Recommendations for Adoption: Heart Failure Care in the Community

Quality Standards

Recommendations to enable widespread adoption of this quality standard

Health Quality Ontario

Let's make our health system healthier

CorHealth Ontario

Advancing cardiac, stroke and vascular care

The Quality Standard for Heart Failure Care in the Community

Quality standards are concise sets of statements outlining what high-quality care should look like across a range of conditions or topics. They represent care that can and should be made available today. Although many organizations, health care professionals, and other health system partners may be offering the care described in the quality standard, the quality statements, related measures, and adoption supports will help organizations determine where they can focus their improvement efforts.

This quality standard addresses care for adults who have heart failure, including the assessment and diagnosis of people with suspected heart failure. It applies to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care.

This quality standard does not address care provided in hospital emergency departments or inpatient settings. It does not discuss heart failure related to inherited cardiac conditions. It also does not address the prevention of heart failure, although it does provide guidance on risks and lifestyle factors that may affect the progression of heart failure. This quality standard was developed in partnership with CorHealth Ontario.

Click here to access the quality standard.

About This Document

This document aims to support uptake of the quality standard at local and system-wide levels. This is achieved through the identification of programs, resources, initiatives, and tools that will support high-quality care on the ground and through the provision of key recommendations that address identified system-level gaps and opportunities for improvement.

Putting the Heart Failure Quality Standard Into Practice

Quality standards are a resource to help health care professionals and organizations make improvements to care based on the best available evidence. While organizations and providers may be offering the care described in this quality standard, the statements, related measures, and existing tools available on Health Quality Ontario's website can be used to guide improvements to care at a local or practice level. Health Quality Ontario's *Getting Started Guide* outlines the process for using the quality standard as a resource for delivering high-quality care.

There are many programs and initiatives across the province that can support the delivery of the care outlined in the quality standard. These resources can be used or referenced when putting the quality statements into practice. See Appendix A for examples.

CorHealth Ontario

CorHealth Ontario is an organization formed by the merger of the Cardiac Care Network of Ontario and the Ontario Stroke Network. Its expanded mandate includes cardiac, stroke, and vascular care.

CorHealth proudly advises the Ministry of Health and Long-Term Care (MOHLTC), local health integration networks (LHINs), hospitals, and care providers to improve the quality, efficiency, accessibility, and equity of cardiac, stroke, and vascular services for patients across Ontario.

The Integrating Heart Failure Care Initiative, championed by CorHealth Ontario and implemented by regional networks of diverse health care providers and teams, is broadly aimed at transforming the management and coordination of heart failure care in Ontario. This initiative will help create or build upon regional alliances of heart failure care providers to generate locally meaningful and innovative solutions that will address current gaps in heart failure care. Solutions will be guided by the latest evidence and best practices, including the "spoke-hub-and-node" model of organizing heart failure care and the quality standard *Heart Failure: Care in the Community for Adults*. The "spoke-hub-and-node" model[i] is a multidisciplinary, team-based approach to improve integration, accountability, and patient management across the care continuum. For more information, visit corhealthontario.ca.

Key CorHealth reports related to community management of heart failure in Ontario were used to inform this document, including the *Strategy for Community Management of Heart Failure in Ontario*[ii] and the *Standards for the Provision of Cardiovascular Rehabilitation in Ontario*.

How Health Quality Ontario Is Supporting the Use of the Quality Standard for Heart Failure

Health Quality Ontario has a number of ways to help drive the dissemination and implementation of quality standards. These include Quality Improvement Plans, sector-specific practice reports, health technology assessments, and more. These levers will be applied to support adoption of quality standards where applicable and as appropriate.

