



A Roadmap for Improving Integrated Heart Failure Care in Ontario

Recommendations

May 2019

About CorHealth Ontario

Since June 2017, we became CorHealth Ontario, an entity formed by the merger of the Cardiac Care Network of Ontario and the Ontario Stroke Network. Our expanded mandate spans cardiac, stroke and vascular through the entire course of care, including secondary prevention, rehabilitation and recovery.

CorHealth Ontario proudly advises the Ministry of Health and Long-Term Care, Local Health Integration Networks, hospitals and care providers to improve the quality, efficiency, accessibility and equity of cardiac, stroke and vascular services for patients across the province.

Acknowledgements

CorHealth Ontario would like to thank and acknowledge the Ministry of Health and Long-Term Care, the members of the Provincial HF Roadmap Task Group and many other key contributors who generously contributed their time, resources and expertise to this work. A full list of contributors can be found in Appendix B. The Provincial HF Roadmap Task Group was co-chaired by Ms. Debbie Korzeniowski and Mr. Ted Alexander. We thank them for the leadership and guidance they offered in all aspects of this work.

Executive Summary

Along the continuum of cardiac disease, heart failure (HF), with its associated poor outcomes and high utilization of health care resources, has emerged as an area of focus in recent years. There is currently no single entity responsible for ensuring that all parts of HF care (e.g. acute care, community care, performance measurement and monitoring, funding, and others) are considered together and that the cycle of system quality improvement is consistently orchestrated. As such, there is considerable variability and fragmentation of patient care and outcomes in Ontario. CorHealth Ontario has a mandate to drive evidence-based practice, planning and resource allocation, and to measure and report on quality and outcomes, and is well-positioned to partner with key stakeholders to help steward a more coordinated and patient-centred approach to HF care.

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) and the provincial level (among system agencies). With an outstanding demonstration of commitment and engagement, 3 Early Adopter Teams agreed to take on the Integrating Heart Failure Care Initiative (IHFCI), and are testing the implementation of a collaborative model of quality HF care delivery. This Roadmap is a culmination of the learnings from the sites, and aims to provide guidance and critical considerations to HF care providers and leaders across Ontario on implementing integrated and evidence-based HF care.

This important work could not have been undertaken without the generous contributions in time, energy and expertise of the Provincial HF Roadmap Task Group, key stakeholders, health care providers, patients and system partners. It is our hope that the efforts of the Early Adopter Teams, along with this Roadmap to guide others, begins to lay a foundation for improved HF care in Ontario at the system, provider and patient levels.



Sheila Jarvis
Interim CEO

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Purpose of this Document

The purpose of this document is to provide recommendations and guidance to heart failure (HF) care providers and leaders across Ontario around implementing integrated and evidence-based HF care. In doing so, the following outlines the Integrating Heart Failure Care Initiative (IHFCI), and presents the learnings gained from 3 Early Adopter Teams in Ontario. The key learnings to date are summarized as a “Roadmap for Improving Integrated HF Care” with recommendations around *how* to implement a [model of integrated care](#) delivery (Box 1) and a HF care [quality standard](#) (Box 2).

An [Evaluative Report](#) which includes more detailed information on the Early Adopter Teams’ experiences, as well as an evolving [Implementation Support Toolkit](#) (See Appendix C for an outline of the toolkit), complement the information within this document. These are available on the CorHealth Ontario website (www.CorHealthOntario.ca) and will be referenced throughout.

This Roadmap highlights the critical success factors for providers, teams, and organizations across Ontario to deliver HF care to patients that is seamless and connected, and that meets a standard of quality. Creating a connected system that supports care delivery (i.e. the integrated care model) and ensuring the care itself meets a standard of quality (i.e. the quality standard) are distinctly different in scope, yet complimentary and synergistic to improve HF care.

