CorHealth Ontario

Advancing cardiac, stroke and vascular care

Evaluative Report

A Compendium of Activities, Learnings, and Reflections from the IHFCI Early Adopters

May 2019

Executive Summary

This is a supplemental document that accompanies the *Roadmap for Improving Integrated HF Care in Ontario* (the Roadmap). The information contained within this Evaluative Report is intended for those interested in connecting with other local health care providers to work together on implementing an integrated approach to heart failure care. It tells the stories of the Early Adopter Teams as they embarked on the Integrating Heart Failure Care Initiative in 2018/19. The work of the Early Adopter Teams resulted in a wealth of experiences and learnings around implementing integrated, quality heart failure care, which informed the recommendations in the Roadmap. However, it was not possible to include all the details of their 'lived experiences' within the Roadmap. This Evaluative Report serves as a rich repository of activity descriptions, project artifacts, and reflections from the Early Adopter Teams on their process of implementing integrated heart failure care. For teams that are interested in transforming the delivery of heart failure care in their local context, the information in this document can help answer the question "where do we begin?"

Of note, there was no singular approach taken to implementing integrated HF care. Each Early Adopter Team had a unique journey, with very different starting points and outcomes. Although CorHealth Ontario was able to support the work at the Early Adopter Teams, the road ahead is long as these committed teams continue to construct and refine their local integrated HF care models.

Individual's names have been left out of this document to respect privacy. For those interested in speaking with team members from the Early Adopter Teams to learn more, please contact CorHealth Ontario to be connected with the appropriate individuals. The reports that follow were prepared by the Project Managers of each Early Adopter Team, in consultation with their project teams.

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Section 1: London-Huron Perth

The London-Huron Perth Early Adopter Team IHFCI Experience

Overview

This section reflects the efforts of the CorHealth team, the Project Manager, and clinician leads across London and Huron Perth during the Integrating Heart Failure Care Initiative (IHFCI) in the London-Huron Perth Early Adopter Team. Central to this initiative was improving integration of heart failure (HF) care in the region through a spoke, hub, and node model. Key clinician leaders in the Huron Perth sub-region led the work, which was facilitated by the CorHealth team and the local Project Manager. This report examines the composition of the Huron Perth region, describes the work and lessons learned in each of the 3 phases of the project, and provides key insights.

Background

Early Adopter Team Membership

The London-Huron Perth Early Adopter Team consisted of the following members:

- Spoke Physician Leads – a Family Physician from the Maitland Family Health Team (FHT) and a Family Physician from the Stratford FHT
- Hub Physician Leads – Two Internal Medicine specialists from Stratford General Hospital
- Node Physician Leads – Two Cardiologists from London, with expertise in heart failure
- Primary Care Physician Lead from the South West Local Health Integration Network (SW LHIN)
- Local Project Manager

About Huron Perth's Geography

The Huron Perth sub-region is located in the middle of the South West LHIN between the Grey Bruce, London Middlesex, and Oxford sub-region areas. Huron Perth is comprised of two counties: Huron County and Perth County. Huron County is located to the west along Lake Huron, and is predominantly rural. Its largest settlement is the Town of Goderich. Perth County is to the East, bordering Waterloo Region, and is also predominantly rural. Its largest settlement is the City of Stratford.[1]

Characteristics of the Population

The proportion and density of Indigenous, ethno-cultural and recent immigrant populations in the Huron Perth sub-region are lower than those in the rest of the SW LHIN. The population of

seniors, however, is relatively high in comparison with the rest of the region with the highest density located in Stratford and Goderich. [1]

A majority (60.5%) of the population lives in rural areas which represents more than twice the proportion in the rest of the SW LHIN. Of significance, Huron Perth has the second highest proportion of older adults and seniors of the five sub-regions of SW LHIN. With a higher incidence and prevalence of chronic disease, this means there are a greater number of people living with and managing chronic disease and co-morbidities in this predominantly rural setting.[1]

As of July 2015, there were 101 total Family Practitioners providing comprehensive primary care to the Huron Perth population of 145,794. Most (80%) of those Family Practitioners are affiliated with Family Health Teams. [1]

Rates of hospitalization for ambulatory care sensitive conditions (ACSC) are high in Huron Perth compared to the LHIN. A higher prevalence of chronic disease, an older age distribution of a population, and admission of rural residents to urban hospitals drive increased ACSC hospitalization rates. [1]

Project Work and Key Insights

Phase 1: Getting Started

Understanding the landscape

Identifying all existing and potential stakeholders is important to ensure a wide net can be cast to help initiate or build on strategic and opportunistic relationships. It is helpful to document this information through a stakeholder inventory or stakeholder map (Appendix A, page 13). Plotting stakeholders visually on a geographic map (Appendix B, page 14) is also helpful to visually appreciate pockets and gaps of service provision.

Initial engagement session

An initial engagement session took place on May 4, 2018 in London, Ontario. The intent was to start communicating the model to a wider population and identify teams within South West LHIN who were ready or interested in participating in the Integrating HF Care Initiative. More than 40 key stakeholders from across the spoke, hub, and node continuum attended. The day-long, didactic and interactive session provided attendees with a detailed look at the need for HF quality improvement, the Spoke-Hub-Node model of HF care, the HQO HF Quality Standard, and generated much discussion around gaps and opportunities for improvement.

1. [1] South West LHIN (2016). Understanding Health Inequities and Access to Primary Care in the South West LHIN. Retrieved from: http://www.southwestlhin.on.ca/primarycare/Resources.aspx

One of the critical byproducts of this event was engaging stakeholders in an open dialogue and idea sharing, and in doing so creating an appetite for what is possible. Another important function of this meeting was to paint a picture of the landscape of HF care within the region for the CorHealth project team. Robust CorHealth and HQO participation at this meeting was important to reinforce system's commitment to improving heart failure care with all stakeholders.

Through this event, Huron Perth emerged as a sub-region that had ready and willing clinician leadership and were selected as the Early Adopter Team.

Key Insight

- Wide distribution of the model, the intent, and the desired effect for the initiative will generate appetite and understanding in both the heart failure care community and in communities/practices that support these patients.

Site visits

During the summer of 2018, the CorHealth project team visited six of nine Family Health Teams across Huron Perth. The aim of these visits was to enhance knowledge of the spoke, hub, and node model, provide a 'Heart Failure 101' as a refresher training for doctors, nurses, and allied health professionals, and survey resources available to support heart failure care. By design, site visits occurred shortly after the initial meeting in May. Revised versions of the Current State Assessment Survey, that were used during site visits can be found in the Implementation Support Toolkit, under the folder 'The Spoke-Hub-Node Model.'

Feedback from each of the sites indicated that the visits were well received, and much data was harvested on the capabilities to provide HF care across the six Family Health Teams. Care providers and administrators identified issues in care and support. These included timely access to ECHO, provider education around interpreting ECHOs and complex HF management, and repatriation coordination. In addition, both clinical and administrative leadership were engaged in planning for an eventual spoke, hub, and node rollout.

While the HF refresher was eagerly welcomed and participants were highly engaged, there was insufficient time to present a full refresher that met the needs of the care providers in the region. Subsequent planning has occurred around designing a HF workshop in the spring of 2019 that will allow time to present a more thorough education package to a wider group of providers. Additional HF education resources are also available in the Implementation Support Toolkit, under the folder 'Heart Failure Education'.

Overall, both clinical and administrative leadership were engaged to become committed to and support working towards integrating the spoke, hub and node levels of HF care.

Key Insights

- A self-diagnostic survey is a beneficial way to engage clinical and administrative leadership at the sites to assess current capacity as a spoke, hub or node, including gaps and opportunities, strengths and weaknesses.
- While well received, there was not sufficient time during all the site visit meetings to deliver the HF refresher. Pamphlets and information around HF were timely and could help situate the need for a HF refresher workshop as an inaugural event of the provider and patient education program.

Sub-Regional Working Group

Through the May 4th event, and through visiting the 6 FHTs, key stakeholders were identified and invited to attend the first working group meeting in Stratford, Ontario on September 18, 2018. Providers, patient representatives, and administration from each of the spoke, hub, and node levels of care in Huron Perth participated in the 4-hour event. The objective of this meeting was to further solidify understanding of the spoke-hub-node model of care, report on findings from the site visits, present local HF data (the burden of HF in Huron Perth), and generate collaboration among attendees on opportunities and a heart failure QI plan for Huron Perth. Minutes from this meeting can be found in Appendix C, page 15.

CorHealth Ontario attended the meeting, and the interactive discussion was led by a facilitator. In small groups, participants discussed the current state structure across the care continuum in Huron Perth. Next, the groups used the draft heart failure quality standard as the foundation for discussions around what effective heart failure management and care in Huron Perth looked like. Through the discussions, the team developed a short list of priorities and work to be done.

This meeting was also attended by a patient representative. It is important to ensure that integration of HF care is patient focused with easy transitions between health providers and between community and hospitals is coordinated and seamless.

Key Insights

- One lesson learned from this working group was the value of clearly identifying the combined clinical and administrative leadership structure that will act in a steering capacity for the overall project.
- Organizing a collaborative leadership team of health care providers and administrative professionals into a coordinated team with clear goals focused on patients and specific local needs is of the utmost importance.

Communication

A core and fundamental need in change management is frequent, intentional communication. Developing a structured communication strategy early will guide transaction, namely getting from "saying" to "doing". It should also address interaction both internally within the project team and externally to key stakeholders. The communication strategy should encompass multi modal tools that allows information to be "pushed" and to “pull" engagement and interaction from stakeholders. This is critical for steering the project and for future work on expanding integration of care in the spoke, hub, and node model. Celebrating success and demonstrating progress are critical indicators and predictors of future success.

Key Insights

- Never assume that current modes of communication are sufficient to sustain significant change. Agreeing on even the smallest details of minutes formats, records of discussions, how the group will make decisions during the change process, and who needs to be involved in recurring meetings is a key foundational component that influence success.
- Intentional and recurring communication to involved stakeholders will reinforce success and create appetite for change; this includes actively involved stakeholders, as well as stakeholders who are on the periphery of the work.

Bandwidth

By its very nature, the process of better integrating HF care across the spokes, hubs and node is complex and demanding work. A core team of integrated clinical and administrative leadership must have the time and space to contribute. Early in our process, certain Rules of Engagement were discussed and agreed upon, including moving forward with meetings and project work, in the absence of full membership attendance. This meant that even though one, two, or multiple members of the leadership team may be absent from meetings or working groups, the goals of the group would be furthered and those who were absent would receive briefs on progress. This was crucial to maintaining momentum.

Key Insight

- Establish a regular meeting schedule where clinical and administrative leadership can accomplish work and receive updates.

Knowledge management

A fundamental part of the work that the leadership team completed was establishing a lessons learned process. In this, the team actively harvested and kept a “lessons-learned template” populated with changes in practice or in process. This is critical for future work in scaling and expanding the spoke, hub, and node model to shoulder organizations and

regions. It will also be critical to support quality improvement processes as a higher degree of integration of HF care occurs.

Key Insight

- A current state assessment survey is a beneficial way to engage clinical and administrative leadership at the sites to assess their readiness to evolve into the spoke, hub, and node model, and understand their role. The current state assessment surveys can be found in the **Implementation Support Toolkit**.

Phase 2: Taking Action

Communication

The leadership team quickly identified the requirement for regular meetings. These meetings had regular agendas, records of discussions and follow up reminders on tasks from the meetings. This process of scheduled and recurring collaboration, primarily using teleconferencing, was both critical to developing the project and was successful in maintaining momentum. The team used concurrent, asynchronous communication strategies and platforms to communicate across the stakeholder base. The group established a community of practice on a web-based platform, where participants exchange information and ideas, and to collaborate on the development of referral templates and treatment algorithms.

Key Insights

- Establish the needs and expectations of the leadership team early.
- Create space in schedules to meet and exchange.
- Use consistent methods, templates, and tools to capture progress.
- Records of discussion and decisions are important to maintaining momentum.

Provider education strategy

The hub clinical leadership played an active role in the design of and overall strategy for provider education and delivering an inaugural provider education session in Huron Perth. This was in response to requests from all levels of care for greater education around HF management. A HF education program for patients, family and caregivers is under development. The intended impact of this program is to help patients with HF continue living in their home communities while maintaining their highest level of health and wellness, as well as to support clinicians to maintain the highest standards of HF care. Avoidance of admissions, readmissions, and having a real impact on current issues like hallway medicine is central to the design of provider and patient education strategies.

Key Insights

- Provider education is only one piece of the puzzle. Patients and their circle of care need initial and ongoing HF education support to confidently manage their HF, without the need to leave their home community whenever possible.
- Health leaders need to place significant effort into examining the needs of the patient population (including their co-morbidities) and survey resources in the region that are available to support those needs. Cross-discipline integration are critical opportunities to help bridge care gaps. For example, consider partnering with existing chronic disease management programs.

Trial at pilot sites

Two Family Health Teams volunteered as pilot sites for the spoke, hub, and node model in Huron Perth. Clinical and administrative leadership at these two pilot sites have been engaged in all aspects of designing the implementation of the model. Planning is underway to start up these pilot sites as early as late spring or early summer 2019. Key considerations in choosing early sites include compatibility or parity of electronic health records, willingness to participate in a demonstration project, and administrative support in running the project. Ensuring smooth referral to and from each echelon in the spoke, hub, and node is a critical first component for this project. To that end, the hub and spoke leadership teams have put significant effort into designing a common HF referral form for Huron Perth based on the Node's current referral template (Appendix D, page 19). This will be a key component of the trial and assessing its impact will be part of the quality improvement project.

Key Insight

- To ensure the greatest chance to assess the impact of this trial, the FHT teams need formal project management support. CorHealth has already developed a Project Charter and a Terms of Reference for the project. These documents need to be the architecture for the trial and a Project Manager assigned to plan, do, study, and act/react/change will increase the probability of a successful rollout.

