CARDIAC CARE NETWORK

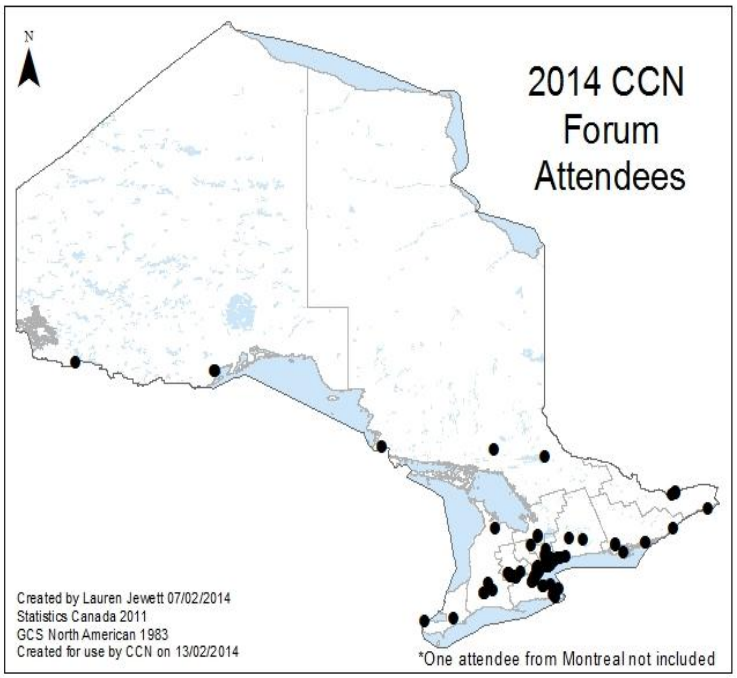
2014 CCN Provincial Heart Failure Strategy: Forum Summary

INTRODUCTION

In response to the growing impact of heart failure (HF) on patients, caregivers, and the healthcare system as a whole, the Cardiac Care Network of Ontario (CCN) convened a Heart Failure Working Group (hereafter referred to as CCN-HFWG) in the summer of 2011. This multidisciplinary group worked diligently to produce the CCN Provincial Heart Failure Strategy, a cohesive and integrated provincial approach to managing this complex, chronic disease.

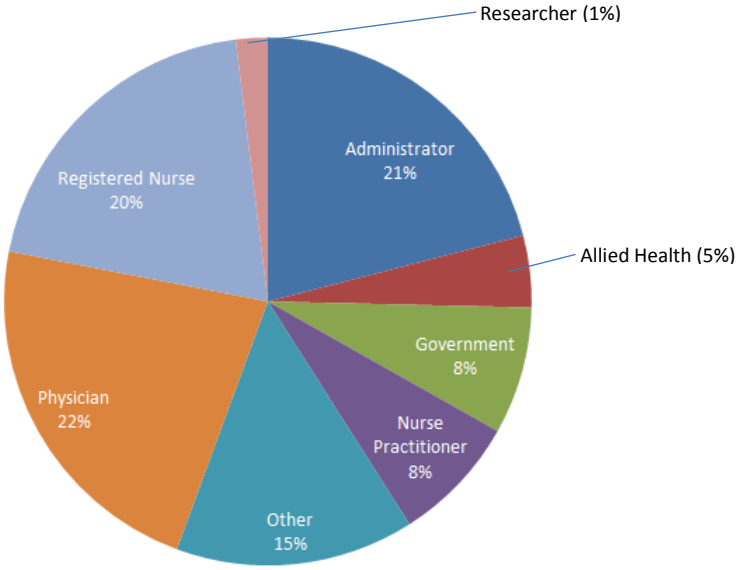
On February 13, 2014, 190 clinicians, administrators, and health system partners from every LHIN across the province (Figure 1) joined together to attend the CCN Provincial Heart Failure Strategy Forum. This day marked the official launch of the CCN Provincial Heart Failure Strategy and created an opportunity for attendees and presenters to network and share their unique challenges as well as potential solutions to the delivery of optimal HF care in Ontario (Please see Appendix A for a copy of the Forum agenda). Forum attendees represented hospitals, family health teams, medical/community clinics, solo practices, LHINs, Community Care Access Centres, Cardiac rehabilitation facilities, Health Links, Health Quality Ontario, The Ministry of Health and Long-term Care, Ontario Telemedicine Network, Institute for Clinical Evaluative Sciences (ICES), and others.