Box 1 – The Spoke-Hub-Node Model of HF Care	Box 2 – Heart Failure Care in the Community Quality Standard
<p>The Minimal Requirements and Key Clinical Services for Heart Failure Programs within a Spoke-Hub-Node Model of Care was released by CorHealth Ontario in 2017, and is an evidence-based strategy to patient-centred HF management that is rooted in highly integrated and connected care teams across the entire care continuum (e.g. primary care, specialty services, and community-based teams of health care professionals).</p>	<p>The Heart Failure Care in the Community for Adults Quality Standard was released by Health Quality Ontario in February 2019. This quality standard includes 10 quality statements which address care for adults who have HF. It applies to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care.</p>

Introduction

About Heart Failure

HF is a complex and chronic condition where the heart is no longer able to meet the metabolic demands of the body. The most common symptoms of HF include shortness of breath, fatigue, and leg swelling (Ezekowitz et al., 2017). Even with advancements in treatment, HF continues to be a progressive and ultimately fatal condition – 50% of people with HF will not be alive within 5 years of diagnosis (Roger, 2013).

HF 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 (HQO, 2019). HF hospitalization is expected to increase, with a 3-fold increase between 1996 and 2050 (O’Meara et al., 2014).

Approximately 250,000 people in Ontario are living with HF (HQO, 2019).

Heart failure predominantly impacts older adults. Roughly 80% of individuals with HF are over the age of 65 (HQO, 2019).

HF can be difficult to diagnose and manage. Much of what is known about the diagnosis and management of HF is based on research in men and with reduced ejection fraction (i.e. a “pumping” problem in the heart). HF with preserved ejection fraction (i.e. a “filling” problem in the heart) is much less understood by providers and has similar outcomes as HF with reduced ejection fraction (Loop et al., 2016), but with a higher prevalence in women (Sun et al., 2018). Managing HF is also complicated by coexisting comorbidities. In Ontario, approximately 1/3 of individuals with a diagnosis of HF have four or more other coexisting chronic conditions (HQO, 2019). There are many aspects of managing HF that are not well understood, however, what is becoming increasingly apparent is that in order to improve HF care, more coordinated and systematic approaches to organizing care are needed (Hayes et al., 2015).

HF is a chronic, progressive condition

There is no cure for HF. It is progressive condition with periods of stability interrupted by periods of worsening symptoms and instability, often leading to hospitalization (Figure 1).

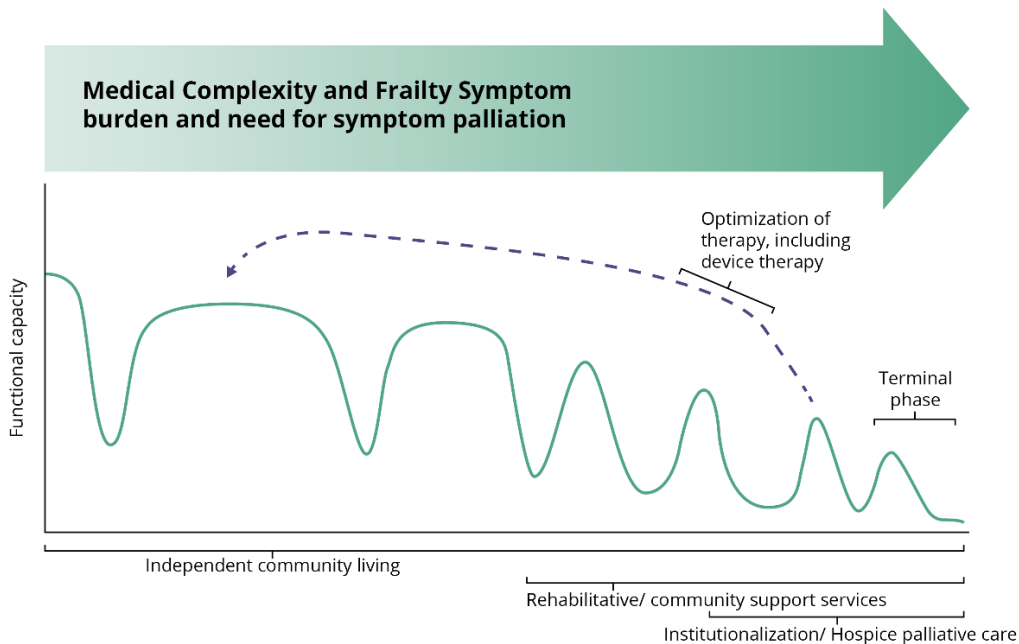


Fig. 1 - The trajectory of heart failure (Heckman et al., 2014)

Impact of HF on patients and caregivers

Living with HF can severely restrict an individual's ability to perform their activities of daily living, their psychosocial wellbeing, and their independence, as well as negatively impact their cognition and quality of life (Jeon et al., 2010; Cannon 2017). Social isolation, losing a sense of control, and feeling poorly equipped and supported to care for oneself are some common themes heard from patients living with HF (Jeon et al., 2010). Family caregivers often provide a substantial amount of support for their loved one with HF and are at risk for caregiver burden and poor quality of life (Noonan, 2018).

