CHF-HOME

(Congestive Heart Failure - Home, Community, Monitoring and Exercise)

Program: A Partnership Program with Community resources to improve the outcome of patients with Congestive Heart Failure

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Introduction

Congestive Heart failure (CHF) is a growing public health problem in Hong Kong. In Pamela Youde Nethersole Eastern Hospital, numbers of admissions for CHF continued to increase, with 1.5 fold increase from 2001 to 2005. It is one of the leading causes of hospitalization in individuals older than 65 years of age. Readmission rate for CHF is very high, with 60% of patients readmitted within 1 year. And it has been shown that readmissions for CHF could be prevented up to 50 percent of cases.

Purpose of the Project

To improve the clinical outcome of patients with CHF, and reduce hospital admissions and resources utilizations.

Material & Methods

A team of Cardiologist, Ambulatory Care Physician and Cardiac Nurse was established in October 2007 to identify, assess, intervene and monitor selected patients admitted with CHF, i.e., in-patient clinical assessment, predischarge education and counseling, post-discharge management plan, telephone follow-up and enquiry service, early clinic follow-up. However, because of limited resources in hospital, this program can only focus on clinical needs of patient, while the psychosocial aspect and rehabilitation program are equally important in this group of patients.

Results

In view of this, a multidisciplinary heart failure team (Clinical and Allied Health Department) is established. And through partnership program with community resources, an extended community program is designed, which covers the following scopes:

1. *Extended Telephone Concern by Peer Volunteers from Care For Your Heart (Patients Association)*
2. *Psychoeducational group, with consecutive sessions for both patients and carers (Multidisciplinary Heart Failure Team, Patients Association)*
3. *Extended maintenance rehabilitation service in the community (Non-Government Organizations)*

Conclusions

Through collaboration between hospital multidisciplinary team and community resources, a partnership program can be established to take care of the clinical, psychosocial and rehabilitation needs in patients with CHF, improving their clinical outcome and quality of life.