Project Title

Empowering Heart Failure Patients in the Community

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Organisation(s) Involved

National Heart Centre Singapore, Changi General Hospital, Singapore General Hospital Community Nursing, Tan Tock Seng Hospital Community Health Team

Healthcare Family Group(s) Involved in this Project

Allied Health

Applicable Specialty or Discipline

Medical Social Work

Project Period

Start date: 2021

Completed date: 2022

Aim(s)

- Aim to uses an Empowerment model which is a process that uses a strengths based problem solving and person in environment approach to intervene through a collaboration at individual, group and community level to bring about change in self-perceived health status and ability to attain their social and health goals

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Conclusion

See poster appended/ below

Additional Information

Singapore Healthcare Management (SHM) Congress 2022 – 1st Prize (Patient Experience category)

Project Category

Care Continuum

Preventive Care, Community Health

Care Continuum

Intermediate and Long Term Care & Community Care, Social Care

Keywords

People-Centric, Heart Failure, Community

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Empowering Heart Failure Patients in the Community

Singapore Healthcare Management 2022

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1. Background

Fragmented and episodic care poses barriers in providing seamless continued care for Heart Failure (HF) patients, resulting in varied patient's care experiences. Health and social care providers also face systemic challenges in delivering optimal care. This programme aims to transform the service model and delivery of holistic care, with a paradigm shift in empowering and activating patients and their social networks as vital resources in their own care journey.

Desired shifts in healthcare's service delivery model

Current Healthcare	*Envisioned Healthcare*
Provider-Centric Care	People-Centric Care
Problem-Based Care	Strengths & Asset-Based Care
Episodic & Fragmented Care	Joint-Up Social & Health Care Community Networks

Current State

High resource burden & dependency on healthcare system & formal service providers

- High A&E utilisations
- Frequent re-admissions for symptoms relief

Goal State

Integrated health ecosystem with empowered patients and enabled Communities of Care (CoC)

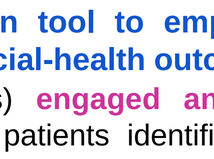


Figure 1: Transforming healthcare from addressing needs to empowering patient activation

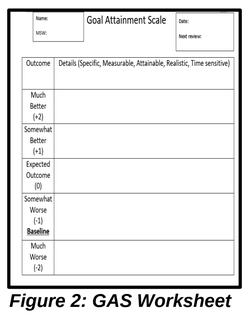
2. Methodology

This programme uses an **Empowerment model**, which is ***a process*** that uses a ***strengths-based, problem solving*** and ***person-in-environment approach*** to ***intervene*** through ***a collaboration at individual, group and community level*** to bring about ***change in self-perceived health status and ability to attain their social and health goals***.

Coordinated Care Pathway for Heart Failure Patients (HF CCP)

- ➔ Enrolled patients with **significant health and psychosocial risk factors**
- ➔ Established **escalation points of contact** and held **regular huddles** between hospital and community social-health service providers to enhance care coordination.
- ➔ Achieved **delivery of holistic, integrated and seamless care** for patients discharged from hospital to the community.

Goal Attainment Scale (GAS) as a conversation tool to empower and build individual capabilities and resources for better social-health outcomes


Goal Attainment Scale

Outcome	Details (Specific, Measurable, Attainable, Realistic, Time sensitive)
Much Better (+2)	
Somewhat Better (+1)	
Expected Outcome (0)	
Somewhat Worse (-1) Baseline	
Much Worse (-2)	

Figure 2: GAS Worksheet

- ➔ Medical Social Workers (MSWs) **engaged and facilitated goal setting conversations** with HF patients identified with health and psychosocial risk factors.
- ➔ Team **connected and worked collaboratively with** appropriate **health and social community care partners** such as Community Nurses to **support patients in achieving their valued social and health goals.**
- ➔ Team **followed up** with the HF patients on CCP **every 3rd and 6th month in their empowerment journey.**

