Integrated Heart Failure Care
Frequently Asked Questions

Background

In 2014, CorHealth Ontario (Cardiac Care Network of Ontario, at the time) proposed a strategy for community management of heart failure (HF) in Ontario. The strategy recognized that people with HF require an integrated, multidisciplinary team-based approach to their care that spans the full continuum of care from early disease management through palliative care. A formal **spoke-hub-node model** of integrated HF care was proposed to improve patient management and transitions across that care continuum. Between 2017 to 2019, CorHealth Ontario worked with 3 Early Adopter Teams to test the implementation of the Spoke-Hub-Node model, through the Integrating Heart Failure Care Initiative (IHFCI).

What is Integrated Heart Failure Care?

Integrated HF care implies a comprehensive organization of care that facilitates an integrated and person-centred approach to coordination and delivery. Using a shared care approach, less complex care is provided in the patient's own community and more complex care, when required, is provided at a more centralized and specialized centre of HF practice or a HF program. Care plans, resources, and health information are regularly shared across all sites to enable more seamless care and improved outcomes.

What is a Spoke? What is a Hub? What is a Node?

The Spoke-Hub-Node model is a framework for integrated HF care. For patients with HF, the location and intensity of care is determined by disease complexity and risk of adverse outcomes. Individuals with HF who are low risk and complexity can be cared for in a **spoke**, close to home. Individuals of intermediate risk require the more complex care provided by a community **hub**. High risk individuals require the most complex level of care and care is delivered in a tertiary **node**. The intensity and level of care may vary over time with the patient's complexity and risk changes, but the goal is to ensure that high quality care is available as close to home as possible and that care is coordinated across the spokes, hubs and node.

Why should I/my organization consider making integrated heart failure care a priority?

Heart failure is associated with high costs and frequent use of health care resources. The Heart and Stroke Foundation estimates that HF costs the Canadian health care system $2.8 billion per year (Heart and Stroke Foundation, 2016). HF is one of the five leading causes of hospitalization and 30-day readmissions, and the most common cause of hospitalization for people over age 65. The current and evolving demands associated with a chronic, complex condition like HF in Ontario, and the challenges in meeting these demands, requires a collaborative partnership approach at the local level (among primary care physicians, specialists, and allied health professionals).

How do I get started?

Critical steps to getting started can include:

- Identifying local HF champions from the spoke, hub and node levels, that include both clinical and administrative leadership, and establishing a local leadership table.
- Identifying impactful, feasible and achievable initiatives, by using available information and data to inform a comprehensive current state of HF care to understand local HF care needs.
- Identifying and engaging patients with HF and their caregivers, and involving them in the planning and co-design of improvement initiatives.
- Providing targeted HF educational opportunities to gain interest and support

These and other recommendations around implementing an integrated approach to HF care are included in the Roadmap for Integrating HF Care in Ontario, and the supplementary Evaluative Report.

Where can I find more information?

For more information on Integrating HF Care, visit the CorHealth Ontario website: www.corhealthontario.ca, go to 'Resources for Planners and Providers', and look under 'Heart Failure'.