Phase 3: Sustaining, Scaling Up, and Spreading

Expand leadership team scope (and participants)

A clinical leadership team with representation from the spoke, hub, node, and SW LHIN has been working hard since the initiation of this project. A logical next step in the evolution and expansion of this initiative is to create a ***collaborative clinical and administrative leadership team*** that has the authorities needed to make changes to the patterns of practice and the infrastructure to support scaling and spreading the model. As the organization becomes more complex with more spokes and hubs collaborating with nodes, leadership teams will have to evolve to reflect the specific regions integrating HF care.

Key Insights

- The steering table must include a collaborative clinical *and* administrative leadership across the spokes, hub(s) and node.
- Other key stakeholder/key partners can include (but not limited to) Partnering for Quality, Health Quality Ontario, partners in complex care and common co-morbidities (cardiac rehab, seniors' programs, diabetes, COPD, stroke), and Sub-Region Integration Tables (under the LHIN structures).

Strategic partnerships

Examining the successes of other agencies and organizations who have undertaken integration using a spoke, hub, and node model will become increasingly important. Patients who experience HF often have other co-morbidities that make their care extremely complex. If we are not designing HF integration in parity with other agencies structures, we will truly not meet the needs of our patients and could possibly not be delivering on intended positive outcomes. Integration of care across specialized provincial programs will be more effective if we work together to deliver complex care programs that meet patients' complex needs. Specifically, this will have an impact on keeping complex care patients optimally managed in their communities, avoid hospital admissions whenever possible, and contribute to cost avoidance by reducing admissions and lengths of stay.

Key Insight

- Key partners in complex care who have established networks (e.g. stroke, renal, diabetes), can be considered a resource for local networks in place.

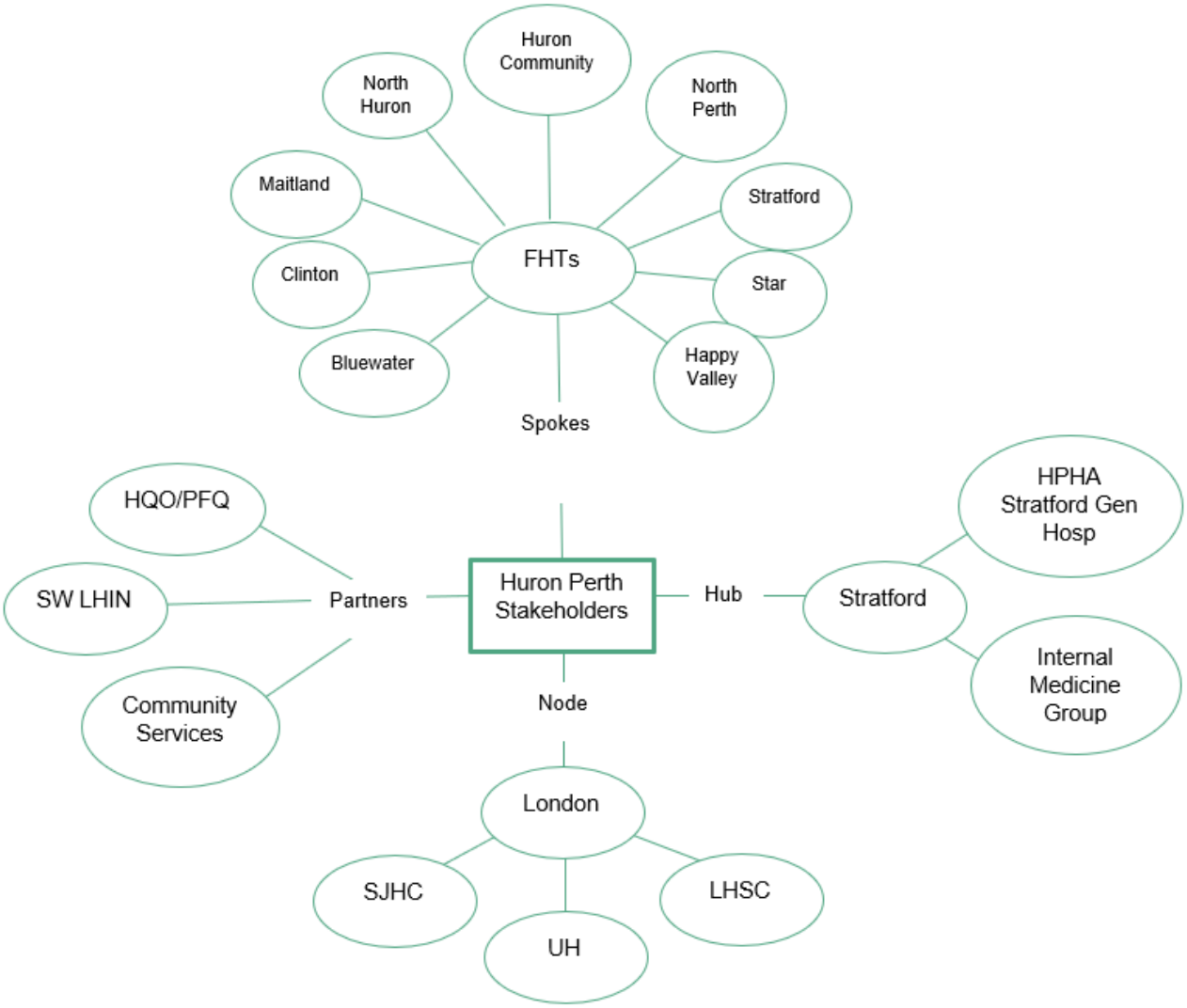
Mapping patient flow

A critical next step in designing for expansion is identifying HF patient populations within Huron Perth, mapping ideal patient flow through the spoke, hub, and node levels of care, and partnering with regional support structures to keep patients optimally managed in their communities. Local system level leadership (i.e. the SW LHIN) is a key stakeholder in this next step. Mapping patient flow and understanding patient care needs in Huron Perth will also help identify resources required to optimally manage patients with HF. This will allow regional clinical and administrative leadership to manage support to programs including optimizing clinician staffing, allied health services support, and administrative resources. Economies of partnering across complex care agencies are likely to provide sufficient support to the spoke, hub, and node model.

Key Insight

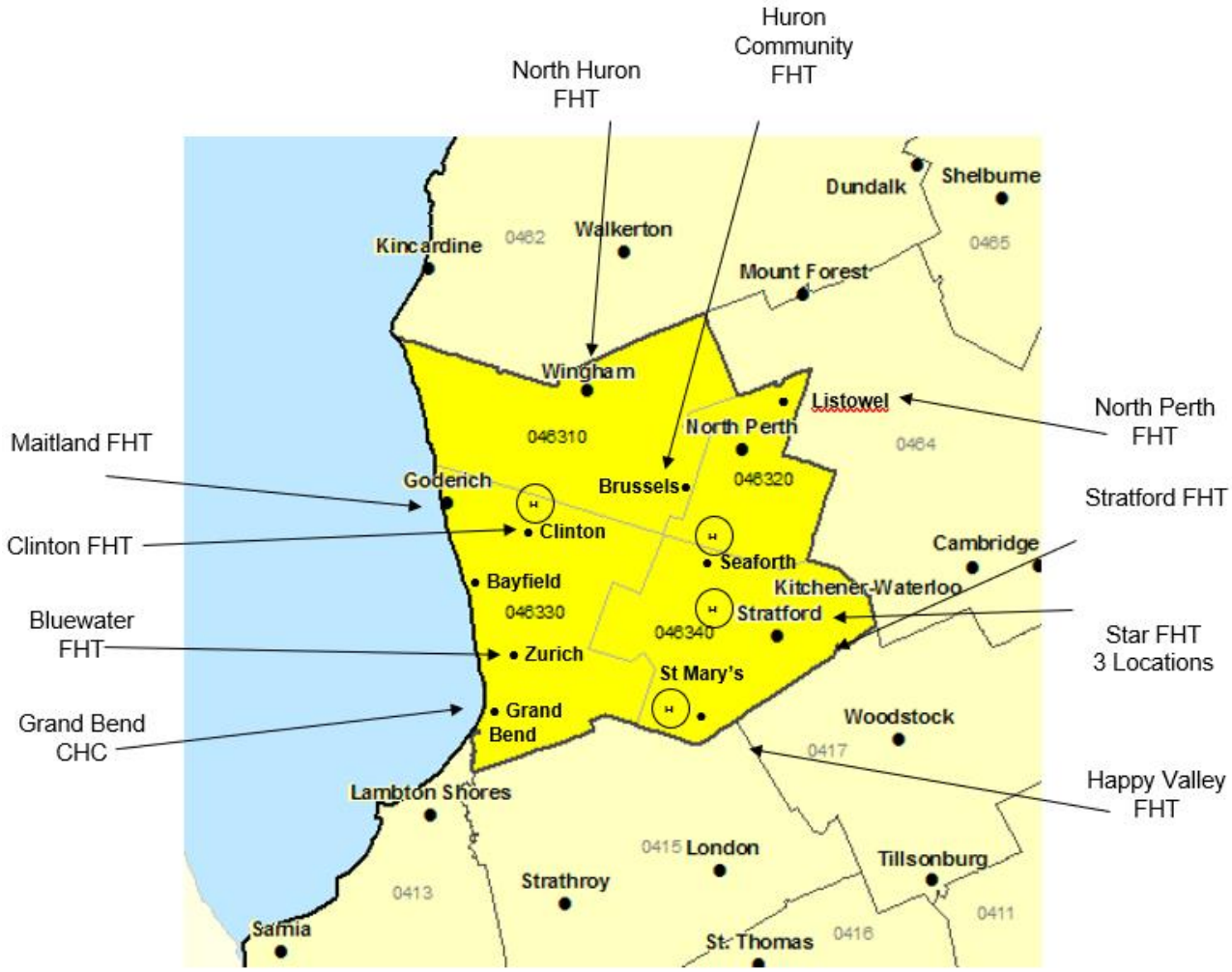
- The leadership team must collaborate with decision support resources at community and tertiary hospitals to map patient and referral processes for each of the spoke, hub, and node.

Appendix A – Stakeholder Map- Initial Version



Legend
FHT- Family Health Team
HPHA-Huron Perth Health Care Alliance
HQO - Health Quality Ontario
LHSC- London Health Sciences Centre
SJHC- St. Joseph's Hospital Centre
UH- University Hospital

Appendix B – Map of Huron Perth



Appendix C – Meeting Minutes from September 2018

Minutes/Summary from Huron Perth Sub-Regional Heart Failure Working Group –

18 September 2018

Situation – The Huron Perth Sub-Regional Heart Failure Working Group occurred on September 18, 2018 (3-6pm) hosted by Stratford General Hospital. Twenty-seven stakeholders from across all levels of care in Huron Perth came together to exchange ideas on the Integrated Heart Failure Care Initiative (IHFCI). Stated goals for the meeting included level-setting understanding of the spoke-hub-node model, conducting a high-level gap analysis, discussing the draft quality standards for heart failure from HQO, and follow-on work priority setting. The discussion was facilitated by an external professional. While teleconferencing was available, it was not conducive to including remote participants in the group work.

Background - The aim of the IHFCI is to initiate the implementation of the spoke-hub-node organization of care. The initiative also includes implementation of the Heart Failure Quality Standard that HQO will release later this year. Lessons learned from this work will inform a provincial road map to support larger scale implementation. During the month of September, the CorHealth team conducted site visits to administer a survey to six of the nine Family Health Teams in the region. The data collected during these visits informed the scope and goals of the working group.

Analysis –

Session	Aim	Discussion	Comments/Key Learning
1	Level-setting overview of the ICHFI initiative and background on the initiative	• CorHealth provided an initiative overview presentation • Participants were then broken into smaller groups and self-selected into two table groups of ~10 people • Each group confirmed their understanding of the spoke-hub-node model • There was some confusion concerning which level of care fit into each category in the model	• Participant were at various stages of knowledge of the model • Deeper engagement may have been achieved with smaller table group numbers • Not yet at a place of “shared care” because of structural barriers/gaps (communications and alignment)

Session	Aim	Discussion	Comments/Key Learning
2	Gap Analysis – Current state	• Process – Communication, consistency across practice, and alignment	• Transparent and efficient communications across the echelons of care within the model • Real time updates • Consistency in EMR and EMR usage, flowsheets, letters • **both groups agreed that a key element of success is alignment of patients to their acuity within the model – identify a "spoke patient" etc.
		• Resources – EMR and access	• Capabilities in EMRs that enable management and sharing of care • Consistency in patterns of practice across providers at all level • Access to treatment and diagnostic tools including BNPs (for example)
		• Knowledge – patient education and engagement, tools that align processes and information flow across the S-H-N continuum, enhancing provider skills and awareness in HF management	• Develop/share common education and engagement tools across all levels of care • Develop tools that would be consistently applied/available across Huron Perth • Clarify definitions of care and manage patient and provider expectations • Specific learning on reading ECHOs
		• Access – specialist and diagnostic resources	• Need to develop a Huron Perth solution for access and availability for ECHOs – both administration and timely reading
3	Quality standards discussion	• Unilateral agreement around the validity of the Quality Statements • Agreement that if all of the Quality Statements were fleshed out, it would constitute a	• Agreement that the S-H-N model would be the best vehicle to operationalize the Quality Statements • The group identified the following Quality Statements as high priority:

Session	Aim	Discussion	Comments/Key Learning
		"heart failure system of care" • Prioritizing the Quality Statements was difficult	1. Empowering and supporting people with self-management skills 2. Physical activity and rehab 3. Triple Therapy for people with HF who have reduced EF 4. Worsening symptoms of HF 5. Transitions from hospital to community • Agreement that these priorities reflected the gaps identified in the previous session – gap analysis

4	Work plan/priority setting	• Tool Inventory
		• Further development of QIDSS tool
		• Referral templates and pathways development
		• Management Template
		• Capacity and champion building
		• Identify patient categories/acuity indicators at each level for S-H-N
			• Develop tools for education, engagement, flow charts, and clinical documentation that would be the standard for all providers across Huron Perth and all levels of the S-H-N.
			• Work from the Node referral templates back though Hub then Node to align documentation and processes that contribute to consistency and repeatability
			• Recognition that a care plan at the Node level will look far different than one at the Spoke level, further work is required on a management template that enables a comprehensive coordinate care plan that fits the S-H-N continuum
			• Answers required to the following questions:
			  • Who is a Spoke patient – describe a typical clinical profile?
			  • Who is a Hub patient – describe a typical clinical profile?
			  • Who is a Node patient – describe a typical clinical profile?