System-level integration needed to support people with HF

Currently, the health care system in Ontario is failing people living with HF and their caregivers. Without substantial change to system structures and funding policies, the overwhelming high use of acute care services by this patient population, inefficient use of expensive healthcare resources, poor patient outcomes, and poor patient and caregiver experiences with fragmented care will continue (Wodchis et al., 2016).

The dynamic nature of HF presents challenges in its care and management, with patients receiving care in primary, acute and community care settings, and with frequent

A Roadmap for Improving Integrated Heart Failure Care in Ontario

transitions between care providers (Virani et al., 2017). These frequent transitions of care across multiple providers and multiple settings are poorly coordinated, leaving patients and caregivers feeling frustrated, confused, and with poor health outcomes (Sevilla-Cazes, 2018).

As with other chronic and complex conditions, improvements in patient care require a coordinated and connected system that enables the efficient and safe transition of patients across the various levels of care. There is a growing body of evidence to support that it is the model of care delivery, that is, connected and seamless system level integration, that could benefit from improvement efforts (Ezekowitz et al., 2017; Huitema et al., 2018), and lead to better outcomes for patients with HF.

The Opportunity for Improving Heart Failure Care

In recent years, there have been pockets of innovation in some areas of the province for improving HF care, as well as several guidance documents disseminated to promote and define HF care quality improvement (Box 3). Nevertheless, patients with HF continue to experience high readmission and mortality rates.

As with other chronic conditions, patients living with HF experience frequent transitions in care. These transitions, along with the complex nature of HF management, present many opportunities for improvement, specifically around 'how' and 'what' care is provided.

Box 3 – Guidance Documents around HF Care

- *Strategy for Community Management of Heart Failure in Ontario (CorHealth Ontario, 2014)*
- *QBP Clinical Handbook for Heart Failure (Acute and Post-acute) (HQO, 2015)*
- *Minimal Requirements and Key Clinical Services for HF Programs within a Spoke-Hub-Node Model of Care (CorHealth Ontario, 2017)*
- *Heart Failure Care in the Community Quality Standard (HQO, 2019)*

IHFCI was broadly aimed at transforming the coordination of HF care. Specifically, IHFCI involved the implementation of CorHealth Ontario's 'Spoke-Hub-Node' model of organizing HF care (the Model of Care), and HQO's Heart Failure Care in the Community Quality Standard (the Quality Standard). Through the work of the 3 Early Adopter Teams, the hope was to understand **how** providers and teams could improve HF care, with regard to:

- Improving compliance with clinical best practices
- Reducing variation in practice and outcomes
- Improving patient and caregiver experience
- Providing evidence-based care closer to home
- Integrating care across the continuum
- Increasing efficiencies and better value for money

For more detailed information on the approach, activities and learnings from the 3 Early Adopter Teams, please refer to the [Evaluative Report](#).

The Approach to IHFCI

The Idea

Despite the many efforts already made in HF quality improvement in Ontario, it was recognized that a better understanding was needed around how to *organize* evidence-based HF care, and what is required to enable seamless transitions in care. CorHealth Ontario's Spoke-Hub-Node model of HF care, and HQO's HF Quality Standard created an opportunity to test their implementation and begin to better articulate the requirements to enable integrated, quality HF care.

Early Adopter Teams

Testing the implementation of the model of care and quality standard required willing volunteers of care providers, teams and administrators. As the initiative evolved, several stakeholders known to CorHealth Ontario self-identified as champions of HF care. These individuals represented three areas across the province: London-Huron Perth, the Ottawa area, and Guelph. Within each of these geographical areas, small working groups formed to learn about HF, the model of care and quality standard, and how they could work together to improve care. Additional details regarding membership of Early Adopter Teams can be found in the supplementary [Evaluative Report](#).

