Service Priorities and Programmes

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Heart failure in frail, high risk elderly patients: We can do "BETTER"

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Introduction

Congestive heart failure is the most common indication for admission to hospital among elderly. Behavioral factors, such as poor compliance with treatment, frequently contribute to exacerbations of heart failure, a fact suggesting that many admissions could be prevented. Therefore a comprehensive approach is necessary in managing heart failure in frail elderly. The "BETTER" heart failure program has been established in local acute hospital-United Christian Hospital to provide optimal care in heart failure patients. This year review aims to evaluate the effectiveness of "BETTER" program on reducing these patients' avoidable healthcare utilization

Objectives

The "BETTER" program demonstrates the effective in reducing 28day emergency readmissions for high risk elderly patients in heart failure.

Methodology

The program commence in October 2011 to September 2012. Heart failure patients who were hospitalized & HARRPE score ≧0.2 could be recruited. The" BETTER" program was run by nurse - case manager with case management training. The key components of the program include case manager provide 6-8 home visits after hospital discharge, immediate home care support service, ad-hoc medical follow up and hotline inquiry. During case manager home visit, the acronym "BETTER" of what heart failure management should include: Best practice from evidence base knowledge, patient and carer Empowerment, caring skills and knowledge Transformation, Transitional care approach from hospital to community, End-of –life issues, and Restrictions.

Result

We report 147 patients recruited in "BETTER" program. The gender ratio was about 0.89 to 1.1 (70, 47.3% of female and 78, 52.7% of male) with mean age of 82.1.

Under program total 65.3% elderly without unplanned admission within 28 days after discharged. 77.1% elderly HARRPE score in-between 0.2-0.4 and 76% elderly HARRPE score in-between 0.41-0.6 without unplanned admission within 28 days after discharged. In addition, 71.4% elderly HARRPE score in-between 0.61-0.8 reported that could not avoid unplanned admission within 28 days after discharged. According result, high risk elderly who were HARRPE score 0.2-0.59 after receiving “BETTER” heart failure program, their attendance numbers in emergency department and unplanned admission were significantly reduced. More outcome indicators will be evaluated in one-year review such as Quality of Life and performance in activities of daily living.