A systems approach to integrating heart failure care: A 'how to' Roadmap based on lived experience

CorHealth Ontario



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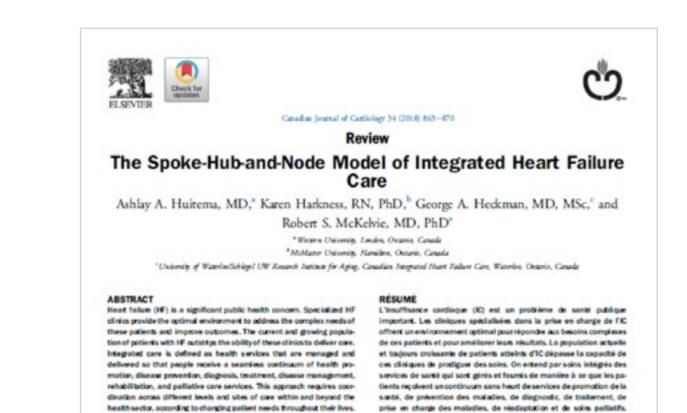
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Background

National CCS guidelines recommend a system level approach to organizing care for patients with heart failure (HF). The spoke-hub-and-node (SHN) model represents an organization of care that works collaboratively with the primary care sector and is highly integrated with community-based multidisciplinary teams of health care professionals and specialty care. In Ontario, two sets of standards were released -the SHN model for integrated HF care (care organization) and the Quality Standard for HF Care in the Community (delivery of care).



Huitema AA, Harkness K, Heckman GA, McKelvie RS. The Spoke-Hub-and-Node Model of Integrated Heart Failure Care. Can J Cardiol. 2018;34(7):863-870.



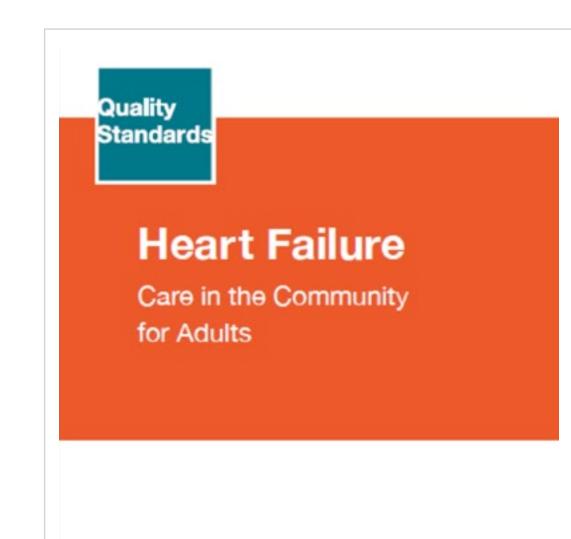
CorHealth Ontario. Minimal requirements and key clinical services for heart failure programs within a spoke-hub-node model of care. 2018. www.corhealthontario.ca

Health Quality Ontario. Quality Standards

for Heart Failure Care in the Community

for Adults (2019) www.hqontario.ca

Minimal requirements and key clinical services for heart failure programs within a spoke-hub-node model of car August 23, 2018