CorHealth Ontario

The role of CorHealth Ontario was to support the Early Adopter Teams, providing some clinical education, meeting facilitation, interpretation of the model of care and quality standard, as well as some project management support. Each site was assigned a Project Manager, who provided the team with leadership, coordination, and liaised between the Early Adopter Team and CorHealth. As the work evolved in each site, their experiences and learnings were shared through meetings and teleconferences with CorHealth and through documented reports.

CorHealth Ontario's ongoing role is to act as a steward of continuous system level quality improvement in HF care through:

- Coaching;
- Fostering peer to peer connections and mentoring;
- Knowledge translation; and
- Supporting an integrated approach to HF care and funding.

The Patient and Caregiver Voice

From the Patients First Act (2015) to the People's Health Care Act (2019), meaningful engagement of patients and caregivers in Ontario's healthcare planning and transformation is increasingly held as an expectation and a necessity in order to deliver patient-centred care. For care to be centred on patients, they must be part of the discussion.

Throughout the IHFCI, CorHealth and the Early Adopter Teams worked with patients and caregivers to ensure that their experiences were shared and informed the work. Through ongoing discussion and engagement, several clinical care gaps were identified by patients and caregivers as areas in need of HF improvement initiatives (Box 4). These were similar to those identified in the Quality Standard (HQO, 2019). Beyond working with patients and caregivers to identify the issues, co-designing solutions together will help ensure the work being done will ultimately meet their needs.

Box 4 – Areas of HF quality improvement as identified by patients and caregivers involved in the IHFCI

- More timely diagnosis of HF, which may be aided by improved access to diagnostic testing (ECHO, BNP testing), and HF expertise
- Psychosocial support for patients with HF and their caregivers, including support groups, and better palliative/supportive care
- Access to HF care, expertise and resources closer to home (especially among rural populations)
- HF education for patients and caregivers
- Advance care planning

A Roadmap for Improving Integrated HF Care

This Roadmap for Improving Integrated HF Care, informed by the learnings of 3 Early Adopter Teams across Ontario, aims to support health care sectors in working effectively together and taking action to improve the care of patients living with HF. The recommendations in this Roadmap aim to answer two questions: How do we implement integrated HF care? And how do we ensure HF care being provided meets a standard of quality?

This Roadmap for Improving Integrated HF Care is described in three phases:

- **Phase 1:** Getting Started
- **Phase 2:** Taking Action
- **Phase 3:** Sustaining, Scaling Up and Spreading

Through testing by implementation at the 3 Early Adopter Teams in 2018/19, CorHealth Ontario's Heart Failure Roadmap Task Group worked to refine the critical considerations that were agreed as a necessary lens through which to prioritize recommendations in each phase. The result of this work is a roadmap of 3 phases, each of which includes an *overview* of the phase, and the *recommendations* around what should be done during that phase.

Within each phase there are also 'Practical Tips' which include some helpful considerations gleaned from the Early Adopter Teams' experiences, as well as suggestions around what to look for 'From the Toolkit' to apply as enablers of that recommendation.



Practical Tips!



From the Toolkit...

Critical Considerations

Several considerations that are critical for success, were identified across the 3 Early Adopter Teams. These considerations are integral to the successful implementation of a HF quality improvement endeavor. These considerations are a common thread across the recommendations and in the remainder of this document, the icons will appear beside the associated recommendations.



Patient and Caregiver Voice

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



Collaborative Leadership

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



Education

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



Data and Reporting

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

Phase 1: Getting Started

Overview

Transforming the structure of HF care delivery is a long-term endeavor requiring a strategic and well-considered plan. The effort required up front is significant and must be emphasized as it represents a major shift in the current delivery of care. Many activities are needed to set the stage for the successful and sustainable implementation of an improvement initiative. Different teams and regions of the province (e.g. urban vs rural) will have varying approaches. Regardless of the order of activities, the following should take place during the planning phase, and are described in greater detail in the recommendations below:

- Identifying the spoke(s), hub(s) and node;
- Identifying clinical and administrative leadership (sponsor) from the spokes, hubs and node;
- Engaging patient and caregiver representatives from the spokes, hubs, and node, to include them from the very beginning;
- Educating participants on HF, the integrated model of care, and the quality standard;
- Acquiring data (through EMR, system level data files, surveys) to inform a current state, challenges, and areas requiring improvement; and
- Gaining commitment from leadership to acquire or leverage resources that can be dedicated to the work.

