Spreading better cardiac care for Aboriginal and Torres Strait Islander people

Initiative Type

Service Improvement

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Deliver

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Summary

This Better Cardiac Care model will comprise a multidisciplinary team (Clinical Nurse Consultant, Indigenous Health Worker and Pharmacist) to support Aboriginal and Torres Strait Islander people

with heart disease navigating the health system and transition between acute and community settings. They will work across services, sectors and geographical boundaries and provide advocacy, education, counselling, coordination, discharge planning and transitional support. The model forms part of the broader Statewide Networked Cardiac Service program being rolled out across Queensland Health.

Key dates

Sep 2022

Jun 2024

Implementation sites

Cairns and Hinterland, Mackay, Central Queensland, Wide Bay, Gold Coast, Darling Downs and Townsville Hospital and Health Services

Partnerships

Metro South Hospital and Health Service Better Cardiac Care

Key Contacts

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Aim

Facilitating cardiac care for Aboriginal and Torres Strait Islander people across services, sectors and geographical boundaries to improve their cardiac outcomes.

Benefits

- culturally appropriate health care
- reduce the gap in access and outcomes
- reduce avoidable Emergency Department presentations to facilitate improved access and patient flow
- reduce potentially preventable hospitalisations to facilitate more sustainable utilisation of inpatient capacity
- more timely and appropriate access to care that is as close to home as possible where clinically appropriate

Background

Cardiovascular disease is the leading contributor to the fatal burden of disease for A&TSI people as they have a disproportionate use of the healthcare system which contributes to poor health outcomes.
This Better Cardiac Care project is designed to address the needs of this vulnerable population. This project supersedes the successful Metro South Hospital and Health Service model of care (Better Cardiac Care for A&TSI people) and will be implemented in several other Hospital and Health Services. It will be based in their cardiac specialty hospital, reaching into surrounding communities.
Outcomes from the Metro South service included:

- statistical improvement in 90-day outcomes for acute coronary syndrome
- secondary heart attack rates fell from 6.4% to 1.6%
- unplanned cardiac readmissions reduced from 30.5% to 16.7%
- 300 bed days saved over 12 months
- seven-day follow up to GP from 40-50% to 85-98%

Solutions Implemented

Education – The multidisciplinary team will regularly visit patients in the hospital system (emergency, inpatient and outpatient) to provide culturally appropriate education, including a booklet to improve understanding and self-management strategies. The evidence based ‘Teach Back’ method will be used (Caplin & Saunders, 2015).
Care Coordination and Integration – The multidisciplinary team will proactively facilitate transition of care back to the community and/or appropriate carer. Clinical handover, medication and specialised medication titration plan will be shared. The duration and intensity of care coordination after discharge will vary according to need, however, it will typically be maintained through to the first outpatient specialist review. Partnerships with Aboriginal Community Controlled Health Services will be established to ensure integrated and coordinated transition of care.
Target cohort – Aboriginal and Torres Strait Islander patients who are admitted to hospital for cardiac care and transitioning to primary and or community care are the target cohort for this model of care. However, non-indigenous patients who reside in rural and remote places with complex health needs, may also be prioritised where capacity allows.

Evaluation and Results

Queensland Cardiac Outcomes Registry (QCOR) will support the data capture and reporting process as part of existing Networked Cardiac Services initiative.

Lessons Learnt

The lessons learnt from the Metro South HHS Exemplar Model were incorporated in this model. It included:

- the importance of working with hospital Indigenous liaison officers
- the integration of cardiac clinic support in hospital and community settings
- understanding the person's circumstances
- the capacity to be flexible to ensure appropriate discharge planning

References

Utilizing Teach-Back to reinforce patient education: A step-by-step approach (2015), Caplin, M & Saunders, T. Orthopaedic Nurse, 34 (6), 365-8