There are several resources that align and can be used in conjunction with the heart failure quality standard:

- In 2015, Health Quality Ontario and the Ministry of Health and Long-Term Care developed the *Quality-Based Procedures: Clinical Handbook for Heart Failure (Acute and Postacute)* to provide guidance on hospital care for patients with heart failure.
- In partnership with the Ontario Palliative Care Network, Health Quality Ontario has developed a quality standard for palliative care for adults with a progressive, life-limiting illness. Quality standards for a number of other conditions that are typical comorbidities among people with heart failure, such as major depression and chronic obstructive pulmonary disease, are also available.
- Health Quality Ontario has developed a patient conversation guide to support patients, families, and caregivers with the management of heart failure.
- An application has been initiated to propose a health technology assessment evaluating the natriuretic peptide test, which would inform a recommendation from the Ontario Health Technology Advisory Committee (OHTAC) to the Ministry of Health and Long-Term Care as to whether this test should be publicly funded.
- Health Quality Ontario's online quality improvement community, Quorum, offers an opportunity to connect with providers and teams who may be implementing the quality standard.

- Efforts are underway by Health Quality Ontario to add codes to distinguish HFrEF and HFpEF to an updated ICD-10-CA code set. A request form has been submitted to the Canadian Institute for Health Information (CIHI) to propose that the World Health Organization ICD-10 codes for heart failure to distinguish HFrEF and HFpEF (I50.2: systolic heart failure and I50.3: diastolic heart failure) be incorporated into the Canadian ICD-10-CA code set.

  Upon implementation, Health Quality Ontario and CorHealth will work with CIHI to ensure that that the addition of the codes is communicated effectively to the right audiences and that education around uptake and appropriate use of the codes is rolled out.

Health Quality Ontario will continue to assess ways in which new or existing quality improvement initiatives can be leveraged to support quality standards implementation.

The Recommendations for Adoption

The purpose of these recommendations is to address identified, system-level gaps in care. In accordance with Health Quality Ontario's mandate, set out in the *Excellent Care for All Act*, the board of directors will formally provide recommendations related to the heart failure quality standard to the Minister of Health and Long-Term Care as applicable. Recommendations may be directed to other bodies to facilitate the adoption of the quality standard in everyday practice.

Some recommendations are common across a number of quality standards and support closing gaps in care and uptake of the quality standards more generally; those that are especially relevant to the heart failure quality standard are detailed in Appendix B. Recommendations unique to this quality standard are listed below.

Identifying Gaps in Heart Failure Care

The recommendations were developed after a review of the available evidence and a scan of existing programs, as well as extensive consultation with the Heart Failure Care in the Community Quality Standard Advisory Committee, CorHealth Ontario, stakeholders and organizations providing care in this area, and feedback gathered through public consultation. (See Appendix C for further details.)

These discussions highlighted some overarching themes:

- There is poor coordination across the various health care services required to manage patients with heart failure in the community (primary, secondary, and tertiary care).
- There is significant geographic variation in access to heart failure clinics and cardiac rehabilitation. Available cardiac rehabilitation programs are usually time-limited and are sometimes associated with a cost.
- It can be difficult for patients to access specialized heart failure care, palliative care, and end-of-life care in the community. This is partly due to limited capacity and a lack of educational resources and supports for primary care providers.
- There is a high rate of emergency department visits and hospital readmissions following discharge, particularly for patients who do not have a family physician.
- Some patients who experience worsening symptoms or who are discharged from hospital are not receiving timely follow-up care in the community.
- There is a need for increased access to services and resources that build self-management skills and support mental health among patients and their families/caregivers.
- Financial barriers, such as the lack of extended health insurance coverage for programs and services, may prevent people with heart failure from properly managing their condition.
  - Individuals between the ages of 25 and 65 years who do not have access to private insurance can experience difficulties affording essential prescription medications.
  - Individuals are seeking out care in the community (i.e., those who are not receiving care in a hospital or hospital-based clinic) can experience difficulties paying for costly diagnostic testing (e.g., the natriuretic peptide test).

The issues identified here should be taken into consideration to ensure specific adoption strategies do not reinforce current states of inequity and inequality, but rather contribute to improvement or highlight areas of opportunity.