Phase 1 Recommendations



Recommendation 1: Establish a local leadership table and an implementation structure that includes integrated clinicians and administrators spanning the continuum of HF care (e.g. at the spoke, hub and node levels). This starts with getting to know who the local HF champions and stakeholders are, ensuring there is engagement with them, and identifying the spokes, hubs and nodes.



Practical Tip!

- To learn more about what Recommendation 1 looks like in action, refer to the Early Adopter Teams' description of their experiences in the [Evaluative Report](#).



From the Toolkit...

- A [Business Case for Integrated HF Care](#) may be a practical communication tool to engage leadership in discussion and gain sponsorship for integrating HF care.
- HQO's '[A Case for Improvement](#)' provides a ready-to-use slide deck that succinctly communicates the need for HF quality improvement.
- Refer to the '[Spoke-Hub-Node Model of HF Care](#)' folder from the toolkit for help with understanding the model of care, and for tools to help teams understand if they are a HF spoke, hub, or node.



Recommendation 2: To help identify impactful, feasible and achievable initiatives, use available information and data to inform a *comprehensive current state* and understand local integration and HF care needs (e.g. clinical care gaps, non-rostered patients, alignment with concurrent HF activities). Review current state assessments against the HF Quality Statements.



Practical Tips!

- Spend time considering the gaps and opportunities in the transitions across spokes, hubs and nodes.
- Pick 'low-hanging fruit' that everyone can agree to work on, to help build momentum.



From the Toolkit...

- The Ottawa Early Adopter Team developed a '[Self-Assessment on HQO HF Quality Statements](#)' which can provide a quick snapshot of how providers are performing against the 10 Quality Statements.
- Based on current state and gap analysis, identify clear areas for improvement and set manageable goals and initiatives to start. Refer to the '[Environmental Scanning](#)' folder of the Toolkit, and HQO's [Getting Started Guide](#).



Recommendation 3: Take the necessary time to actively engage with patients living with HF and their caregivers during the planning phase, and let their experiences, stories, and viewpoints guide the local priorities.



Practical Tips!

- Healthcare providers can help identify and assist with engaging patients with HF and their caregivers.

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- Draw upon existing Patient and Family Advisory Councils (PFACs) to find patients and caregivers. There may already be established PFACs in healthcare organizations or healthcare leadership tables within the community.
- Investigate patient communication opportunities (i.e. part of eReferral, provider to patient e-mails).



From the Toolkit...

- Refer to the [Patient and Caregiver Engagement](#) folder of the Toolkit for helpful resources. Several resources from [The Change Foundation](#) can help with getting started with patient and caregiver engagement.



Recommendation 4: Provide targeted HF educational opportunities for providers (at the spoke, hub and node levels), as an effective way to increase HF expertise, generate interest and to find undiscovered HF champions, willing participants, and supporters.



Practical Tip!

- Refer to the [Evaluative Report](#) to learn about the Early Adopter Teams' experiences with providing HF educational opportunities.



From the Toolkit...

- Refer to the '[Heart Failure Education](#)' folder of the Toolkit for various HF education links and resources for providers and patients/caregivers.

Phase 2: Taking Action

Overview

Once the team is identified and an agreed upon work plan is established, teams can begin to take action. Selected initiatives and projects are dependent upon locally identified priorities and approaches. However, certain strategies and critical success factors related to collaborative leadership, the patient and caregiver voice, and data and reporting, should be considered, and are detailed further in the recommendations below.

Based on the learnings from the Early Adopter Teams, what is certain is that this work requires a sustained commitment of time, energy and resources. This is not work that can be done 'off the side of the desk'. Collaboration and innovation are needed among teams to jointly identify, leverage and share resources, including human resources (e.g. coordinators and project managers), technological resources (e.g. eReferral, EMR tools, remote conferencing), and stakeholder networks (e.g. telehome monitoring, relationships with homecare organizations, palliative care, rehab), to name a few.

Patient and caregiver engagement does not end at the planning phase, and must continue into the design and execution of solutions. Their continued involvement is critical to help teams stay the course. As the work of integrating quality HF care progresses, goals and approaches may evolve - this is expected. However, teams must continue to assess whether their work is impacting patient experiences and health outcomes.