PURPOSE

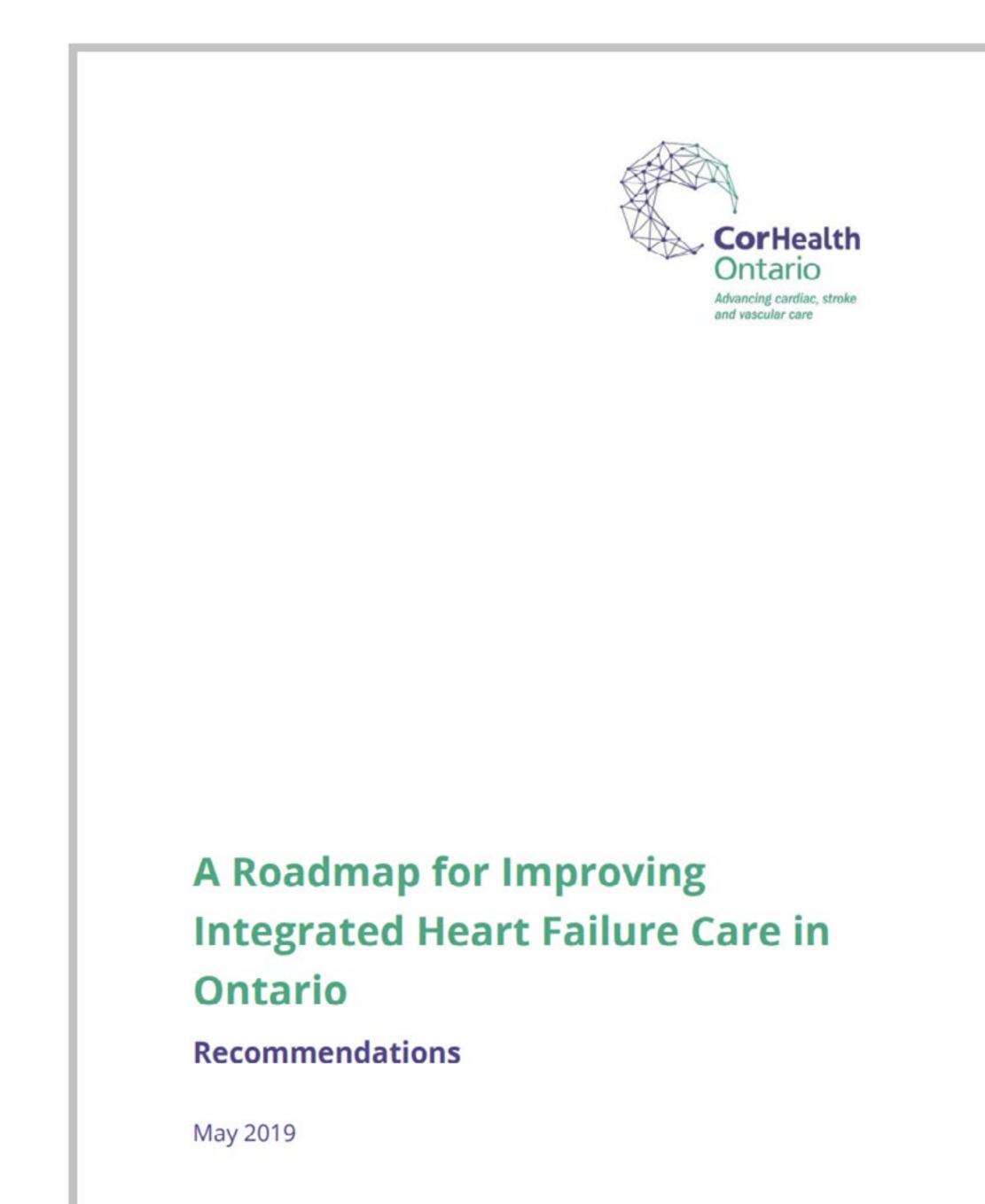
The purpose of this quality improvement project was to develop a set of recommendations, or a 'Roadmap' that provides guidance and critical considerations on 'how to' implement integrated and evidence-based HF care in regional teams using 'on the ground' experience from early adopter teams in Ontario.

Methods

This quality improvement project led by CorHealth Ontario involved three early adopter teams (London, Ottawa, and

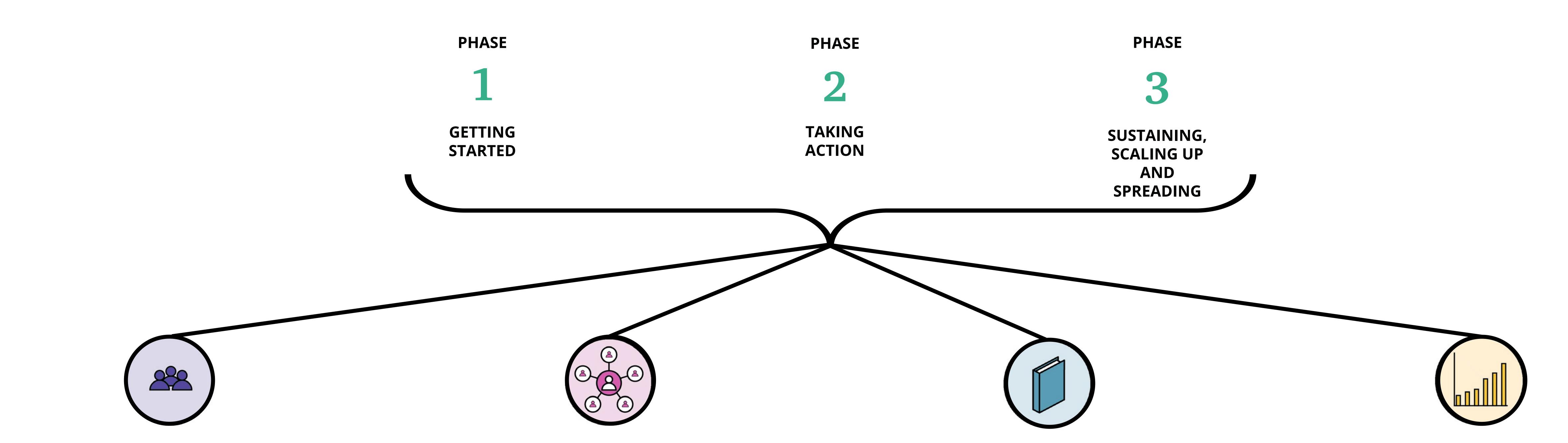
Results

ROADMAP



The Roadmap describes the implementation process in 3 phases. Critical considerations for successful implementation were identified and organized into 4 main themes or categories (Figure 1). Recommendations for implementing a systems approach for integrative heart failure care are outlined in Table 1.

