Empowering Patients with Heart Failure & Enhancing their Community Support Network

Singapore Healthcare Management 2019

Dr Julian Loh, Nor Syamsul & Clarice Ng

ESTHER Network for Health & Social Care SINGAPORE

National Heart Centre Singapore
SingHealth

Introduction

Establishing a direct care pathway with community service providers to monitor and support the care of heart failure patients in the community is key to improved long term health outcomes. This ensures that Esthers with medical and social risk factors have their symptoms, psychosocial needs closely monitored and well supported at home.

The goal of this project is to improve Esther's experience through a wider source of medical, nursing, psychosocial care and support in the community from chronic disease to end-of-life care. This project will present the **key strategies** of :

1) Establishing holistic community partnerships
2) Engaging Esthers and internal stakeholders in the development of the self-management guide.

Methodology

Using a multi-pronged approach, networking sessions between the NHCS team and the community service partners were held to discuss partnerships. We had engaged 4 service providers and we eventually reached an agreement with 1 of them, St Luke's Elder Care (SLEC), on the operations, risk management, funding and the use of point of care devices to ensure that our program is comprehensive. *Table 1* shows the profile of patients identified.

A clear care pathway between NHCS and SLEC team was established to have bi-directional updates on the patient's needs and progress resulting in clear and timely management of patients' conditions. We also worked out the financial structures to support financially needy patients. Trainings were conducted by our medical and nursing team to support SLEC's medical and nursing capabilities to manage these patients in the community.

Table 1

Type of risk factors	Target population
Medical	NYHA Class II - IV
	Readmitted at least once in the last 6 months
	Polypharmacy (>5 types)
Social	Frail with impaired senses
	Elderly and socially isolated

Home visit to our first Esther

Home visits were conducted to understand the needs of our Esthers at home. We also engaged our Esther's family members to hear from their perspectives on what matters to them. From this, we narrowed our target population to those with the greatest medical and social risk factors identified from our Esthers.

Team visit to community provider

Team meeting with community partner

Team visits to community service partners were conducted to discuss alignment of workflow and organization's capacity. We also approached organizations who were able to provide chronic care to end-of-life support.

Team meetings were held regularly

Interviews with patients to seek feedback

Esthers and inter-disciplinary team feedback were sought on the original patient education material. Fonts were enlarged, colours and pictures were added to increase its attractiveness. The development of the 21-page heart failure self-management guide, which includes self monitoring charts is ongoing.

Result

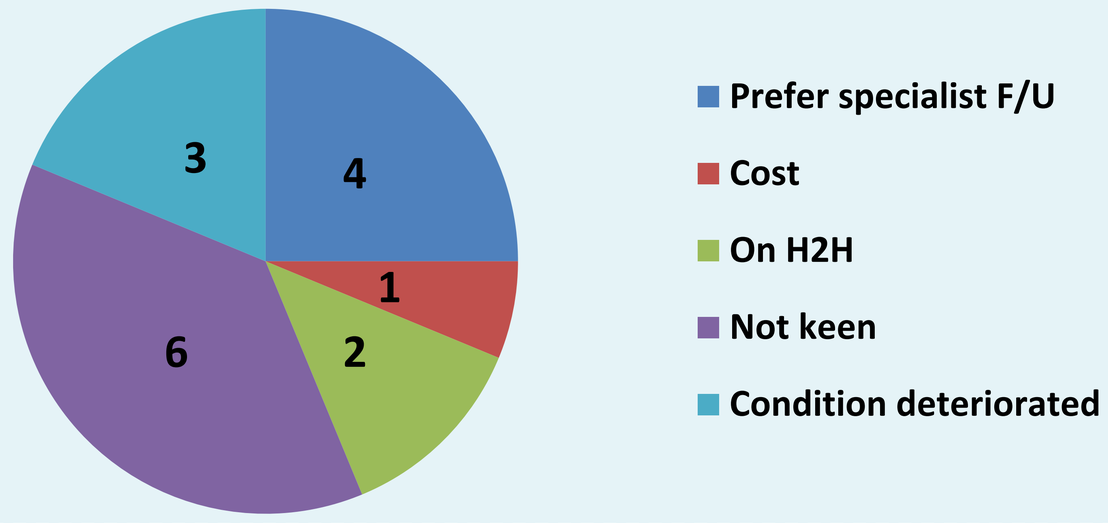
Close partnership was established with SLEC since April 2018. To date, 28 patients were recruited based on medical and social risk factors. 12 patients were successfully followed up, mitigating some unnecessary readmissions. *Table 2* depicts the outcomes of the project to date. Other 16 patients either passed away or declined due to various reasons.

Table 2 Outcomes of project to date	Results
No. of Esthers interviewed to understand their HF baseline knowledge	12
No. of Esthers referred to community service partners for follow up	28
No of Esthers successfully follow up	12
No. of community partnerships engaged	4
No. of training conducted for community partners	2

Chart 3 below shows the reasons for declining program. 4 feedback sessions were held to discuss the program progress.

Chart 3

Breakdown of reasons for not being agreeable to SLEC Care Programme:



Conclusion

The success of this project depends greatly on the deployment of effective communication and acting on feedback given from our collaborators (i.e. Esthers and community partners).

Future plans

Plans in place include expanding the programme to other cardiac patients who require home monitoring. Usage of INR devices loaned to SLEC are in the pipeline where patients are able to monitor blood coagulation in their circulatory system. Raising awareness to patients on Heart Failure with an educational booklet are in the works too. We also plan to study the reasons for dropout through survey interviewing.