Recommendations – The product developed at the Huron Perth Sub-Regional Heart Failure Working Group represents a solid foundation that will establish a consolidated HF system. Next steps are critical in maintaining the momentum and ensuring wide participation and deep engagement. They include:

- Review of these minutes by CorHealth and Huron Perth/South West LHIN Sub Region Clinical Leads;
- Distribution of the minutes for feedback to working group participants;
- Soliciting/assigning "quarterbacks" to the initiatives in the work plan;
- Publication of minutes to all affected Family Health Team and hospital stakeholders;
- Project Lead meeting with stakeholders and support work plan development, communication, monitoring, feedback, and reporting processes;
- Scheduling next meeting date to report back on progress and map further initiatives; and
- Ongoing effort to describe the ideal state as at March 2019

Appendix D – Huron Perth Heart Failure Clinic Referral Form-Draft

Heart Failure Clinic - Huron Perth
107-444 Douro St. Stratford, ON N5A 0E6
Phone: 519-273-0100 Fax: 519-273-0675

HEART FAILURE CLINIC REFERRAL FORM

Please complete all FOUR sections, ATTACH all related documents, and FAX to the Heart Failure Clinic

1. PATIENT INFORMATION
Name: _____
Date of Birth: _____
Health Card #: _____
Address: _____
Telephone #: _____

2. REFERRING PHYSICIAN
Name: _____
Telephone #: _____
Fax #: _____
Family Physician: _____

3. MANDATORY - PRIMARY REFERRAL CRITERIA -Patients must meet one of the following criteria (Check A, B or C)

☐ **A.** Urgent consult request to be seen in 1 week
- Known heart failure with decompensation

☐ **B.** Consult requested
- Known heart failure
- NYHA class _____

☐ **C.** Consult requested
- Suspected heart failure

Clinical history:
_____
_____

☐ shortness of breath
☐ PND
☐ peripheral edema

4. PATIENT/TREATMENT HISTORY AND INVESTIGATIONS:

Cardiac history & investigations:

Echo ☐Yes ☐No ☐Pending
EF: ☐<20% ☐20-39% ☐40-59% ☐>60%

	NO	YES
Previous CABG	☐	☐
Previous PCI/Stent	☐	☐
Previous Valve Surgery	☐	☐
ICD: CRT present	☐	☐

Comorbidity Assessment:

	NO	YES
CKI (Crt ≥200) or Dialysis	☐	☐
Diabetes. If yes, ☐ Insulin ☐ Oral Agent ☐ Diet		
Smoking History	☐	☐
Hypertension	☐	☐
Previous MI	☐	☐
History of Atrial Fib/Flutter	☐	☐
PVD/Stroke	☐	☐
Severe COPD/Pulmonary Ht	☐	☐
History of Valvular Heart Disease	☐	☐
Permanent Pacemaker (PPM)	☐	☐
Hx of ETOH/Drug Abuse	☐	☐
Social Issues	☐	☐

Supporting Documents:

Send copies of the following:

☐ Consultation note(s)
☐ Discharge notes
☐ Recent laboratory investigations including: CBC, Electrolytes, BUN, Creatinine, AST, ALP, ALT, Total Bilirubin and Albumin, Lipid Profile
☐ 2D echo completed within the past 6 months if available
☐ Chest x-ray report and ECG

Additional Notes:
_____
_____

Date: _____ **Thank you for your referral.**

**We shall prioritize seeing the patient in their home community as capacity allows.

Section 2: Guelph

The Guelph Early Adopter Team IHFCI Experience

Overview

This section is the culmination of several months of collaborative and integrative work to assess and develop a plan to improve care for heart failure patients in the Guelph sub-region of the Waterloo Wellington Local Health Integration Network (WW LHIN). In 2018 CorHealth established two Early Adopter Teams to integrate HF care through evidence informed practice, planning, access, resource allocation and measuring and reporting on patient outcomes. These 2 Early Adopter Teams started their work in the Ottawa and London regions in early 2018. Independently, Guelph had accomplished significant strides in an action plan to improve HF care within their community prior to collaboration with CorHealth. Throughout early 2018, the already established HF working group in Guelph partnered with multiple community agencies and approached St Mary's General Hospital (designated Regional Cardiac Centre for WW LHIN) as their HF care plan began to unfold.

By the fall of 2018, CorHealth identified Guelph as a potential 3rd Early Adopter Team and invited them to join the Integrating Heart Failure Care Initiative (IHFCI). This introduced an opportunity for support of the current work in Guelph. IHFCI nicely aligned with the ongoing work in Guelph and offered an integrated spoke hub and node model along with a recently developed Health Quality Ontario (HQO) Quality Standard for HF care in the community.

In November 2018, the executive leadership supporting the Guelph HF work met with CorHealth and made a commitment to establish an IHFCI Early Adopter Team in Guelph. CorHealth provided a Project Manager and in the pursuit of a Provincial roadmap for HF care they requested that the Guelph committee provide insight into how their work was successfully established and recommendations for other regions that may be interested in improving HF care for their patients.

Background

In early 2018, the Guelph Family Health Team (Guelph FHT) and the Guelph General Hospital (GGH) collaborated to address hospital readmissions of patients with a diagnosis of HF. The Guelph FHT led the development of a diverse group that included representation from the Guelph FHT, GGH, St. Joseph's Care Centre (SJHC), St Mary's General Hospital (SMGH), Home and Community Care, Guelph YMCA, Guelph Community Health Centre (GCHC), Guelph Paramedicine and the WWLHIN. Three meetings were planned with the objective to map out the current client journey and draft a future state. The group came together for 3 half-day meetings resulting in a comprehensive list of challenges, and a glimpse of a fragmented patient experience (Appendix A, page 31). Their work also projected a future look at a model of spoke, hub and node care (Appendix B, page 32). Over the 3 meetings the participants arrived at a priority list for change; 1) Heart function clinic in Guelph, 2) Standardized pathway

for primary care, 3) Lifestyle program with the YMCA, 4) Training and mentoring, and 5) Acute Care improvements and Transitions.

In May 2018, the Guelph Family Health Team and Guelph General Hospital partnered to draft a collaborative Quality Improvement Plan (cQIP) (Appendix C, page 33) and begin to actively address HF in the community of Guelph and Puslinch. The cQIP was signed by the senior leaders of the organization partnering and the journey began. The overarching goal of the cQIP is improving care of patients with HF. The measure would be the 30-day same or related readmission rate for HF (GGH only). The rate in June 2018 was 22.2% with an aim to reduce by 30% over 3 years.

In April 2018, the working group met to further define the HF challenges and invited SMGH to participate in an integrated strategy. The leadership group mapped out a direction and 3 working groups focused on 1) Primary Care Improvements, 2) Training and Mentoring, and 3) Acute Care Improvements and Transitions. In addition, there was significant work with primary care to identify patients with HF and work to provide access to tools for evidence-based team support. The working groups were also interested in the patient experience with a view into living with HF in Guelph.

In a parallel process, CorHealth had been consulting with SMGH throughout the development of the Waterloo Wellington Regional Cardiac Strategic Plan. CorHealth was aware of the work on HF care led by the Guelph FHT and GGH. In September 2018, CorHealth approached SMGH with the opportunity to lead IHFCI in the Waterloo Wellington region. SMGH approached GGH and Guelph FHT with the proposal to begin the work in Guelph, where there was already a substantial collaboration among community and healthcare stakeholders. The Guelph FHT and GGH had made considerable progress to improve HF care in that community. Guelph became the 3rd Early Adopter Team in November 2018. The opportunity would provide Guelph additional administrative support through a Project Manager to build on the work previously accomplished and expand efforts to focus more specifically on the spoke-hub-node system of care in the sub-region.

Project Work

On November 14, 2018, Guelph leadership met with CorHealth and SMGH to establish a commitment to become an Early Adopter Team for the IHFCI (Appendix D/E, pages 34/35). The Guelph leadership represented by the lead physician from the Guelph FHT and the CEO at GGH agreed to pursue IHFCI by building on the work that had already been accomplished and relationships that had already been built. CorHealth's mandate with the 3 Early Adopter Teams was to provide recommendations within a roadmap for any community or region in Ontario wanting to implement the integrated model of HF care.

Following this meeting, the project leads came together to discuss the IHFCI committee and identify a governance structure. The group landed on a single *leadership structure* that included 2 executive leads from the Guelph FHT, the CEO at GGH, and the SMGH Cardiac Program Director with all parties being regularly apprised of the ongoing work by their respective project leads. The *implementation group structure* was an amalgamation of the working groups (cQIP, Heart Failure, Cardiac Rehab in Guelph) along with clinical and

administrative representation from the SMGH Cardiac Program. CorHealth was represented by a Project Manager and leads. The project leads emerged as the Quality Improvement and Evaluation Manager from the Guelph FHT, the Medicine Manager from GGH and a Program Manager of Cardiac Strategy and Innovation from SMGH.

Over the next 4 months, the Project team worked collaboratively to develop an IHFCI plan using the extensive work already completed in Guelph. The goal was to achieve understanding of the Spoke-Hub-Node model and initiate a gap analysis of current care against the best practice standard being developed by HQO. With the governance structure in place, a meeting to bring the working/implementation group together was the next step. The timeline for the project only extended to the end of March 2019, and 2 meetings were planned to establish the CorHealth initiative.

A planning meeting on December 5, 2018 (Appendix F, page 36) began with a discussion around the meaning of the Spoke-Hub-Node model. How would the model impact and fit with the work that was already well underway. Representation of the Spoke, Hub and Node in Waterloo Wellington was discussed. How would the HQO quality standards impact the goals and objectives of the current working groups? Could the current committee structure be integrated into a governance model that would provide oversight as well and an implementation team? There was significant discussion on what the governance model might look like and an executive oversight encompassing senior leadership at GFHT, GGH and SMGH, was created. The working group and implementation committee would address the status of the work accomplished in Guelph against the components of the IHFCI. A schematic diagram (Appendix H, page 40) described the project direction.

The first meeting was scheduled for January 8th at SJHC from 1:30 to 4:30pm. The Guelph working group had several meetings penciled in over December and January and for ease of planning the project decided to utilize these dates. A planning meeting was held on December 13 at the Guelph FHT office with the project leads from GGH, Guelph FHT, SMGH and Guelph Cardiovascular Rehab Steering Committee identified areas of focus for the meeting and potential agenda items. The purpose of the meeting would be to introduce and arrive at a shared understanding of IHFCI, the purpose for collaborating with CorHealth and review the progress to date of the work in Guelph. Several phone discussions occurred as the agenda came to life. There was a strong sense of respect for the work accomplished in Guelph as well as for the staff who had been committed over the past year to attended meetings meet action plans. It was important to establish a feeling of moving forward on the action items that were prioritized before IHFCI.

Patient participation became a key discussion point and the project team agreed to pursue appropriate representation. Two patients agreed to join the committee to share their stories at the January 8th meeting and continue as ongoing partners in the work. Prior to the meeting, the Guelph FHT lead provided an orientation to both patient participants (Appendix G/H, pages 37/40), providing them the opportunity to understand the work ahead, ask questions and meet some of the committee members as they arrived for the meeting.

Meeting #1 Description (January 8, 2019 – St. Joseph's Health Centre – Guelph Auditorium)

The Guelph FHT lead provided a welcome and introduction of all participants in the room and on the teleconference line. She outlined the purpose for the meeting and the goals for the afternoon. Participants had free parking and light refreshments available. The meeting was well attended with 24 in person participants and several on the teleconference line.

Patient representative #1 shared her journey, as a patient with HF, with the working group, and provided a vibrant voice around standards of care by asking the group "how will I know I got good care?" This led to the discussion of patient and community awareness of HF care. The second patient was representing both a patient and care provider voice. She had previous patient advocacy roles and shared the difficulties in being diagnosed in a timely manner. Her perspective lead to a discussion around access to necessary lab/diagnostic tests and patient transitions to higher levels of care when required. Her care provider background also sparked discussion on the Long Term Care sector and their needs in caring for patients with HF. It was clear that the patient voice is a necessary part of a HF committee/project.

The SMGH lead provided an overview of the Regional Cardiac Program at SMGH and how their role in a regional model fit into the IHFCI. The Guelph FHT lead provided a review of the work that was started in Guelph in early 2018 and how this work is the foundation for next steps in collaboration with CorHealth. CorHealth staff in attendance outlined the origins of IHFCI as a provincial vision for HF care in Ontario, defining the core concepts and the framework for the model of spoke, hub and node. A Geriatrician in attendance provided background to his current research on heart failure, and the prevalence of HF in Long Term Care facilities.

The meeting concluded with discussion around the need to move ahead with Guelph's current work and action plan. The work over the next few weeks was discussed - working groups would continue to lead action plans on clinician education (assessment skills and patient transitions).

The Guelph FHT lead shared the key data points that were being tracked in a test group of physicians working on heart failure - number of patients diagnosed with HF and number who were overdue for physician follow-up.