FIGURE 1. CCN HEART FAILURE STRATEGY FORUM ATTENDEES- LHIN



A major strength of the Forum was the diversity of participants. The cohort of physicians, nurses and nurse practitioners represented 50% of the participants, followed by administrators at 21%. Please see Figure 2 for a summary of the role of Forum registrants.

FIGURE 2. SUMMARY OF HEART FAILURE STRATEGY FORUM ATTENDEES BY ROLE



The objectives of the Forum were to:

- Develop a clear understanding of CCN's Provincial Heart Failure Strategy;
- Understand the current state of HF care coordination and delivery in Ontario;
- Build a network of HF providers in their local community and across the province;
- Have an opportunity to take an active role in discussing solutions to address system challenges.

Purpose of the document

The purpose of this document is to summarize the major findings from the Forum and is divided into three sections as follows:

Part 1. An overview of the speaker presentations and discussion points generated from audience participation;

Part 2. Key takeaways based on evaluation forms; and

Part 3. Exploring next steps /looking ahead.

Part 1. Speaker presentations and discussion points

After each session, participants had an opportunity to ask questions of the speakers, followed by a one-hour panel "Q&A" session at the end of the day. The following section describes key points from each presentation followed by a consolidation of the discussion points after each speaker and during the question and answer period with the panel at the end of the day.

Health system transformation

The day began with an introduction by Ms. Helen Angus, Interim Deputy Minister at the Ontario Ministry of Health and Long-Term Care (MOHLTC). Ms. Angus highlighted the overwhelming challenges that our health care system is facing, and the transformational changes that the MOHLTC is undertaking to continue to provide exemplary care to Ontarians. In addition to substantive changes to funding models, the Health Links initiative is well underway, working to wrap a circle of care around the complex, resource-intensive patients who comprise only 5% of the population of Ontario but account for 66% of healthcare spending. While the picture of a Health Links patient varies across the province, many of these patients live with chronic comorbid conditions, including HF. Spread widely across the province, Health Links have already begun to improve intersectoral collaboration and break down the silos between health care sectors. Many complex patients are now attached to primary care providers, and have been engaged in developing individualized care plans that suit their needs. Ms. Angus gave a variety of concrete examples of how this Health System Transformation is already underway and making an impact in the cardiac care community.

Why a provincial heart failure strategy is necessary

Ms. Kori Kingsbury, CEO of the Cardiac Care Network of Ontario (CCN), began this session by providing an overview of the origin and evolution of CCN, with a focus on the integral role CCN plays in ensuring the delivery of high quality adult cardiovascular care in the province. Ms. Kingsbury then painted a picture for the audience of the typical HF patient in Ontario as frail, elderly, and having multiple chronic comorbidities. The burden of this complex disease was then described as well as variations to accessing care across the province as a result of a fragmented system of care with insufficient emphasis on chronic disease management. Ms. Kingsbury proceeded to describe the extensive environmental scan conducted by CCN to determine existing HF services and resources. The differences between hospital-based and community-based clinics were noted, in particular disparities in ability to titrate medications, number of referrals, and complexity of patients. Ms. Kingsbury highlighted the many key initiatives underway across the province, and the opportunity that we have to improve care and support patients and caregivers living with this complex illness.

Please click here for a link to the slides from this presentation.

Heart failure: Bridgepoint's evolving complexity model

Ms. Marian Walsh, CEO of Bridgepoint Active Healthcare, provided an overview of Bridgepoint, a rehabilitation hospital in Toronto that strives to meet the needs of people living with complex health problems and disability. With the goal to provide integrated care, there is a shift away from isolated treatment by multiple care providers to a collaborative plan that encompasses each patient's individual medical and psychosocial well-being. Using an Active Healthcare Model, the patient is at the centre of their care as each patient receives a comprehensive assessment and an individualized care journey that is right for them. Services are delivered through the integration of specialized inpatient, outpatient, and ambulatory programs and in collaboration with community partners based on individualized patient need. Ms. Walsh also shared her personal experience about her father who was living in Newfoundland with HF. His care was primarily managed by his family doctor, who she described as the 'pillar' of his care. However, when his symptoms advanced and despite his desire to be managed at home, his only option for additional help was to seek treatment at the Emergency room. The challenges faced by her father and family during these difficult times had an influence on her career journey to her current position as President and CEO of Bridgepoint Active Healthcare.