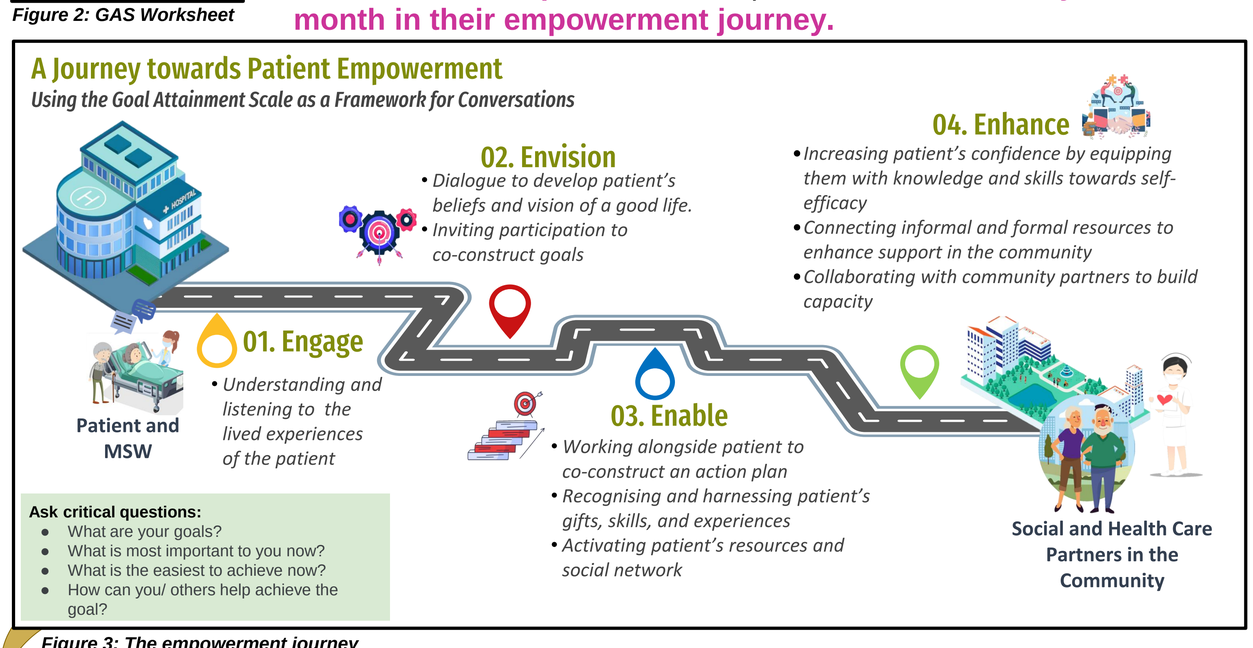


Figure 3: The empowerment journey

Multi-disciplinary training to empower and build community capabilities and resources

Figure 4: A role-play on GAS training pre-recorded via Zoom

- ➔ **Co-constructed and planned** a series of **10 workshops** on "Caring for HF Patients" with our community partners to **build their capabilities** to respond appropriately to patient's health and social care needs.
- ➔ Workshops were conducted via **ZOOM** during the COVID-19 pandemic between June to September 2021.

3. Results

Figure 5 (see below) shows the process indicators from the programme:

HF CCP Enrolment
67 patients recruited in Year 1.

Partnership
2 key partnerships established with SingHealth & TTSH Community Nursing.

Community Partners' Capability In Cardiac Care Management
>90% respondents from social-health service agencies found the multi-disciplinary workshops **useful in their care and management of heart failure patients** in the community.

Figure 5: Process indicators

Using SPSS software, data analysis was done on a group of 35 patients under the pilot phase of the Heart Failure Coordinated Care Pathway (HF CCP), who had completed the 6 months follow-up. **The outcome indicators are reflected in Figure 6 below:**

Improvement In Quality Of Life (EQ-5D)
EQ-5D scores for the group **increased by a mean of 0.12 points.** *This showed a medium magnitude of increase in quality of life reported by the patients.*

Improvement In Goal Attainment
*Statistically significant at the $p < 0.05$ level
91.4% of the recruited patients achieved better than expected goal attainments (T-score of ≥ 50 points).
GAS scores for the group increased by a mean of 17.1 points. Mean sample T-score was 57.1, indicating that overall, participants achieved their goals better than expected.*

Reduction In Re-admissions & Healthcare Utilisation
11.4% of all enrolled cardiac patients saw a **reduction in inpatient urgent admissions**. There is **5.7% reduction** among all enrolled patients **between baseline and during the 6 months' intervention**.

Figure 6: Outcome indicators

Intangible Results

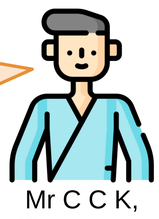
i. Impact on Patients

- ➔ Patients experience **self-efficacy and support** to monitor and manage their vital signs and treatment adherence in the comfort of their homes.
- ➔ They feel **empowered** after GAS conversations are carried out as they are able to take **ownership** of their health and social challenges, set personally valued goals and work towards them despite their physical ailments.

Mr H S X, 39 years old

*I was initially overwhelmed with my heart condition. **After prioritizing my goals**, I **feel more supported** and **in control of my health** and **plans to upgrade my skills**. I feel I have **more support from the hospital now** and I am looking forward to my internship.*

*Through the **conversation on setting my goals**, I **gained a clearer understanding** on **what is it that I want to focus in life**. I also realize how **having good health helps me continue in my new job**. I **understand the importance of talking to my doctor about my condition** and **taking his advice on diet and medicine to better manage my breathlessness"***



Mr C C K, 45 years old

ii. Impact on Service Delivery

- ➔ With the disruptions from COVID-19, it prompted us to **adapt and integrate** the use of technology (zoom) into our service delivery model to creatively mitigate the challenges arising from restrictions of face to face interactions.
- ➔ The empowerment journey with patients and community partners was **advanced in a borderless manner** through **virtual sessions for GAS and e-training**.

iii. Impact on Community Social & Health Service Partners

- ➔ The GAS conversations enabled the various social and health service providers to better understand patients' goals and to **align interventions** in a targeted manner, thereby fostering a **stronger sense of collaboration**.

4. Conclusion

This project is aligned with Ministry of Health (MOH) approach towards value driven care beyond hospital to the community. In this programme, creating the best value for patients means working with them and their ecosystems to take responsibility for their total well-being, regardless of where they are being cared for. Providing person-centered care closer to home in a borderless manner also makes our healthcare system more efficient and sustainable as a whole in the long run. Given the promising results from the pilot phase, we hope to co-create a patient-led peer support to empower and mobilize their informal networks in the community, to be less reliant on formal services to improve their social and health outcomes.