Description of Planning for Meeting #2

The project team debriefed and identified that meeting #2 would build on the outcomes of meeting #1. The purpose of the meeting was to better understand the Spoke-Hub-Node model and identify how it could work in Guelph. A planning meeting was scheduled for February 7th with a facilitator from CorHealth to facilitate the discussion planned for the next meeting. With approximately 20 participants expected, the format for facilitation included round tables for working group participation along with enough flip charts to document discussions and key points. The group expressed a desire to ensure Guelph cardiologists had an opportunity to participate in this process. The SMGH lead would connect with them prior to the meeting, ensuring they were aware of the IHFCI.

The plan for the facilitated discussion included reviewing the Spoke-Hub-Node model definitions and characteristics of each, and a detailed review of the HQO Heart Failure Quality Standard, and having the group identify the gaps in current care in Guelph. This would be accomplished in break out groups of 6 to 8 individuals per table. The project team drafted the agenda and circulated the slide deck. The meeting package would include the CorHealth document; *Minimal requirements and key clinical services for heart failure programs within the spoke hub and node model of care* and the Health Quality Ontario *Quality Standard.*

Meeting #2 Description (February 19, 2019 – Guelph General Hospital Auditorium)

The meeting was held at GGH which allowed for additional frontline staff who were working that day to attend. Participants were provided with a short review of meeting #1 and the purpose of the work for the day. Participants expressed their views about current HF care, specifically what is and is not working well. The outcomes for this meeting were based on the following questions:

1) What does Guelph have that resembles a Spoke-Hub-Node model?
2) What is working well in relation to the quality standard outline by HQO?
3) Where are the gaps in care?
4) How should we prioritize our work?

Key points from the break-out groups:

1. What do we have in place that resembles a Spoke-Hub-Node model?
   - Primary care in Guelph – FHT is the spoke
   - Direct referrals from GGH to Node – managing HF care under hospitalists
   - SMGH identified as node
   - Identified that the Hub is not visible (yet) in the patient pathway
2. What is working well in Guelph?
   - Remote patient monitoring
   - Primary care nursing
   - Tertiary care at SMGH
   - Renal care is set up as hub and spoke with Nurse Practitioner resource
3. What are the gaps in our current model of care?
   - Spoke – diagnosis – complex
   - Hub – communication of health information (especially at transitions)
   - Node – distance / access
   - A Hub in Guelph that is close to patients' family physicians.
   - Access to local cardiologists
   - Inpatient cardiology consults
   - Rehab close to home – patients do not want to travel far
   - Specialist in a clinic to guide care
   - Access to a Nurse Practitioner as a resource, support or navigator

- Little risk stratification – how is complexity defined? Timely access to diagnostic testing
    - Brain Natriuretic Peptide diagnostic testing is not available in hospital
    - Access to imaging
    - Same day outpatient lab results (without going to Emergency Department)

4. Possible Priorities
    - Definition of needs for HF hub and explore possibilities for options to implement (i.e. with Cardiac Rehab)
    - Improve Discharge planning by opening up back line communication for hospital to FHT
    - Community awareness – utilize Guelph FHT newsletter for regular updates
    - Continue to build up use of Quality Based Improvements in Care (QBIC) form to support diagnosis
    - Comprehensive care plan - patients get same message regarding medications and self-management (Red/Yellow/Green Zone handout)
    - More education – basic and advanced, or on specific topics
        - Dry weight / volume assessment
    - Traveling clinic – specialists come in for clinic at specific intervals
    - Communications – hospital to FHT at transitions
    - Self-management – the YMCA and FHT collaborating on exercise and nutrition resources
    - Consider supports for HF at YMCA (physician, dietitian, exam table)

The working group was also asked to consider how they would advise another community or region embarking on integrating HF care. Are there lessons learned and recommendations from the work they started last year that would assist another region in the early implementation phase of a HF improvement initiative? The group quickly arrived at the following:

- Ensure the right people are at the table
- Identify current champions in support of IHFCI
- Book meetings with respect to staff time and availability
- Do not reinvent the wheel; conduct a thorough environmental scan
- Broad communication - Utilize physician newsletters for project updates

Post Meeting Debrief

The project leads met by teleconference to debrief on Wednesday February 27th and to plan for the next meeting in March. Six key areas of focus for were identified:

1. Develop Primary Care Provider skills to assess and diagnose HF
2. Transition planning – collaborative and integrated planning for patients moving through the spokes, hub and node levels of care, and discharge planning
3. Pursuing a cardiac rehab program in Guelph

4. Define the "hub", as this was unclear
5. Develop a primary care pathway, to implement within an Electronic Medical Record
6. Strengthen community awareness for heart failure and the HQO Quality Standard

The meeting generated similar discussion regarding gaps as in the previous current state assessment, however, there was strong consensus on the lack of a HF hub in Guelph. The project leads determined that the subsequent meeting would need to support a more targeted discussion of the Spoke-Hub-Node model, to help determine what a hub in Guelph looks like. The focus of the next meeting would be on defining and envisioning a "hub" for HF care in Guelph.

Critical Success Factors

1. The key success in introducing IHFCI in Guelph was the existing commitment to improving heart failure care as demonstrated by the community's collaboration on the cQIP and willingness to partner more closely with SMGH and CorHealth to expand upon their heart failure improvement efforts.
2. The governance/leadership structure was in place and simply needed to be refined.
3. The concepts associated with Spoke-Hub-Node and the HQO Quality Standard provided additional context and structure to the Guelph work that had not been formally addressed.
4. The introduction of IHFCI presented SMGH with an opportunity to take on a more active role in guiding heart failure care delivery in the Waterloo-Wellington region, beginning with Guelph.

Challenges and Barriers

Amalgamating 4 working groups and a leadership group into a single committee was a challenge. While the idea of a governance structure was important, the work in Guelph was so well-established, with a strong implementation framework that changing the structures came with some feelings of uncertainty. The leadership/executive sponsorship was identified first, then working group members from all the groups were invited to join a single working group, blending all their work into the IHFCI. The group felt it was important to highlight the progress and initiatives already underway in Guelph and emphasize that the purpose of IHFCI was to build on this work and expand to a system focus rather than to divert from previously established goals. Nevertheless, some duplication of discussion occurred as it was difficult to pursue a gap analysis relative to IHFCI without addressing previously identified gaps.

Meeting Milestones

The critical milestones of the project were met through the continued work of the project leads and the participation of the working/implementation group. The executive oversight at Guelph FHT, GGH, and SMGH were continually apprised of project work and direction which may be helpful to support the future planning of the project. The critical outcome of accomplishing a gap analysis provided the next step in Guelph's own cQIP work and the community collaborative work around a HF clinic and a local cardiac rehab program. Perhaps if the project had had a few more months there may have been less pressure to complete the critical meetings.

Reflections from the Project Manager on the PM Role

"As a Project Manager (PM) my role was primarily supportive. Initially I reviewed the CorHealth material supporting the development of an IHFCI and current health system benefits of a HF program. The system requirements and the model were a tall order for any region to grasp and implement. I met with SMGH leadership prior to being introduced to the Guelph committee and I stressed the need for node (SMGH) leadership in implementing and spreading the initiative not only in Guelph but eventually through the WWLHIN."

"My role included establishing lines of communication and providing support and guidance to the project work. The Guelph project team were the leaders of the collaborative initiative which was now joining into the IHFCI. The CorHealth goals for the project were to support the current work and provide a window into the how it came about, the lessons learned along the way and to provide recommendations to another health care community interested in embarking on improving heart failure care. It was difficult to arrive at recommendations because the project working group had not had an opportunity to reflect on their project path. After the second meeting there was a clearer view of what they might share with another HF project team starting out. Another PM function was to ensure that the quality of the program work supported the principals and values of CorHealth and the subsequent requirements of the IHFCI work through assisting with planning and development of meetings and agendas."

"The Guelph project team had their project well under control when CorHealth invited them to be an Early Adopter Team. As a PM, I was able to support the integration of SMGH into the current work in Guelph and provide context to the Spoke-Hub-Node model. Our meetings focused on what the core group direction could be now that they were an Early Adopter Team and where it could be in the future. With the CorHealth goal for the end of the fiscal year simply being lessons learned and recommendations for others interested in IHFCI I realized that the work in Guelph was not a start-up project but rather a transitional project with a working group embarking on implementation. This should provide an opportunity to reflect on the reasons they had been able to achieve such success in less than a year. It was interesting that when asked, they really had not stopped to look at their successes or why they were successful because they were on the journey and not ready yet to look back. They did identify several important points at the end of the second meeting."

Sustaining the momentum for IHFC beyond March 31, 2019

The team in Guelph will to continue to meet and move forward on their cQIP as well as the other foci related to improving heart failure care in their community. They are committed to working alongside SMGH and developing the Spoke-Hub-Node model as well as assessing their current clinical practices against the HQO Heart Failure Quality Standard. They will continue to look for ways to meet the needs of primary care providers around HF education and training (i.e. identification, management, assessments).

Key Insights

- Ensure that you have clinical and administrative representation from spoke, hub, and node (or from the different levels of care if the community does not have a clear spoke-hub-node model) as you bring the community to the table. Within the Guelph Early Adopter Team, IHFCI involved the SMGH (node) administration closely in the work, which will help move the work forward from a systems perspective.
- Ensure that clinicians and administrators have current HF data for their community, region and facilities, to provide clarity around the current state.
- Understand the indicators for quality patient care/outcomes and the fiscal efficiencies gained with an IHFCI.
- Engage change agents to support and guide your journey to improve HF care in your community.
- Provide educational opportunities to learn about the complexities and clinical management of HF, connecting the frontline clinicians with the tertiary care cardiologists and integrating the patient pathway from start to finish.
- Establishing an EMR and documentation process that allows for cues in the clinical assessment prompting the ordering of appropriate laboratory/diagnostic tests enabling early. accurate diagnosis of HF

Key messages for:

Spokes:

- Identify a lead to provide the background information and data to support assembling a lead committee to connect with a hub and node to work together to establish a working committee
- Link with other spokes who have done similar work, for support and tips
- Support/adopt processes that can spread the critical components of care, without necessarily needing to be identical processes to capture the variability in clinic operations.
- Define the role of other community providers (paramedics, LTC etc.)

Hubs

- Identify a lead to bring interested clinicians and administration together to understand the Spoke-Hub-Node model and heart failure Quality Standard.
- Link with the node and explore the current care in your region identifying gaps in the patient pathway

- Establish a working group to review current data and patient experience
- Review the HQO Quality Standard for Heart Failure
- Explore the options for hub-level care provision (i.e. a virtual Hub vs a 'bricks and mortar' hub)

Nodes

- Identify a lead to bring clinicians and administration together to review the Spoke-Hub-Node model and ensure the organization's leaders understand the accountabilities for a node designation
- Identify the gaps in your organization and link with the spokes and hub(s) in your region and understand the current patient pathway.

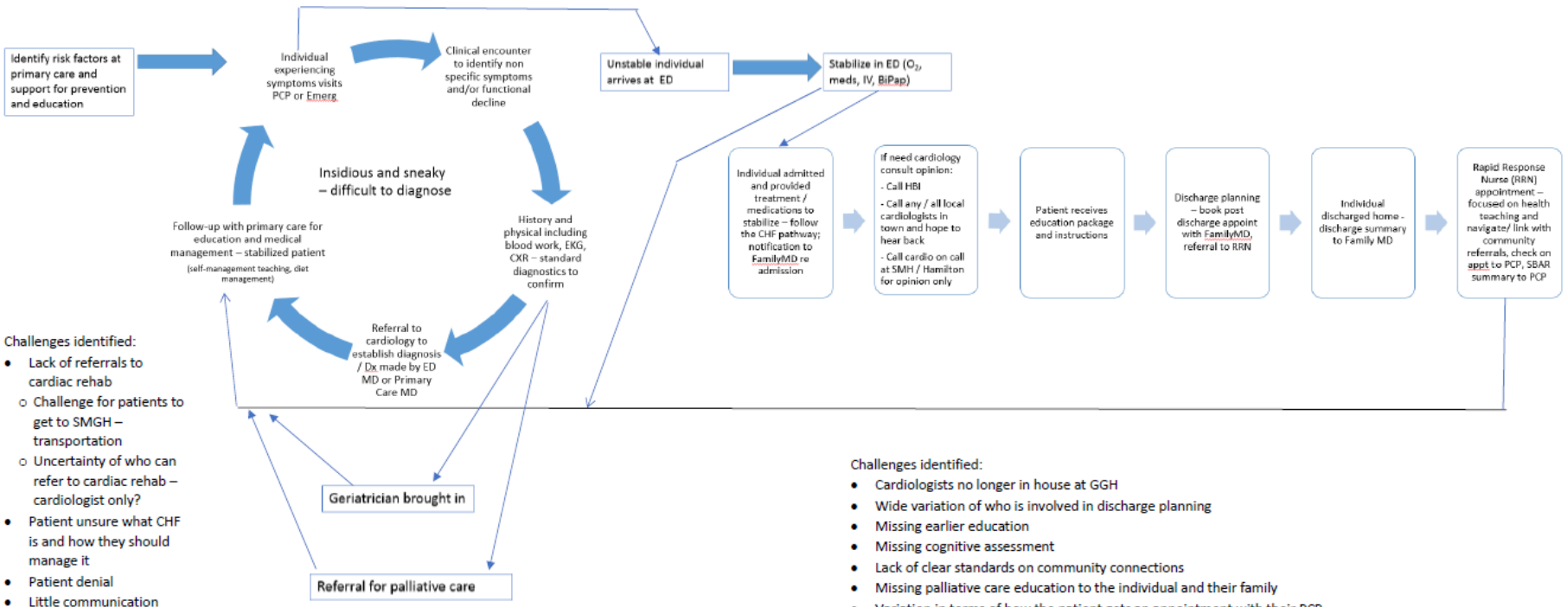
For the full table of recommendations from the Guelph Early Adopter Team, see Appendix I, page 41.