Heart failure from a primary care perspective

This session began with Dr. Adam Grzeslo sharing a serious, honest look at the challenges that family physicians face on a day-to-day basis in caring for the challenging HF and chronic disease population. Despite Dr. Grzeslo's location in a Family Health Team in Burlington (less than 45 minutes from Toronto), a location and practice type that would traditionally be considered well resourced, Dr. Grzeslo faces challenges in accessing higher levels of care for his patients and access to mentoring and advice from cardiologists and other specialty care providers in his community. Dr. Marie Lynn Lacasse, the session's second presenter, discussed her experiences as a family physician and Chief of Staff at Englehart and District Hospital, located in a small rural town in North Western Ontario, with a catchment area of around 8,600 patients. Dr. Lacasse described strong connections with cardiologists at Health Sciences North in Sudbury (about 3 hours away), whom she calls for support, mentoring, and access to higher levels of care. Additionally, Dr. Lacasse discussed a recent addition to the Englehart and District Family Health Team, the Ontario Telemedicine Network Telehomecare program for HF and Chronic Obstructive Pulmonary Disease (COPD). This program enables patients with these chronic diseases to benefit from monitoring in the home as well as self-management education. While there are still many challenges for the Englehart and District community, including timely access to diagnostics and specialists, Dr. Grzeslo and Dr. Lacasse's presentations challenged the dominant discourse that urban communities have many resources, while rural and remote communities often work in isolation.

Please click here for a link to the slides from this presentation

Heart failure and special populations

In a dynamic "tag-team" session, Dr. George Heckman began with a call to action—the burden of HF is on the rise—incidence is increasing, hospitalizations are growing, and patients with HF are living with serious challenges like frailty and cognitive impairment. Dr. Arlene Bierman then stepped up to highlight the variations in HF outcomes as a result of income disparities as well as geographic differences (e.g. between rural and remote communities). Using data from the POWER study (www.powerstudy.ca), Dr. Bierman explained that sizable variations in rates of hospitalization between LHINs may result from inequities in access to and/or quality of care. Low income Ontarians, older adults, individuals with multimorbidity and frailty, and those living in rural and remote communities are all at increased risk for having a potentially avoidable hospital admission for heart failure. Dr. Bierman highlighted the urgent need for an integrated, proactive, patient-centred approach to managing chronic disease. Dr. Heckman returned to the microphone to discuss the challenges faced by frail, older adults living in the home, some with home care services, and some with no support services whatsoever. For those who are connected to home care services, there is a rich dataset from the interRAI that offers the potential to improve care by anticipating the risk of emergency department use (e.g. the DIVERT scale, Costa, 2013). Another vulnerable group is the long-term care population (approximately 20% of which are living with HF) who are particularly prone to emergency department visits and increased hospitalization with longer length of stay. Dr. Heckman's closing remarks reminded us that HF truly is a disease of the elderly. Dr. Heckman urged cardiologists, geriatricians, and family physicians to work collaboratively, and to help address knowledge gaps in clinical skills related to recognition, diagnosis, and management of HF. Ultimately, the need for an integrated approach involving open communication with patients and caregivers is urgently required to improve care delivery and outcomes for patients with HF.
Please click here for a link to the slides from Dr. Heckman and Dr. Bierman

