff, and primary care providers. Engage local community / social groups, language and cultural support services.

Carefully choose measures and methods of monitoring and reporting success

Teams found the following most useful to collect at baseline and ongoing/regular intervals during service delivery, and share with leadership and front-line staff:

- rates of clients presenting to ED or readmitting to hospital (including reasons for and timing of presentation/ readmission)
- relevant clinical and patient-reported outcome measures, and self-care goals to monitor progress and achievement of goals
- service activity data such as referrals, active client list, responsiveness indicators, number of client contacts
- clinical incidents
- consumer feedback in multiple ways such as informal feedback, service survey, focus groups, and collection of case studies - plan for how to include multicultural consumer feedback.

Note, if multiple sites / health services involved, align measures wherever possible to enable grouping and comparison.

Consider sustainability and align with existing home/community-based funding structures

Consider how to leverage existing funding structures where appropriate, and plan for trial periods to demonstrate the impact for the organisation. Seek early support to develop robust business proposals for ongoing roles in areas of success.

Broader project learnings

- Establish a project team that includes leadership support, clinical expertise, and consumer members that reflect the local population.
- Having a project lead and a project team can maintain momentum and share the workload.
- 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 improvement work and sustainability of interventions.
- Partner with consumers including those from priority populations when undertaking improvement work (such as team membership and embedding client feedback methods).
- Review data and progress regularly, let go of what is not working and focus efforts into supporting people most at risk.

EVALUATION APPROACH

An evaluation of the Heart Helper Pilot was conducted by Deloitte Touché Tohmatsu. Its findings have informed this report.

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