Conclusion

The Premier's Council released their interim report on *Improving Healthcare and Ending Hallway Medicine* in early 2019, providing an overview of the key challenges facing the Ontario health care system and setting the stage for recommendations to follow. Integrating heart failure care aligns with the council's direction of integrating care around the patient and across providers; greater efficiency in the system, including streamlining and aligning system goals to support high quality care (Spoke-Hub-Node); and the long-term plan to ensure that healthcare professionals, services, and facilities are able to meet Ontario's changing needs (Early Adopter Teams as demonstration projects).

The framework built into the IHFCI is solid. It is transferrable to any community and perhaps any clinical service, and it is measurable; meeting the essential elements necessary for success. The IHFCI project in Guelph will lead the way for the rest of Waterloo Wellington to adopt the Spoke-Hub-Node model and associated quality care. Though the short-term objective was to provide lessons learned and recommendations to CorHealth Ontario to support a Provincial implementation of integrated HF care, so much more was learned in a few short months. The work within Guelph is a clear example of the positive change that can come from committed champions, and their experiences offer a wealth of insight to other interested teams.

Appendix A - Day 1



Challenges identified:

- Lack of referrals to cardiac rehab
  - Challenge for patients to get to SMGH – transportation
  - Uncertainty of who can refer to cardiac rehab – cardiologist only?
- Patient unsure what CHF is and how they should manage it
- Patient denial
- Little communication between pieces in the system
- Missing access to information from cardiology
- Patient unsure who to contact with symptoms of exacerbation

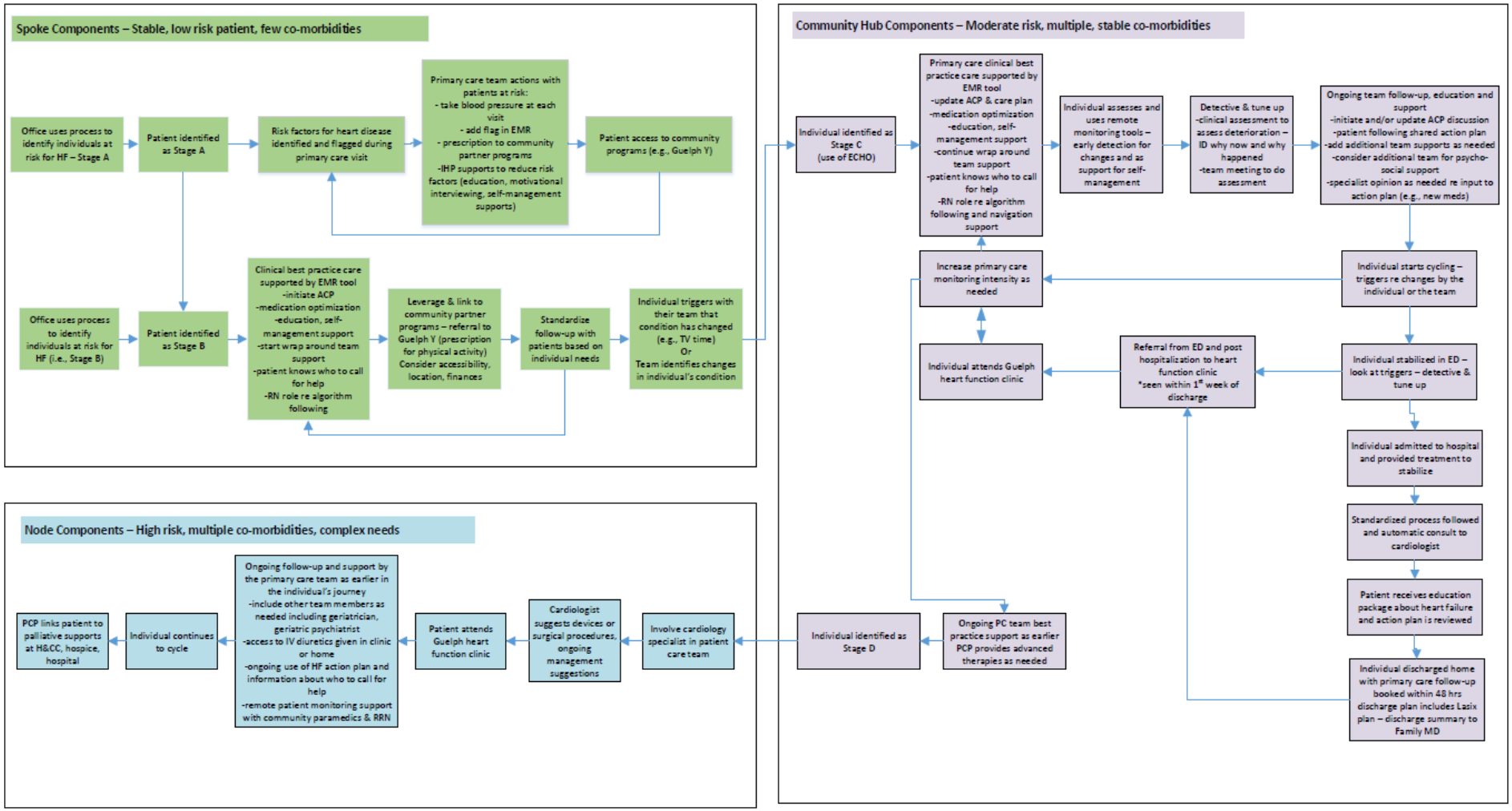
Guelph Current State Journey for an Individual with Heart Failure – January 2018

Challenges identified:

- Cardiologists no longer in house at GGH
- Wide variation of who is involved in discharge planning
- Missing earlier education
- Missing cognitive assessment
- Lack of clear standards on community connections
- Missing palliative care education to the individual and their family
- Variation in terms of how the patient gets an appointment with their PCP
- Not always able to get a PCP appointment
- Patient not always coming home with health teaching package
- Patient unsure of what PCP knows about their hospital visit
- Not getting all information about the patient treatment plan
- IHP staff get caught in conversation re giving diagnosis
- Competition between chronic diseases – pt well informed re DM but not re CHF
- Education provided in an unrelated visit (e.g., DM)
- Lack of places to refer patients to (e.g., cardiac rehab)
- Patient is expected to navigate the system, have good health literacy and self-management skills
- Geriatrician sometimes brought in for assessment but not always
- All providers need to talk more – within organizations communication is good but opportunities to improve between organizations
- Lack of early approach to palliative care and historically difficult to access for individuals with CHF
- What happens with devices during end of life?

Appendix B – Day 2

Guelph Heart Failure Future State – Feb 21, 2018



Appendix C - Update to Guelph Working Group – CQIP (Spring 2018)

Hello to all,

Thank you for your patience in awaiting the next steps on our community Heart Failure improvement work.

We were temporarily slowed down in part due to several transitions in participants from our agencies and are excited to announce that we have an identified co-lead for the work. I am excited to have [redacted] from Guelph General Hospital agree to take this on with me from the Guelph FHT.

Thank you to all who participated in the voting on our change ides! The top 4 responses as priority change areas are:

1. Heart Function Clinic in Guelph
2. Standardized Pathway for Primary Care
3. Lifestyle Program with the YMCA
4. Training and Mentoring

We have drafted a cQIP for this work reflecting change ideas for all 4 of these ideas above and are looking to also incorporate an additional one reflecting connection to services from acute care (Rapid Response nursing/ remote patient monitoring).

Next steps:

1. To have a meeting with senior leaders from our participating organizations to share the work that was done at the three sessions and endorse and support the work and the direction of the cQIP
2. To share the cQIP with all involved and to submit to HQO (hopefully by July 1st).
3. To pull together a steering committee and start meeting monthly to get the work going. If anyone is interested in participating in the steering committee, we would love to hear from you.

Looking forward to working with many of you on this work,

Guelph FHT & GGH Project Leads

Appendix D - Initial Meeting to discuss collaboration with IHFCI

Tuesday, November 13, 2018

Meeting Agenda

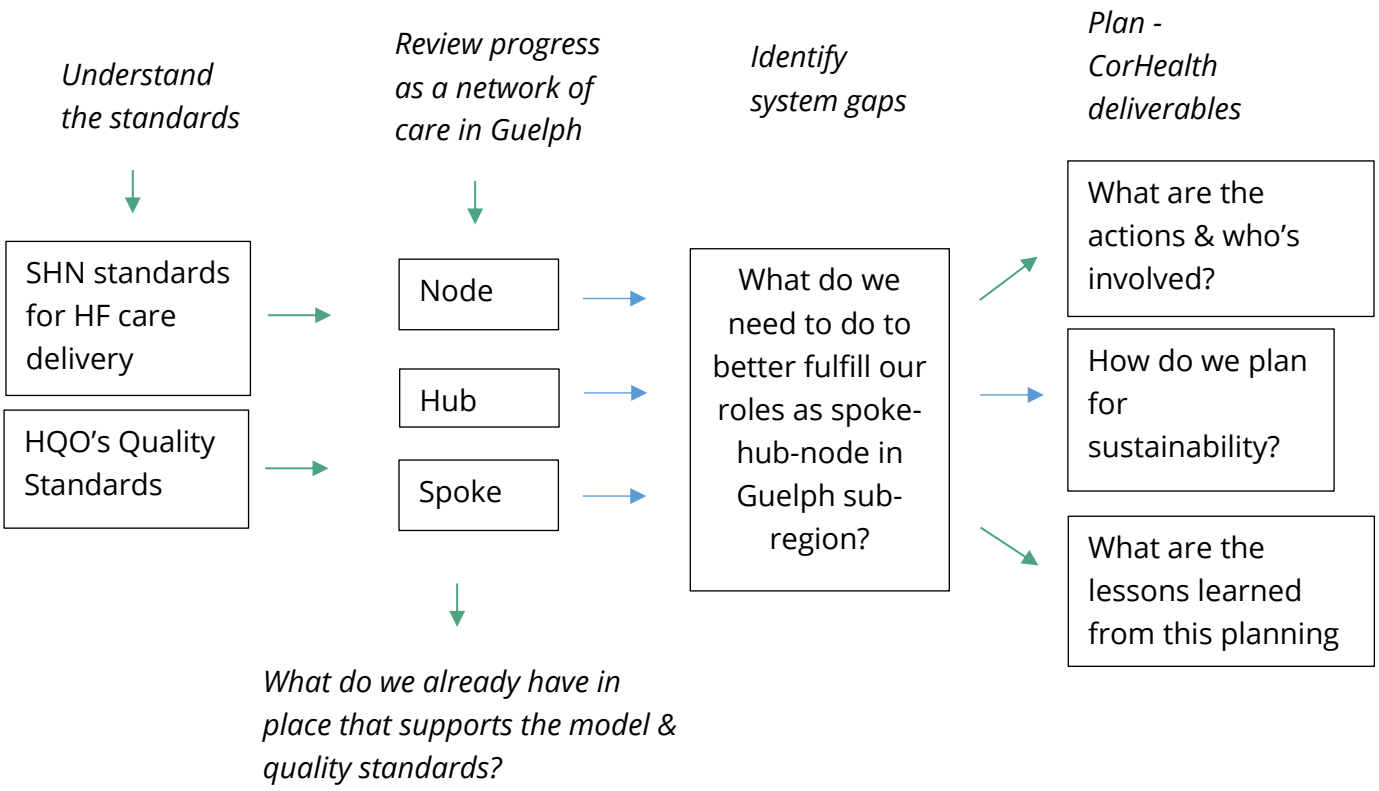
In-person: Guelph General Hospital –Boardroom, 2nd Floor, Admin
Teleconference: 1-866-862-7608 / ID 4049004

Moderator: SMGH Manager Cardiac Program

Purpose: Leadership understands project and agrees to collaborate as the executive sponsor for the Integrating HF Care Initiative in Guelph sub region

1. Welcome and Introductions
2. Ensure understanding of the Integrating Heart Failure Initiative goals and objectives
    a. Implementing CorHealth's spoke-hub-node model
    b. Implementing HQO's Heart Failure Care in the Community Quality Standards
3. Agree on project goals
    a. Short-term until March 31, 2019
    b. Long-term to implement and sustain SHN model
4. Obtain commitment to collaborate as spoke, hub and node to achieve project goals
    a. Do we have the right representation at this table?
    b. Do we agree to meet at an appropriate frequency to direct the project, address barriers & ensure resources?
5. Next steps

Appendix E – Project Schematic



<u>Vision for the Integrating HF initiative</u>

1. SHN model helps drive evidence-informed practice on how HF should be organized. **Goal** is to ensure heart failure patients receive the right care at the right place and time, by the right provider
2. Quality standards drive evidence-informed practice on what quality HF care should look like.
   Goal is to help people and their families know what to ask for in their HF care; providers to know what they should be offering; and organizations to measure, assess and improve their performance in caring for people with HF

Appendix F - Dec. 5th Project Planning Meeting

Guelph IHFCI – Stakeholder Engagement Plan

December 5th Planning meeting

Meeting 1 – January 8, 2019
Time: 1:30-3:30PM
Location: St. Joe's, Guelph

Objective: Continue progress towards HF improvement work in Guelph & introduce IHFCI initiative

Facilitators Guelph FHT, SMGH, GGH and CorHealth

1. Welcome, Introductions, Objectives
    - Setting the stage - expansion of cQIP agenda & the opportunity for Guelph sub region
    - IHFCI –objectives & plan for engagement
2. Patient Story – HF
3. Update from St. Mary's General Hospital
    - Waterloo Wellington Regional Cardiac Program Strategic Plan
    - Regional HF Working Group
4. Overview of IHFCI – Presentation by CorHealth
5. Review progress to date
    - Guelph cQIP initiatives and progress to date
        - Review metrics
        - Education update – review of HF education session
        - Primary care improvements – testing forms/identifying patients
        - Transitions after HF related admissions – review test of daily weight forms, review test of RRN to PCNC process, on-going discussions about transition tools
        - Patient involvement
6. Next steps
    - Meeting 2 – Tuesday, February 19th 2:00-5:00PM
        - Update on progress of local improvements and change ideas
        - Facilitated group discussion: Gap analysis on spoke, hub and node
        - Facilitated group discussion: Identifying top priority quality standards
    - Meeting 3 Friday, March 8th 2:00-5:00PM
        - Update on progress of local improvements and change ideas
        - Group discussion: Action plan to implement spoke, hub, node & quality standards
        - Structure/membership for ongoing meetings