How do you know you have integrated HF care? How do you know the HF care you are providing meets the standard of quality? There is a long way to go with measuring and reporting on HF care. However, having clear project objectives, and beginning to measure, monitor and report on HF locally, in a coordinated fashion, and across a patient journey, will begin to inform a provincial strategy for system-wide performance measurement and monitoring of HF care.

Phase 2 Recommendations



Recommendation 5: Leaders focus on the outcomes for the patients they jointly serve. To connect care for the HF population, leadership at the spoke, hub and node levels should work collaboratively and innovatively to identify, leverage and share resources to support local coordination and implementation, including human resources, technological tools, and be open to expanding and sharing stakeholder networks.



Practical Tip!

- Communication is vital to sustaining engagement, accountability, relationship building, and change management and can be accomplished by establishing different communication channels and platforms (e.g. regular meetings or teleconferences, email groups, document sharing platforms), assigning at least one individual who is accountable for communicating project progress, finding ways to remain informed in the face of competing priorities (e.g. assigning proxies to attend meetings).



From the Toolkit...

- A [Project Charter](#) and a [Terms of Reference](#) are basic project management tools that can provide a newly formed team with a shared understanding of the group's purpose and commitment. Templates for these can be found in the '[Project Management Resources](#)' folder.



Recommendation 6: As work plans are implemented, project goals may evolve. Patients and caregivers should continue to be regularly engaged and have ongoing opportunities to provide leadership and insight to the work, and informing “will this improve patient care?”



Practical Tip!

- For more guidance on co-designing solutions with patients and caregivers, refer to the [Change Foundation](#) website.



Recommendation 7: Focus quantitative and qualitative measurement and key data elements on project implementation objectives. Use data gathered to drive quality improvement.



Practical Tips!

- HQO collects HF indicators using administrative data sets – these can provide some guidance around key data elements to consider. Refer to the [HQO Heart Failure Quality Standard](#) website for a Data Table and Measurement Guide.
- Consider using data collection forms that are standardized and shareable across sites.
- Refer to the Canadian Cardiovascular Society '[Quality Indicators for Heart Failure](#)'.

Phase 3: Sustaining, Scaling Up, and Spreading

Overview

Sustaining the work implies commitment to move forward in the face of challenges, and continuing to strive for improvements even after early successes are celebrated. Integrating HF care is the forging of new pathways, relationships and networks that take time and attention to strengthen and take hold permanently. It is the creation of a new normal in HF care. Sustaining also means remaining committed to ensuring the voices of patients and caregivers continue to be heard.

Scaling up implies building on what has been done and making it better. It means moving beyond the 'low hanging fruit' and tackling some bigger issues in HF care. Locally, this may mean tailoring solutions to meet urban and rural populations, building new partnerships, or implementing this work as a complementary element of an Ontario Health Team. At a system level, this may mean exploring and implementing new approaches to supporting integrated care, such as funding models, or implementing data and reporting mechanisms, as standardization, collection and sharing of HF data is currently very limited.

Spread happens locally and provincially. All patients with HF should have the right to reap the benefits of an integrated approach to their HF care. All providers of HF care, whether at the spoke, hub, or node level, have a responsibility to patients to improve their care. Engaging in an integrated approach and becoming more knowledgeable on quality HF care are essential for success.

Having leaders who are enablers, continuing to engage patient and caregivers, and establishing a provincial reporting strategy for HF are some identified critical success factors for ensuring this work can continue into the long-term.

Phase 3 Recommendations



Recommendation 8: Clinical and administrative leadership at the spoke, hub and node levels, function together as a team to champion and endorse an integrated approach to HF care, through *fostering partnerships and acting as enablers*.



Practical Tips!

- Early Adopter Teams, and others who embark on this work over time, become mentors to others who are interested, providing advice and sharing experiences.
- Build strategic partnerships with other complex care programs that have implemented integrated structures to find alignment and efficiencies (e.g. other chronic disease management programs).
- Work together on solutions for joint accountability.
- Join HQO's [Quorum](#), an online community for health care quality improvement, to find ideas, collaborate, and share your work.



Recommendation 9: Regular and iterative patient and caregiver engagement continues, with an ongoing focus on identifying and prioritizing areas to improve the patient and caregiver experience. This can be supported through evaluating Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs).