Key performance and outcome indicators for heart failure

Dr. Jack Tu shared his expertise and enthusiasm for 'measuring care' as a method to assess the performance of healthcare organizations or individual practitioners within an organization. Dr. Tu outlined the decision making process by which the Canadian Cardiovascular Outcomes Research Team (CCORT) and the Canadian Cardiovascular Society (CCS) selected the process-of-care and quality indicators for HF. Despite the need to measure and evaluate care, challenges regarding data collection from administrative and clinical data sets were presented. For example, simply defining and determining a valid diagnosis for HF or determining HF with reduced or preserved ejection fraction using administrative data sets can be quite complex. Dr. Tu also shared data from studies to improve target levels for quality indicators in HF through 'report cards' interventions. Although there were some modest improvements in process-of-care measures, wider variations in HF care and outcomes persist in Ontario. Finally, current risk adjustment models to help predict mortality in people with HF (e.g. EFFECT - HF risk index and the EHMRG) were presented. Even though a number of key HF performance and outcome indicators have been developed, Dr. Tu summarized by suggesting that we need to design efficient clinical data collection methods, be able to distinguish between cases with preserved and reduced ejection fraction, and strive for better outcomes in people living and dying with HF in Ontario.
Please click here for a link to the slides from this presentation

CCN Provincial Heart Failure Strategy

The speaker sessions culminated with the presentation of the CCN Strategy for the Community Management of Heart Failure. Highlights from the development of the strategy and recommendations were presented by Dr. Robert McKelvie, the chair of the CCN-HFWG. After a brief recap of the limitations of the current system and challenges with managing patients with HF, Dr. McKelvie introduced the CCN HF Strategy. This included a summary of the process and key findings from the development of the CCN Heart Failure Strategy (Appendix B), and the three key recommendations which included: 1. Development of standardized tools and resources, 2. Improve organization of care, and 3. Enable measurement and improvement. Examples of these recommendations, including the introduction of a hub-and-spoke model of care, were shared with the audience while making reference to alignment of the CCN Heart Failure Strategy with other current health initiatives such as Health Links, Health Quality Ontario's Quality Based Procedure for community management of HF (currently in development) as well as Ontario's Health for Action plan.
Please click here for a link to the slides from this presentation

Key takeaways from audience participation

The following points represent a consolidation of the discussion points after each speaker and during the question and answer period with the panel at the end of the day. Members of the panel included: Ms. Kori Kingsbury, Dr. Robert McKelvie, Dr. Adam Greszlo, Dr. George Heckman, Dr. Marie Lynne Lacasse, and Dr. Jack Tu.

Questions for the participants reflected the passion in the room for the desire to improve outcomes for people with HF and the need to feel part of/informed about the strategy as it moves forward. Attention to including the voices from allied health, caregivers and patients in future activities received support from the panel and audience.

Participants shared examples of how they are using a model that supports a holistic patient approach, supports a chronic disease model and facilitates integration of key care partners (e.g. Mount Sinai HF clinic, Health links initiatives- Prince Edward FHT, The Horizon team FHT). The panel highlighted that the HF Strategy is not intended to duplicate services, but to align with and leverage from current resources/ chronic disease programs.

Examples of challenges with implementing an integrated 'hub and spoke' model for patients with HF included the logistics and confidentiality regarding a provincial shared electronic data set for patient care and clinical level data, local interests (e.g. local LHIN focus of attention),and local challenges (e.g. patient population, lack of resources). The 'elephant in the room' was funding and panel members agreed that this deserves recognition and high level discussions are beginning.

In order to move forward, Ms. Kingsbury and Dr. McKelvie expressed the need for centres/stakeholders to complete the online survey developed by CCN (https://www.surveymonkey.com/s/CCNHeartFailure). This survey will help identify current services and gaps in addition to the current 'hubs and spokes' that exist. Participants asked that an inventory be made available for clinicians/stakeholders to help them locate and navigate through the network of services/resources in their area.

Part 2. Key takeaways based on evaluation forms

Evaluation forms were provided in each participant's package requesting feedback regarding the overall Forum and facilities. Approximately 100 evaluation forms were returned and the following section presents a summary of the responses from Likert scale items and open ended questions.

Likert scale responses

General Evaluation of the CCN Provincial Heart Failure Strategy Forum and Facilities:	Excellent	Good	Average	Fair	Poor	No Resp
Please rate your overall satisfaction of the CCN Provincial Heart Failure Strategy Forum:	56	31	1	1	0	11
Please rate your overall satisfaction with the format of the CCN Provincial Heart Failure Strategy Forum (i.e.- morning sessions, breaks, lunch, afternoon sessions): ➢ Moved well; presentations relevant and concise	53	35	1	0	0	11
Please rate your overall satisfaction with the lunch and breaks: ➢ Needs to be longer ➢ Need break before final panel	47	30	9	0	0	14
Please rate your overall satisfaction with the facilities: ➢ Room too cold ➢ Hotel room rate expensive ➢ Posts blocking view ➢ Exceptional customer service	47	33	8	1	0	11
Please rate your overall satisfaction with the location of the CCN Provincial Heart Failure Strategy Forum (Toronto Marriott Bloor Yorkville Hotel):	54	25	10	2	0	9
Overall, based on your total experience at CCN Provincial Heart Failure Strategy Forum , would you attend or recommend someone else attend a CCN Provincial Heart Failure Strategy Forum:	61	27	1	0	0	11