Meeting 2 – February 19, 2019
Time: 2:00-5:00PM
Location: St. Joe's Guelph

Objective: Data review, Gap analysis & Action planning

1. Welcome, Introductions, Objectives
2. Check-in on c-QIP work (1hr)
3. Recap of IHFI & Burden of HF in Guelph sub region (data – TBD) (15 min?)
4. Facilitated Session: Spoke-Hub-Node Model – Group Discussion (1hr)
    a. What do we already have in place to support this model? What's missing?
    b. Identify top 3 priorities for action and why – what's needed to action these priorities?
    c. Identify top 3 gaps and possible mitigation
5. Facilitated Session: HQO HF Quality Standards – Group Discussion (1hr)
    a. What are the top 3 priority community quality standards for focus and action in Guelph and why?
    b. Prioritize the list of 10 quality standards

Meeting 3 – March 8, 2019
Time: 2:00-5:00PM
Location: St. Joe's, Guelph

Objective: Develop a shared work plan that works toward local adoption of integrated, best-practice HF care that aligns with both the SHN model and quality standards

1. Welcome, Introductions, Objectives
2. Review of Meeting 2 outcomes
3. Check-in on c-QIP work
4. Group Discussion
    a. Priorities
    b. Barriers to be addressed
    c. Roles and accountabilities
    d. Sequencing
5. Structure/membership for ongoing meetings (TBD)
6. Next steps

Appendix G - Patient Advisor Position Description

POSITION: Patient Advisor on Guelph Heart Failure Working Group – Volunteer position
CONTACT PERSON: Guelph Family Health Team - Quality Improvement Manager
LAST UPDATED: January 2019
VISION STATEMENT
The Guelph Health Care community is committed to improving the care for people living with Heart Failure. We have been engaged in this work since January of 2018 when a group of health care professionals met to identify where we thought the gaps in care for heart failure were in our local system. As of November of 2018, we are partnering with St. Mary's Hospital and CorHealth to help push this work up to the next level to help the Heart Failure Care that people in Guelph receive, meet the standards identified by provincial groups (CorHealth and Health Quality Ontario) through the Integrated Heart Failure Initiative Project.
MAIN ACTIVITIES: - Identifying gaps in Heart Failure Care for Residents of Guelph - Identify and evaluate improvements to making the care better - Help to inform the work of identifying gaps in care and process compared to provincial guidelines

Role of the Patient Advisor
• **Share their personal experience from a patient and family's perspective within the healthcare system**
• **Provide input that will help create, implement, and evaluate policies, programs and services**
• **Assist as available for meetings, presentations, review of patient materials and policies.**
• **Respect and protect confidentiality of patients, family members and employees at all times and in all circumstances**
• **Uphold the working groups values**
• **Participate in leadership training, coaching and mentoring as needed**
• **To recommend potential Patient Advisors who represent the diversity of our communities**
Expectations
• **Patient Advisors can expect to have processes/terminology explained as needed, and de-briefing after each meeting if requested**
• **To be given the name and contact information for the organizational contact**
• **To be respected for their insight and suggestions in a safe environment where concerns can be discussed**
• **Participation is voluntary and may be withdrawn at any time with notice.**

Criteria
• To maintain confidentiality of patient and organizationally sensitive information
• To sign a confidentiality form
• Ability to share insights and information about their experience in ways that others can learn from them
• Possess good communication skills and ability to interact with a diverse group of individuals

Appendix H - Patient Advisor Orientation see attachment

How did we start working on Heart Failure in Guelph?

We started with Data.

We knew that Guelph General Hospital had a higher rate of readmissions to hospital for patients with Heart Failure.

In January of 2018, we had meetings with Guelph Care providers to talk about how we provide care for Heart Failure in Guelph

From these meetings we identified priorities for changes:

- Heart Function Clinic In Guelph
- Standardized Pathway for Primary Care
- Lifestyle Program with the YMCA
- Training and Mentoring
- Working closer with Cardiologists

We got the support of the senior leaders in Guelph to go forward and start working on the changes

- Guelph General Hospital
- Guelph Family Health Team
- St. Joseph's Health Center Guelph
- Guelph YMCA
- Guelph Community Health Center
- Waterloo Wellington LHIN
- Guelph Paramedic Service

So we started working with 3 working groups:

- Primary Care Improvements
- Improvements in Acute Care and Transitions
- Training and Mentoring

We have started work on the following things:

- Improving how family doctors document care for Heart Failure
- Improving how family doctors identify Heart Failure in charts
- Improving how family medicine teams share Heart Failure Care with Nurses and Nurse Practitioners
- Increasing our knowledge of Heart Failure by running an education event
- Testing teaching patients while in the hospital to start taking daily weights
- Testing having home visiting nurses, calling to book an appointment with RNs in family doctor office, not just the doctors

We have new partners in CorHealth and St. Mary's General Hospital. Our plan is to work together to make sure Heart Failure Care is the best it can be in Guelph through the use and implementation of Guidelines.

What's Next?

- We are adding patients to our conversations (Thank you!)
- We are continuing to take steps to make Heart Failure Care the best it can be in Guelph

Appendix I - Recommendations

Heart Failure Roadmap Task Group - Informing the Recommendations

We would like to provide you with an opportunity to share some of your thoughts and ideas around the recommendations that we, as a group, will be making to the Ministry of Health and Long-Term Care around heart failure care, and integrating heart failure care. The themes listed in the table were taken from the slides from our last meeting, with the addition of 'Education' which came up in our discussion. As you think about each of the emerging themes, you can ask yourself:

- Within this theme, what is the recommendation?
- What specifically needs improvement?
- What needs to happen to make improvements? Who needs to do what?
-

Enter your comments under the "Recommendations" column. If you are aware of any literature/evidence to support your ideas, include this under the column "Supporting Evidence". If there are additional themes not captured here, that have emerged from the work in the Early Adopter Teams, or from your own experience, please add them under the column "Emerging Themes".

Emerging Themes	Recommendations	Supporting Evidence
Integrated Leadership and Governance	Establishing a unified oversight team to guide the project is a key component to ensuring the project will have support and commitment from the participating organizations. Identifying the key leaders who will have the ability to make decisions and provide support for the project outcomes is imperative for success of any project. IHFCI is a commitment to the patient and the community that SHN model will meet their individual needs. SHN requires that 3 different levels of care will work in concert with each other and this requires representation from all 3 levels. Implementing this recommendation will require fostering a critical mass of engaged leaders equipped with the core project knowledge to enable the leadership tables to make informed decisions as the project unfolds. The integrated leadership not only makes key decisions but also serves as advisor to the project. Each level (SHN) representation requires commitment to implement the core concepts in their own organization(s). Each act as an executive sponsor responsible for communication, coaching and conflict resolution. The representative ensures that their organization has accountability for their processes, allows for the time to participate, ensures project alignment (SHN), removes any barriers to success and communicates both internally and externally as necessary.	The "right people on the bus" (Collins, J., 2001, Good to Great). IDEAS Ontario 2015
Sustainability and Scalability	Recognizing the project components requires rooting to grow. Breaking the components into pieces and phasing in implementation grounding the requirements into everyday practice in all areas (spoke hub and node) may contribute to sustainability. Shared project vision for all team members including	

	the project leadership is important in staying and supporting the course of the project. Early identification of challenges and barriers will allow the leadership to employ adaptive strategies to maintain the project integrity.	
Care Integration and Patient Transitions	This recommendation hinges on the participants understanding the project model –SHN and the accompanying accountabilities. Patient outcome lies within the success of a seamless pathway which is only supported by the SHN working together at all points of the patient journey. Demonstrated commitment from SHN leadership is necessary to ensure that the components of an integrated pathway are accessible for patients. The project education sessions should support the SHN participants acquiring the tools necessary to manage patient clinical needs and allow the patient to move seamlessly through the care continuum. Frequent patient care reviews will provide insight into the model effectiveness within each sub region.	
Patient and Caregiver Experience	This is an important component to the success of the model. Acknowledging the patient understands their care and providing time for them to voice their concerns and feelings as they move through the pathway can only serve to ensure inclusivity in the process. Utilizing the patient advocate stories shared at the committee meetings is an opportunity to document the process through the patient's eyes and consider their view when planning for key components. A proven patient experience survey should be part of the IHFCI model.	
Psychosocial Support	As an integrated model of care all clinical needs of the patients must be included in the individual care plan. It is well documented that HF patients experience depression and anxiety and meeting these needs is also critical to the success of the HF care plan for the patient. Access to psychosocial support must be included in the tool kit for the providers.	

Diagnosis in Primary Care	The model begins at the PCP office and or the ED. There must be opportunity for the PCP to have access to the knowledge of HF and the standards of practice. Developing the medical record and referral process to support ease of sharing the patient history and current clinical status with all providers should improve access to care. Timely access to diagnostics is imperative for quality patient outcomes. Including the stakeholders at the table who have impact on access can only improve how the patient moves through the HR system.	
Education (provider and patient/caregiver)	The collaborative clinical Heart Failure education provided by CorHealth and the sponsoring Node cardiology department has been very successful in our sub-region with the participant evaluations indicating support for implementing the HF standards of practice. Evidence based practice standards introduced in a comfortable and collaborative environment supports the sharing and learning of current heart failure advances. The IHFCI leadership should continually plan to support education sessions on an annual basis.	Current evaluations of the education provided in Guelph – Puslinch and KW4 sessions.
Include any other **themes** not listed above:		

Section 3: Ottawa

The Ottawa Early Adopter Team IHFCI Experience

The University of Ottawa Heart Institute
Regional Model of Heart Failure Care

Overview

The University of Ottawa Heart Institute (UOHI) has a long history of developing regional programming that happens at the level of the patient. Examples of this include the STEMI program; the Get with the Guidelines tools for heart failure (HF) and acute coronary syndrome that provide quarterly data, and the Home Telehealth Monitoring program that has demonstrated cuts to hospital readmission of patients with HF by 54%.

The UOHI continuously monitors cardiac outcomes in the Champlain Local Health Integration Network (LHIN). If a problematic issue is identified, the clinical administrative lead works with the physician lead and a designated Project Manager to make regional physician partners aware of the issue, invite them to a meeting to discuss the issue and determine how best to resolve it.

A hub and spoke model have existed within the acute care setting in the Champlain LHIN since the UOHI's inception in 1976. The UOHI acts as a strong voice and supporter of its regional partners.

Background

The Champlain LHIN Integrating Heart Failure Care Initiative (IHFCI) **team** consisted of:

- ***UOHI physician lead,*** the Director of the Heart Failure Program at UOHI. This individual runs a regular heart failure clinic at several regional community hospitals and is well known and respected by regional partners.

- ***Clinical administrative lead***, the Executive Vice President and Chief of Clinical Operations. This individual monitors regional patient-centric cardiac outcomes and is proactive when issues are identified.

- ***Family practice physician representative***, this individual frequently acts as advisor for annual regional symposia.

- ***Regional project manager,*** this individual plays an integral role in all regional activities, including spearheading regional HF initiatives including the annual symposium held for regional physicians and allied health professional partners.

- ***Regional physicians and allied health professionals***, these individuals manage the care of patients with HF. All healthcare providers (MD, APN, NP, RN, dietitian, pharmacist, psychologist, program coordinator) involved with patients with HF were invited to a meeting in each of the four LHIN sub-regions.

The Champlain LHIN is comprised of 5 sub-regions. UOHI organized meetings in 4 of the 5 sub-regions – Eastern Champlain, Eastern Ottawa, Western Champlain and Western Ottawa. Time constraints did not allow for a meeting in the fifth (Central Ottawa) sub-region. Acquiring contact information was one of the more time-consuming aspects of the Project Manager's job. Table 1 outlines the sources used to compile a contact list.

TABLE 1: Contact List Sources

INTERNAL SOURCES	EXTERNAL SOURCES	ELECTRONIC SOURCES
• Executive VP Clinical Services Contacts • Regional Educator Contacts • Annual Symposia Participants	• Regional Hospital Leadership Contacts • Family Health Team & Community Health Centre Executive Directors	• Champlain Healthline • Web searches

We leveraged our internal contact lists and we asked our external partners for contact information and/or to distribute the meeting notice on our behalf. We also utilized Champlain Healthline and undertook web searches to update outdated lists and identify new contacts. Providers were identified for Western and Eastern Champlain and Western and Eastern Ottawa sub-regions. All appropriate providers at the regional community hospitals, FHTs and CHCs were invited to a planning session to establish an integrated regional HF network. Participation was voluntary. People wishing to attend were asked to contact the Champlain Project Manager (PM) to register and/or with questions and comments.

The purpose of the meetings with each of the sub-regions was to disseminate findings – mapping of regional HF services work done in 2017 by the UOHI and the HF utilization and quality outcome measures done by the UOHI in 2018. The responsibility of all team members was to identify gaps in HF services, root causes of those gaps and propose solutions so that a plan could be developed with the UOHI. The work for the IHFCI was organized with the same

approach used by the UOHI for all regional cardiac programming which entails a six-step framework (see Table 2).