About PREMs and PROMs:

Increasingly, evaluating health system performance is going beyond clinical and administrative data, and including the patient perspective (CIHI, 2017).

Patient-reported experience measures (PREMs) provide information on satisfaction with the experience of receiving health care, focused on the process of care delivery (CIHI, 2017).

Patient-reported outcome measures (PROMs) provide information on a patient's overall health to assess the effectiveness of care provided, from the patient's view (CIHI, 2017).



Practical Tips!

- Sustainable and effective patient and caregiver engagement require time, commitment and application of a few key success strategies. Refer to [“Rules of Engagement: Lessons from Panorama”](#) from the Change Foundation – their top tips for patient engagement.
- Leverage existing best practices in PREMs and PROMs from experts, such as CIHI.



Recommendation 10: Look to quantitative and qualitative data that have been collected for project objectives to begin to inform areas of success and future areas of improvement.

Summary

CorHealth Ontario embarked on the Integrating Heart Failure Care Initiative because improving the outcomes and experiences of patients living with HF in Ontario is a priority. As with HF, care organizers overseeing other complex and chronic conditions may also find value and relevance in the information presented in this document. The 10 recommendations within this roadmap offer a pragmatic and tangible approach to implementing integrated and standardized care. Along with the [Evaluative Report](#) and the Implementation Support Toolkit, those who are interested in doing this work will hopefully be enabled and emboldened to do so. CorHealth Ontario continues to recognize the immense value of improving HF care in Ontario and will continue to offer support where possible to other agencies and champions of heart failure care.

Appendix A - Abbreviations

The following abbreviations, listed alphabetically below, are used in this document:

BNP – Brain Natriuretic Peptide

CIHI – Canadian Institute for Health Information

ECHO – Echocardiogram

EMR – Electronic medical record

HF – Heart failure

HQO – Health Quality Ontario

IHFICI - Integrating Heart Failure Care Initiative

MOHLTC – Ministry of Health and Long-Term Care

PFAC – Patient and Family Advisory Committee

PREM – Patient Reported Experience Measure

PROM – Patient Reported Outcome Measure

QBP – Quality Based Procedure

UOHI – University of Ottawa Heart Institute

Appendix B - Acknowledgements

CorHealth Ontario would like to thank and acknowledge the members of the CorHealth Ontario Heart Failure Roadmap Task Group, as well as other key contributors.

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Appendix C – Outline of the Implementation Support Toolkit

The Implementation Support Toolkit is an evolving resource. Over time, resources and tools may be added, revised, or removed as required. The Toolkit includes:

1. An Overview of the IHFC Implementation Support Toolkit

2. A Business Case for Integrated HF Care

- i. Integrating HF Care – Frequently Asked Questions
- ii. A Business Case Template

3. Environmental Scanning

- i. HQO Heart Failure Data Table
- ii. Environmental Scanning Checklist

4. The Spoke-Hub-Node Model (CorHealth)

- i. The Minimal Requirements and Key Clinical Services for Heart Failure Programs within a Spoke-Hub-Node Model of Care
- ii. Current State Assessment for HF Spoke
- iii. Current State Assessment for HF Hub
- iv. Current State Assessment for HF Node

5. Heart Failure Quality Standard (HQO)

- i. HQO Heart Failure Quality Standard
- ii. HQO Recommendations for Adoption
- iii. HQO Getting Started Guide
- iv. HQO A Case for Improvement Slide Deck
- v. UOHI's Self-Assessment on HQO HF Quality Statements

6. Heart Failure Education for Providers and Patients/Caregivers

- i. Annotated List of Provider Education
 - Chronic Heart Failure: General Information and Practical Tips for Healthcare Providers (CorHealth)
 - ICD Deactivation: A Guide for Healthcare Providers (CorHealth)
 - Heart Failure Education Video Series

- ii. Annotated List of Patient and Caregiver Education
 - Heart and Stroke Foundation's 'Living with Heart Failure'
 - Cardiac Services BC
 - HFMatters.org
 - HQO's Patient Conversation Guide
 - Speak Up (Advance Care Planning and Palliative Care Resources)

7. Project Management Resources

- i. Terms of Reference Template
- ii. Project Charter Template

8. Patient and Caregiver Engagement

- i. Links and resources from the Change Foundation

References

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