Open-ended questions

1. *Please provide an example of how your practice will change as a result of attending the Forum.*

Major Theme	Sub-themes	Examples
Broader approach to patient care	Increase communication with care partners	Actively collaborate with HF clinic, enhance communication with family physician, communicate with family physician and not just cardiologist.
	Expand utilization of allied health professionals	Consider more help from CCAC e.g. RD, exercise, palliative care. Advocate for presence of allied health professionals in HF clinic.
	Consider impact of co-morbidities	Building HF clinic, will now consider chronic disease clinic, screening for cognitive impairment.
Improved system integration	Pay more attention to transitions between acute and outpatient care	Develop and improve plans of care to follow through continuum. Importance of transitioning patients to HF clinic and cardiac rehabilitation.
	Enhance partnerships at system level	Liaise with family physician on how to improve coordinated care, continue to work to improve strategies with community links, take more leadership role to assist with community FHT, explore link with LHIN.
Measurement	Consider patient triage	Attention to triage of HF patients, establishing a gold standard for diagnosis, management for the level of illness and needs of each patient.
	Increased appreciation of patient outcomes	Clear outcome indicators; include components of QBP being implemented. Set measureable goals for patient, meet benchmarks.

2. *What were the major strengths of the CCN Provincial Heart Failure Strategy Forum?*

Diversity: Multiple responses highlighted the 'broad approach', 'diversity and expertise of speakers', the diversity of Forum attendees, 'gathering of stakeholders across sectors', and 'key players at the table'.

Discussion: Multiple responses also indicated the opportunity for discussion after each speaker and with the panel at the end of the sessions as a major strength. They found the Forum had "very thoughtful and provoking discussion" and was 'interactive and inviting'.

3. *How could the CCN Provincial Forum be improved?*

Content: Focus more on the 'how' versus 'what' needs to done: Participants indicated a desire for more information on implementation ideas, real world examples of the 'how', and opportunities to share challenges and solutions.

Representation: More input from allied health members/interdisciplinary speakers (e.g. nurses, pharmacists, physiotherapists, dietitians, home care partners). Invite patient as a speaker.

Structure: Slides ahead of time, more opportunity for networking and interaction, case-based approach, reach out to others who couldn't attend in person (e.g. webinar).

Part 3. Exploring next steps /looking ahead.

The implementation has already begun. Key areas include:

1. Completion of the survey: The purpose of the survey is to describe and develop an inventory of the outpatient services for HF patients in Ontario that will be used to guide a gap analysis for this patient population. Follow up to the gap analysis will be recommendations to augment regional/local resources to support the care of HF patients across the continuum of care.

2. Building regional networks (hub/spokes/resources): Existing 'hubs' and 'spokes' will be identified from survey/inventory results. This inventory of HF services in Ontario is considered a dynamic document that will be updated regularly by CCN to facilitate networking and service navigation for care providers.

3. Working with LHINs/inter-agency collaboration (e.g. CCACs, etc), the CCN will expand networking and interaction with these key stakeholders at an administrative and clinical level to explore/support successful initiatives for HF management. This engagement will help to develop a deeper understanding of current challenges, and explore opportunities for further development and optimization of HF patient care in the community.

4. Standardized training programs, HF resources, patient tools, etc: Tools and resources will be developed by the CCN team in collaboration with the HF working group and clinicians (physicians and allied health members) over the next several months. A standard tool kit for HF risk assessment and clinical pathways to define best clinical practices to optimize care based on risk stratification will be developed and shared as a resource to support initiatives underway at the LHIN and regional level (e.g. supported by Health Links). Input from patients/family caregivers will be included for development and evaluation of patient education material.