Figure 1: Roadmap implementation process and requirements.



PATIENT AND CAREGIVER VOICE

To make impactful changes to HF care, patients and caregivers must be empowered to take an active role in the planning and design of HF care improvements. Although unintended by care designers, "blind spots" in HF care have been uncovered, as a direct result of patients' and caregivers' lived experiences. Looking forward, participation of patients and caregivers is imperative to defining and implementing care improvements at all levels of care (i.e. spoke, hub and node) and all phases of the process.

COLLABORATIVE LEADERSHIP

Connecting and integrating HF care requires leaders and champions, both clinical and administrative, working together in a collaborative, organized and effective manner. It requires clear executive sponsorship, support and accountability to navigate the alignment between potentially disparate organizational mandates, and ensure initiatives are focused on the patient and caregiver perspective. Leadership also implies securing or leveraging organizational resources to support efforts in HF quality improvement.

EDUCATION

From patients and caregivers, to physicians, nurses, and multidisciplinary care teams, the need for more HF education is undeniable. Investment in HF education serves as an excellent beginning for increased engagement among providers and contributes to much-needed capacity within the system of HF care providers, as well as among patients and caregivers.

DATA AND REPORTING

In each phase of the Roadmap, information is critical, from establishing a well-informed current state, to monitoring progress for performance improvement. There is room for improvement in HF data availability and reporting, at the system, program, and patient levels to support improvements in diagnosis, transitions in care and patient and caregiver experience.

Conclusion

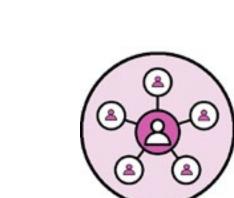
Although a systems approach to organizing care for patients with HF is recommended, the actual 'how to' remains poorly understood. The 'Roadmap' outlines recommendations based on key critical requirements from 'the lived experience' of primary and specialty care clinicians and administrators as they worked together to generate locally meaningful and innovative system-level solutions to address current gaps in HF care.

Future Direction

- Teams continue to meet to: connect and keep the momentum forward by exploring opportunities to build necessary structures and processes within the S-H-N model, engage local HF champions, provide educational events to build capacity and create networks of practice
- Building processes to support access based on needs assessment from initial engagement activities (e.g. improving access to echo in rural areas)
- CorHealth Ontario continues to be available (in-kind support) to teams for ongoing advice, troubleshooting, connecting with others
- Ensure integrating HF care initiative aligns with provincial health system restructuring

Table 1: Recommendations for implementing a systems approach to integrating heart failure care as mapped to the 3 phases are outlined in Table 1.

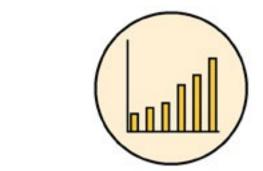
PHASE 1: GETTING STARTED



Establish a local leadership table and an implementation structure that includes integrated clinicians and administrators spanning the continuum of HF care (e.g. at the spoke, hub and node levels). This starts with getting to know who the local HF champions and stakeholders are, ensuring there is engagement with them, and identifying the spokes, hubs and nodes.

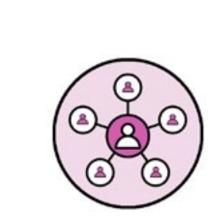


Take the necessary time to actively engage with patients living with HF and their caregivers during the planning phase, and let their experiences, stories, and viewpoints guide the local priorities.



To help identify impactful, feasible and achievable initiatives, use available information and data to inform a comprehensive current state and understand local

PHASE 2: TAKING ACTION



Leaders focus on the outcomes for the patients they jointly serve. To connect care for the HF population, leadership at the spoke, hub and node levels should work collaboratively and innovatively to identify, leverage and share resources to support local coordination and implementation, including human resources, technological tools, and be open to expanding and sharing stakeholder networks.



As work plans are implemented, project goals may evolve. Patients and caregivers should continue to be regularly engaged and have ongoing opportunities to provide leadership and insight to the work, and informing "will this improve patient care?"

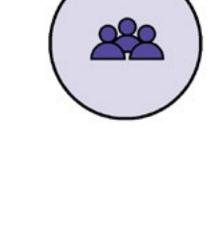


Focus quantitative and qualitative measurement and key data elements on project implementation objectives. Use data

PHASE 3: SUSTAINING, SCALING UP AND SPREADING



Clinical and administrative leadership at the spoke, hub and node levels, function together as a team to champion and endorse an integrated approach to HF care, through fostering partnerships and acting as enablers.



Regular and iterative patient and caregiver engagement continues, with an ongoing focus on identifying and prioritizing areas to improve the patient and caregiver experience. This can be supported through evaluating Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs).



Look to quantitative and qualitative data that have been collected for project objectives to begin to inform areas of success and future areas of improvement.

More Information

For more information on integrating heart failure care (IHFC) and the IHFC Implementation Support Toolkit, please visit the CorHealth Ontario website at: www.corhealthontario.ca/ihfc.