Advice to a Project Manager Organizing Stakeholders and Teams (within a context similar to UOHI and the Champlain LHIN)

- ***Build relationships*** - establishing and maintaining trust among partners is a critical success factor.
- ***Identify champions*** – champions aren't made, they're born, they are passionate, willing to learn and committed – a medical or clinical administrative champion; having both is ideal.
- ***Recognize that this work takes dedication and time*** – set achievable goals and time frame.
- ***Utilize a systematic approach*** – understand who you are serving; understand the patient population; understand the existing infrastructure; follow the process (map services, gather data and analyze, disseminate findings and identify gaps, build a blueprint and validate it with partners, prepare implementation plan, evaluate and monitor).

The **governance model** within the Champlain LHIN is one in which the node (UOHI) provides strong and committed leadership to the hub and spokes. As the only tertiary/quaternary node in the Champlain LHIN the UOHI is recognized as the lead and trusted by its partners to deliver the desired outcomes. It has had a regional hub & spoke model in existence for decades. The role of the regional partners is to be honest and forthright in their assessments and discussions so that an appropriate plan of action can be developed. The UOHI does an annual review of regional care, attended by the region's hub and spokes' leaders giving us regular contact with our partners.

TABLE 2: Regional Spoke, Hub, Node Framework of Heart Failure Care

STEPS	STEP 1: MAP REGIONAL SERVICES	STEP 2: DATA GATHERING & ANALYSIS	STEP 3:DISSEMINATE FINDINGS & INDENTIFY GAPS/ ROOT CAUSES	STEP 4: BUILD A BLUEPRINT & VALIDATE	STEP 5: PREPARE ACTION PLAN & EXECUTE	STEP 6: EVALUATE & MONITOR

ACTIVITIES	• Develop Survey – based on the standards of Heart Failure care defined by CCN
	• Pilot test survey and refine
	• Compile distribution list
	• Disseminate invitation to complete survey
	  • Telephone interview
	  • Independently
	• Summarize finding by sub-region
		• Define target population and healthcare setting
		• Identify measures
		• Define data requirements and data sources
		• Gather and analyze data
		• Map out resource utilization and quality outcomes by sub-region
			• Schedule regional meeting
			• Invite regional healthcare providers involved in Heart Failure care (MDs, RNs, Allied Heath, etc)
			• Present and discuss findings
			• Identify gaps and root causes
			• Complete self-evaluation on HQO quality statements
				• Compile self-assessment of HQO standards
				• Synthesize Gaps & Investigate root causes
				• Propose solutions
				• Draft blueprint
				• Disseminate draft blueprint and seek feedback and validation
				• Revise and finalize blueprint
					• Develop detailed project plan
					. Define activities
					. Identify resources
					. Define timing
					. Develop budget
					. Identify outcome measures
					• Communicate action plan with stakeholders
						• Review outcomes
						• Provide recommendations for changes/revisions
						• Communicate results with stakeholders

PARTCIPANTS	• Project Sponsor & Project Manager • Regional Healthcare Providers: . Hospitals . Family Health Teams (FHTs) . Community Health Centres (CHCs)	• Project Sponsor & Project Manager • HF Clinical Expert • ICES Scientist	• Project Sponsor & Project Manager • HF Clinical Expert • Regional Healthcare providers	• Project Sponsor & Project Manager • HF Clinical Expert • Regional Healthcare providers	• Project Sponsor & Project Manager • HF Clinical Expert • Regional Healthcare providers • Other experts identified in Action Plan	• Project Sponsor & Project Manager • HF Clinical Expert • Regional Healthcare providers •
DELIVERABLE(S)	• Mapping of regional Heart Failure services	• Resource utilization and outcomes	• Gaps	• Blueprint	• Action Plan	• Outcome Measures

Planning and Implementation

The work done in Champlain was step three of a project that began in 2017 at the UOHI. The aim of the project was to create a hub and spoke model of HF care in the Champlain LHIN, as proposed by CorHealth Ontario in 2014 (Cardiac Care Network at the time). The UOHI serves a patient population that spans a large geographical area. A large portion of general HF care was provided in the community setting. There was a need for smooth integration between points of transition, development and implementation of common best practices and timely access to the level of service needed by the patient. The UOHI began by surveying all providers in the region in an effort to map regional services for HF (Appendix A, page 58). Following this a UOHI physician who holds an ICES scientist position collected and analyzed pertinent measures of HF utilization and outcomes. The IHFCI enabled the UOHI to disseminate the findings of this work to regional partners within the Champlain LHIN and to take the next step toward devising a blueprint for distribution to partners for feedback and validation.

The Champlain Project Manager's focus was to ensure as many sub-region meetings as possible could be accomplished. This entailed securing meeting space, securing funding to support the meetings, building PowerPoint presentations, preparing meeting packages, and establishing invitation lists. In order to get more information on how providers saw their personal practices we worked on a review and assessment approach for the Health Quality Ontario Heart Failure Care in the Community quality statements. The Project Manager held many discussions with hospital administrators and Family Health Team physician leads on meeting objectives and approach. The final job of the Project Manager in the IHFCI will be to communicate the results of the meetings and the report to UOHI regional partners. The Project Manager is an important investment and a huge value add for IHFCI as it enabled dedicated coordination time to the process, dedicated discussion opportunities and repeated dedicated efforts to invite regional partners to the table.

The regional HF services mapping and utilization and outcomes measures were assessed at the level of the five Champlain LHIN sub-regions. The regions are varied in geographic size, population, rural and urban orientation, incidence and prevalence of HF and demographics. The IHFCI organized and held four meetings in the Champlain LHIN. Table 3 displays meeting information for four sub-regions.

TABLE 3: Consultation Meetings

Location	Date	No. Participants
Western Champlain	December 3, 2018	30
Eastern Champlain	December 11, 2018	16
Western Ottawa	February 29, 2019	11
Eastern Ottawa	March 6, 2019	17

Partner participants came from hospitals and the primary care community including Family Health Teams and community health centres, and included MDs, APNs, NPs, RNs, RTs, educators and program coordinators. There were Champlain LHIN representatives at two meetings and a Health Quality Ontario representative at one meeting, and CorHealth representatives at two meetings. Each meeting was held at a venue central to the sub-region. We provided a meal to participants since meetings were held at the dinner hour (4:30- 6:30 pm or 6:00 – 8:00 pm). Timing was important as physicians did not wish to cancel their day's work to attend meetings. Meetings were two hours long. Heart failure outcomes and utilization data were presented, followed by a question and discussion period. The Spoke-Hub-Node model of integrated HF care was presented, along wit the HQO Quality Standard, followed by a discussion on HF services gaps, issues and proposed solutions.

The UOHI devised a survey (Appendix B, page 64) to facilitate meeting attendees' self assessment of the importance of the HQO quality statements to their practice or program and whether or not they met the standard. The survey also asked what they would need to make things better. Attendees took 15 minutes at the end of the meeting to complete the survey. The survey provided rich information as outlined below.

TABLE 4: Self-assessment on HQO quality statements

HQO Quality Statement	What I need to make things better
#1 Diagnosing Heart Failure Diagnosing HF with evaluation including medical history, physical exam, blood work, ECG, chest x-ray. Echocardiogram if HF is confirmed or still suspected after evaluation done.	• Participants throughout the region fully agreed with this statement. However, the vast majority only partially meet it. • Access and long wait times for ECHO and cardiologists, particularly in rural areas, was problematic as was lack of access to BNP testing.
#2 Comprehensive Care Plan People with heart failure and their families have a comprehensive care plan they develop in collaboration with their care providers. The care plan is reviewed at least every 6 months and sooner if there is a significant change. It is made readily available to all members of the person's care team, including the person and their family.	• The majority of participants fully agreed with this statement. However, the vast majority only partially meet this statement and about one-quarter of respondents did not meet it at all. • Participants stated a number of supports that would help including a standardized regional care plan, access to a chronic disease management program/Health Links, increased clinic time.
#3 Empowering and Supporting People with Self-Management Skills People with heart failure and their families collaborate with their health care providers to create a tailored self-management program, with the goal of enhancing their skills and confidence so that they can be actively involved in their own care.	• Participants throughout the region fully agreed with this statement. However, the vast majority only partially meet it. • Participants cited time as a barrier. They suggested dedicated RN time in clinic to provide education and the time to follow-up with patients by phone.
#4 Physical Activity and Exercise People with heart failure are informed of the benefits of physical activity. They are offered advice on types of exercises to consider, based on their abilities and activity goals	• Participants fully agreed with this statement. However, the vast majority only partially meet it. • Participants cited access to cardiac rehab as a barrier (wait times, location, patients unwilling) and suggested a home program, motivational tools for interviewing, more time for RN to educate patients
#5 Triple Therapy for People with Heart Failure Who Have a Reduced Ejection Fraction People with heart failure who have a reduced ejection fraction (HFrEF) and NYHA class II to IV symptoms are offered pharmacological management with "triple therapy"…	• Participants throughout the region fully agreed with this statement. However, the vast majority only partially meet it. • Provider education was cited by all regions as the key to successfully meeting this standard.

#6 Worsening Symptoms of Heart Failure People with known heart failure who report worsening symptoms are assessed by a care provider and have their medications adjusted (if needed) within 24 hours	• Participants for the most part agreed that this was important. However, the majority only partially meet this while about one-third do not meet it at all. • The large number of orphan patients seen in ER, but not followed made this challenging to meet. In addition to lack of resources (e.g. NP)
#7 Management of Non-cardiac Comorbidities People with heart failure are treated for non-cardiac comorbidities that are likely to affect their heart failure management	• Participants for the most part agreed that this was important. However, the vast majority only partially meet this. • Orphan patients and too few primary care physicians were barriers. For those with providers, the resource intensity and low OHIP fee made it challenging. Specialized community clinic and more funding was recommended.
#8 Transition from Hospital to Community People who are hospitalized for heart failure receive a follow-up appointment for reassessment of volume status and medication reconciliation with a member of their community health care team within 7 days of leaving the hospital	• Participants across the region agreed with this statement. • Orphan patients, limited primary care physicians, clinic wait times and delay in transfer of discharge documents from hospital were barriers.
#9 Specialized Multidisciplinary Care Patients who have been hospitalized for HF are offered a referral for specialized multidisciplinary HF care.	• The vast majority of participants agreed with this statement. • For rural patients, transportation issues and unwillingness to travel were barriers. Timely access for cardiology resources (rehab, HF clinic) was also cited.
#10 Palliative Care and Heart Failure People with heart failure and their families are offered palliative care support to meet their physical, psychosocial, and spiritual needs.	• The vast majority of participants agreed with this statement. • Access to palliative resources and education on trajectory and early discussions.

Determining **gaps** in regional HF care was one of the main goals of this initiative. Challenges and opportunities gleaned from the discussions fell into four major buckets:

Access to Services

- improved access to primary care and the cardiologist
- a central referral strategy would be ideal
- increased remote clinics
- one-number-to-call for cardiology consults
- consideration for e-consult
- adoption and expansion of UOHI telerehab
- education for remote sites on available services
- need a strategy for orphan patients
- alternate point of care strategies for labs to facilitate monitoring of serum electrolytes and creatinine (underuse of MRAs due to poor follow-up of patient electrolytes and creatinine)

Timely Diagnosis

- access to testing – ECHO and stress testing
- need to better understand the reporting of ECHO and when it needs to be repeated (i.e. moderate disease – we should be providing suggestion when to repeat)

Support for Complex Patients

- support for medication titration
- support for decisions needed for complex patients
- regional care plan
- utilization of Health Links
- improved communication among providers to facilitate management of patients post referral

Education Strategies for Patients and Providers

- need quick access to quick questions
- would like scheduled education programs
- lack of time for patient education during visits
- nurse run clinics
- need ability to educate and follow-up on patients at home

Meeting discussions also revealed important information to be considered when future healthcare planning is done:

- Patients want to be close to home. They do not want to or cannot travel for healthcare treatment. We learned that in many instances they don't even want to go to their doctor's office or community hospital. This was especially true for patients living in rural communities; for some of these patients the paramedic is their only contact with the system.
- Patients are willing to use new technology if it can help to keep them in their homes. Regional partners are willing to engage in trialling new technologies and/or extensions of existing technologies.
- Early identification of disease and risk factors is key. Family physicians and community hospitals are struggling with large numbers of HFpEF patients which are predominately women. We need a comprehensive strategy to manage patients with preserved EF. There are no evidence-based treatments. These patients are resource intense because of their comorbidities, advanced age and mental health (mainly depression); important issues with HFpEF patients

Critical Success Factors

- ***Clarity of roles*** is essential. All partners need to understand their responsibilities. Regional partners see the UOHI as the lead organization or node. They understand that UOHI will report back to them with findings of the meetings and a proposed plan for discussion and validation prior to establishing a blueprint for improvement.

- ***Confidence and trust among partners*** enable honest, forthright communication and the ability to resolve issues. This trust was gained because of the long history of hub and spoke activity and successful project completion.

- ***Data sets a baseline*** from which to begin work and produce improvement. It helps all partners understand the patient-centric picture. Publicly reported data generated at regular intervals enables continuous surveillance. Data generates discussion.

- ***Removing as many obstacles as possible*** so providers could attend meetings meant we held meetings after hours and at meal time. Attendees enjoyed their meals while contributing to the discussion. Partners did not wish to disrupt their patient schedules for meetings.

Major Challenges

- ***Scheduling physicians***: Physician timetables are organized and typically solidified 8 - 10 weeks in advance.

- ***Time of year:*** The IHFCI began in Champlain very close to winter holiday time and this winter was particularly challenging as it related to weather. For some meetings participants were calling right up to getting into their cars to ensure the meeting was still on or if the weather had caused a cancellation.

- ***Engaging stakeholders:*** Using email and social media to engage stakeholders in discussion about meetings is difficult. Healthcare providers are busy people and often these communication formats do not get the attention they need. Direct phone calls were much more successful at inviting people to meetings, but telephone tag can be a time-consuming game.

Key Messages

- **Clinical leadership** should understand the region and the patient data and be available to share the data with regional partners. Relationship building is essential. Going out to meet partners or bringing them in for educational offerings is important to help them understand the node is available to them. Clinical leadership should partner in solutions and help providers understand that not all solutions cost money.

- **Administrative leadership** should communicate new quality standards and any new best practices to regional partners and educate clinical staff. Provide appropriate electronic and/or paper copies to ensure staff have necessary information. Ongoing communication and relationship building are important.

- **Nodes** should develop a regional data collection method, so reliable data is available at consistent intervals to ensure continuous surveillance and ongoing trouble-shooting. Make establishing good relationships a priority. Meet with regional partners face to face at least once a year. Be prepared to serve.

- **Hubs** should make establishing good relationships a priority. Be responsive to the needs of spokes, providers and patients.

- **Spokes** should attend meetings to represent their patients' needs and be prepared to speak openly and honestly so that solutions can be developed. Partner in the solutions and remember that not all solutions cost money.

Table 5: Recommendations for Collaborative Leadership, Patient & Caregiver Perspective, Education, Data and Reporting

Planning Phase	Taking Action Phase	Sustain/Spread/ Scalability Phase	Theme(s) Impacted
• There must be an ***identified lead organization***, which is the UOHI within Champlain. The lead understands its role and responsibility of working with regional providers to identify issues and solutions to enhance the quality of HF care. • A necessary prerequisite is the ***availability of good regional data*** to provide a snapshot of the region and a basis to plan. • Important to differentiate between urban and rural settings which may require customized activities.	• Identify supports (i.e. project management) for lead organization contingent on agreed upon outcome measures • Gather regional data	• Lead site that is able to serve and mentor hubs & spokes	• Collaborative leadership • Data & Reporting
• A central theme that was heard at multiple meetings was ***care integration and patient transitions***. Providers think of integration as everyone understanding the plan. They want a mechanism to update the plan with the help of experts when the patient's condition changes.	• Establish one-number-to-call for referring, triaging and supporting providers. • Develop and implement a regional care plan that accommodates in and out of hospital transitions.	• Attaching resources to the node ensures accountability to provide services to the region. • Establish a patient/caregiver survey.	• Collaborative Leadership Education • Patient perspective
• ***Palliative supportive care*** is important with goal setting and improving quality of life. HF patients have difficult decisions around ICDs etc. • Palliative care resources should be extended to cardiac and attached to the node so that they are available to anyone who needs them.	• Develop services, tools and supports for palliative care for cardiac patients	• Attaching resources to the node ensures accountability to provide services to the region	• Collaborative leadership • Education • Patient perspective

• In the current primary care model, there are many HF ***orphan patients*** with no access to long term care follow-up. They end up in the emergency department and there is no one to follow-up on their care.	• Develop a new model to support primary care in taking in HF orphan patients. NPs may have a role in this model with supervision from either the node or primary care at the spoke level.	• Resources specifically tied to a reduction in orphan patients with commitment to use of technology to pick up patients across the region	• Collaborative leadership • Patient perspective
• Primary care physicians believe i***dentification of HF*** is an issue and may have a number of patients in their practices who remain undiagnosed. • In particular, there is concern about ***elderly females with HF preserved ejection fraction (HFpEF)***. There needs to be a more global, funded strategy to screen and identify patients early. The use of BNP as a mechanism was also discussed.	• Develop a screening strategy to assist in the early detection of HF that includes diagnostics testing (BNP) • Build a strategy tailored to HFpEF patients	• Develop a successful model and scale up across region	• Collaborative leadership • Education • Patient perspective
• ***Access to high quality echo*** is an issue in many communities, particularly rural ones. HF patients require echo as part of their diagnosis. In some settings, UOHI has placed echo machines in the community and developed a training and quality assurance program to ensure appropriate technical skills and standards are met. These programs fall under the jurisdiction of the UOHI and there is potential to expand this model regionally. There are resource implications in terms of echo equipment and manpower.	• Undertake an environmental scan of the current state of echo in the region including wait times and resources • Expand remote access echo strategy to improve access in rural communities which includes certification of trained echosonographer and quality assurance program to ensure standards are met • consider funding an in-hospital discharge echo	• Continue with regular reporting	• Collaborative leadership • Patient perspective • Data & reporting

• Primary care physicians told us their ***patients don't want to attend their offices for visits***. As a result, follow-up care and treatment are not as smoothly transitioned as they would like. This is particularly important in rural settings. We currently have a home monitoring and automated calling system that is used throughout the region.	• Develop strategy that involves remote technology (i.e. PCVC) that allows patients to be seen by primary care provider from home particularly in the rural population.	• Continue with regular reporting	• Collaborative leadership • Patient perspective • Education • Data & reporting
• Primary care was pleased with the annual symposium provided by UOHI. They would also like ***shorter tools*** in which common problems associated with HF can be dealt with.	• Examine just in time strategies that would be helpful for physicians.	• once developed share with region	• Education
• On the patient/caregiver side the use of some of the existing programs such as the Get with the Guidelines program, home monitoring, and telemedicine have been helpful in improving patient and caregiver information. Heart failure clinics and home monitoring allow patients to learn at a pace that recognizes the trajectory of their disease. Patients need a significant amount of follow-up because lifestyle changes are critical. In addition, many of them have complex polypharmacy. Strategies which allow patients to stay at home and engage in their education and treatment are best for HF patients. Family physicians spoke about some of the ***challenges in patient education given the short visit times and reimbursement*** models.	• Provide HF providers with electronic copy of all our patient education materials • consider telerehab expansion	• Share education resources	• Collaborative leadership • Patient perspective • Education •

Appendix A – Regional Assessment Survey

Part A – Demographics

1. What best describes your setting?

❑ Hospital Inpatient Program

❑ Hospital Outpatient Program/Clinic

❑ Cardiology Practice

❑ Community Primary Care Practice (e.g. FHT, CHC)

❑ Other _____

2. Do you have a specific goal for HF care in your organization? (QIB, HSAW)

❑ Yes

❑ No

3. The Heart Failure Program is comprised of the following team members. Check all that apply.

	Onsite	Offsite Through Referral (Access? If yes, where?)
Cardiologist – Heart Failure Specialist		
Cardiologist – Generalist		
Internist		
Nurse Practitioner (NP) HF training? ❑yes ❑ No		
Registered Nurse (RN) HF training? ❑yes ❑ No		
Registered Practical Nurse (RPN)		
Pharmacist		
Dietitian		
Psychologist		
Social Worker		
Physiotherapist		
Other (please specify): :_____		

4. Approximately, what percentage (%) of the HF population you see would fall into the following classes?

NYHA Class I-II, symptoms mild; low complexity or low risk; few co-morbidities; co-morbidities well controlled (e.g. stable)?

NYHA II-III, symptoms (moderate); intermediate complexity or intermediate risk; co-morbidities reasonably well controlled; recent hospitalization?

NYHA III-IV, symptoms moderate to severe; high complexity or high risk; multiple co-morbidities not well-controlled (e.g. active illness); frequent hospitalizations?

Part B – Assessment

5. Please indicate the clinical evaluations and investigations you perform in your setting:

Clinical Evaluations	Hospital Setting	Outpt Clinic (amb care)	Primary Care
Symptom burden (i.e. fatigue, shortness of breath, diminished exercise capacity and fluid retention/weight gain)	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Functional limitation (Do you assign NYHA Class?)	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Cardiovascular disease/ risk factors	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Comorbid conditions	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Volume status and vital signs (e.g. peripheral edema, rales, heart and lung sounds, hepatomegaly, ascites, weight, jugular venous pressure, hepatojugular reflux and postural hypotension)	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Assessment of a patient's endurance, cognition, and ability to perform activities of self-management and daily living	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up
Other	☐ Initial visit	☐ Initial visit ☐ Follow-up	☐ Initial visit ☐ Follow-up ☐

Investigation	Available Onsite	Available Offsite
❑ Serum electrolytes		
❑ Renal function (Creatinine, eGFR)		
❑ BNP		
❑ 12-lead ECG		
❑ chest x-ray		
❑ ECHO ❑ Heart Structure ❑ Ejection Fraction		
❑ MUGA		
❑ Other_____		

Part C – Follow Up in Out-patient/Ambulatory Care Settings

6. When you see a patient who has recently been discharged and diagnosed with HF, do they provide you with a copy of their GAP tool? (Guidelines Applied in Practice - Heart Failure)

❑ Yes

❑ No

7. Is HF education provided?

❑ Yes → by whom? _____ frequency?_____

❑ No

If Yes, what topics are addressed?

❑ Self-Monitoring and the importance of self-management

❑ Symptom recognition and what to do

❑ Medication compliance

❑ Daily weights

❑ Salt restrictions

❑ Fluid restrictions

❑ Alcohol restrictions

❑ Physical activity

❑ Other (please specify):_____

8. Are education materials on HF provided to the patient?

❑ Yes (please specify)

❑ No

9. Do you use any measure of Quality of Life?

❑ Yes

- What do you use?_____
- When?_____

❑ No

10. Are eligible patients referred to cardiac rehabilitation?

❑ Yes

❑ No

Part D – Care Plan and Goals

	Hospitals	Clinics	FHT / GPs
Do you have a formal care plan?			
If yes, when is the care plan and goals of care reviewed?			
Do you offer or refer for supportive / palliative care including advanced directives?			

Part E – Medications

11. Which Heart Failure medications are you initiating and/or titrating?

Medication	Hospital		Clinic		FHT/ GPs
	Initiate	Titrate	Initiate	Titrate	Initiate
❑ Diuretics					
❑ Beta-Blockers (BB)					
❑ ACE-Inhibitors (ACE-I)					
❑ Angiotensin Receptor Blockers (ARBs)					
❑ Direct-Acting Vasodilators					
❑ Mineralocorticoid receptor antagonists (MRA)					
❑ Digoxin					
❑ Entresto					
❑ Other_____					
11a) Are medications reconciled at each patient appointment	n/a - required		☐ Yes ☐ No		☐ Yes ☐ No

***Question for non-hospital settings only ***

12. Approximately, what percentage of your HF population is on ACE inhibitors/ARBs?

- ❑ 0-25%
- ❑ 25-50%
- ❑ 50-75%
- ❑ 75-100%
- ❑ Do not know

***Question for non-hospital settings only ***

13. Approximately, what percentage of your HF population is on Beta Blockers?

- ❑ 0-25%
- ❑ 25-50%
- ❑ 50-75%
- ❑ 75-100%
- ❑ Do not know

14. What level of diuretic therapy is provided by your organization?

- ❑ Initiation/Titration of a single oral diuretic agent
- ❑ Initiation/Titration of two oral diuretic agents (e.g. furosemide and metolazone)
- ❑ Initiation/Titration of oral diuretic agents and IV diuretics

Part F – Outside of Clinic Appointment

15. What is your usual follow-up appointment schedule? (e.g. Every month)_____

_____

16. In general, how quickly can you see a follow-up appointment?

- ❑ Able to provide urgent same-day appointment (Mon-Fri, business hours)
- ❑ Able to provide urgent follow-up appointment within 48 hours
- ❑ Able to provide monthly pre-arranged follow-up

17. Does your Heart Failure population have access to nursing support?

- ❑ 24/7
- ❑ Daily (Monday to Friday - during business hours)
- ❑ During pre-defined clinic hours
- ❑ Not available
- ❑ Other_____

18. In the event of clinical deterioration/ decompensation, what process do you take?

- ❑ Admit patient
- ❑ Send patient to ED
- ❑ Refer to Heart Failure specialist
- ❑ Refer to cardiologist
- ❑ Refer to internist
- ❑ Other (please explain): _____

19. Do you have the ability to follow complex HF patients by remote monitoring?

- ❑ Yes
- ❑ No

20. How would you rate your access to services and interventions for this patient population?

	Poor 1	Satisfactory 2	Good 3	Very Good 4	Excellent 5
Devices					
Diagnostic Tests					
Heart Failure Specialists					
UOHI Admission					
Overall access to heart failure care					

Part G – Additional Insight

21. Are there any other services you would like to see added to the region in order to build capacity for the management of heart failure patients?_____
_____
_____

22. Are there any other ideas or issues that you would like to inform us about?_____
_____
_____

Appendix B – Self-Assessment on HQO Quality Statements

***Note: The quality statements were amended by HQO part-way through our consultation process; however, we maintained the original survey for consistency. For a revised version of this Self-Assessment tool, see the Implementation Support Toolkit on CorHealth Ontario's website, under "Heart Failure Quality Standard".**

Quality Statement #1

Diagnosing HF with evaluation including medical history, physical exam, blood work, ECG, chest x-ray. Echocardiogram if HF is confirmed or still suspected after evaluation done.

Is this standard important to my practice/program?

Don't Agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #2

HF patients & significant others develop a comprehensive care plan with their providers. Plan available to all involved and reviewed every six months or sooner if significant change.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #3
HF patient & significant others collaborate with care provider on a patient specific self management program with goal of active involvement in own care.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #4
HF patients made aware of the benefits of physical activity based on their goals and abilities.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #5
Triple therapy for HF patients with reduced EF & NYHA II – IV symptoms
ACE or ARB, betablocker, mineralcorticoid receptor antagonist (MRA)

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #6
HF patients who report worsening symptoms assessed within 24 hrs & have medications adjusted as necessary.

Is this standard important to my practice?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #7
HF patients are treated for non-cardiac comorbidities that are likely to affect their HF management.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #8
People discharged from hospital with HF diagnosis receive F/U appointment within 7 days of leaving hospital.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #9
Patients who have been hospitalized for HF are offered a referral for specialized multidisciplinary HF care.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print

Quality Statement #10
HF patients & significant others are offered palliative care support to meet physical, psychosocial and spiritual needs.

Is this standard important to my practice/program?

Don't agree	Somewhat agree	Fully agree

In my practice/program I think we .....

Don't meet standard	Partially meet standard	Fully meet standard

What would I need to make things better?
Please print