How Success Can Be Measured

Health Quality Ontario will take a two-pronged approach to monitoring uptake of the quality standard and the recommendations for adoption by:

1. Ensuring quality of care provincially and regionally through the use of a small set of provincially measurable indicators related to the quality standard:
   - Percentage of people with newly diagnosed heart failure who receive an electrocardiogram and a chest x-ray
   - Percentage of people with newly diagnosed heart failure who receive an echocardiogram

- Percentage of people with newly diagnosed heart failure who are age 65 years and older, who are dispensed triple therapy

  Stratify by:
  - Angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) or angiotensin receptor neprilysin inhibitor (ARNI); beta blocker(s); and mineralocorticoid receptor antagonist (MRA)
  - ACE inhibitor or ARB or ARNI
  - Beta blocker(s)
  - MRA

  Note: about 50% of people with heart failure (those with reduced ejection fraction) should receive triple therapy.
- Percentage of people who were hospitalized or treated in the emergency department for heart failure who are seen by a primary care physician, cardiologist, or internal medicine physician within 7 days of leaving the hospital
- Percentage of people with newly diagnosed heart failure who die within 30 days of diagnosis of heart failure from any cause of death
- Percentage of people with newly diagnosed heart failure who die within 1 year of diagnosis of heart failure from any cause of death
  - Rate of hospital admissions and emergency department visits per 1,000 person-days for people with heart failure within each fiscal year for:
    - Heart failure–specific reasons
    - Any reason(s)
  - Percentage of people with heart failure who were hospitalized or treated in the emergency department for heart failure who are readmitted within 30 days of discharge for:
    - Heart failure–specific reasons
    - Any reason(s)

2. Tracking the actions resulting from the implementation of the recommendations

Recommendation 1: **Update or adapt the existing Heart Failure Patient Care Flow Sheet to include all data elements required to support the care outlined in the quality standard, ensuring the flow sheet is available in all EMRs and that data are exchanged among health information systems across the continuum of care in a timely way.**

Action needed by:

CorHealth Ontario, with support from the Centre for Effective Practice, OntarioMD, and eHealth Ontario

Time frame for implementation:

Immediate (initiate within 1–2 years)

Quality statements:

All

Gap:

Several different electronic medical record (EMR) tools are being used across the province to manage heart failure in the primary care setting. Some of these tools may no longer be aligned with the latest evidence. At present, it is not possible to access data that differentiate heart failure patients by ejection fraction (heart failure with reduced ejection fraction [HFrEF] and heart failure with preserved ejection fraction [HFpEF]). Access to these data may help inform the unique care needs of each subpopulation.

In addition, some providers may be more knowledgeable than others of critical elements of heart failure care, hindering the provision of guided, standardized, quality care to all patients with heart failure, and existing provincial assessment/documentation tools are out of date.

Recommendation 2: Increase the uptake of the standardized coordinated care plan among providers across the system and, where appropriate, connect patients to the Health Links approach to care. Using existing resources and digital tools, ensure the coordinated care plans are accessed by and shared among all members of a patient's care team, particularly including home care providers.

Action needed by:

LHINs

Time frame for implementation:

Medium term (initiate within 2–4 years)

Quality statements:

All

Gap:

Patients with heart failure do not often have a coordinated care plan, and those care providers who do initiate a coordinated care plan with patients may not be using the standardized version. In addition, not all care providers have access to their patients' coordinated care plans due to a lack of appropriate digital solutions. These gaps contribute to challenges associated with information sharing and continuity of care.

Recommendation 3: Support cardiac rehabilitation programs through quality improvement to drive adherence with the referral processes and core components of care outlined in the *Standards for the Provision of Cardiovascular Rehabilitation in Ontario*.

Action needed by:

CorHealth Ontario

Time frame for implementation:

Immediate (initiate within 1–2 years)

Quality statements:

3: Empowering and supporting people with heart failure to develop self-management skills

4: Physical activity and exercise

7: Management of non-cardiac comorbidities

8: Specialized multidisciplinary care

9: Transition from hospital to community

Gap:

The quality of cardiac rehabilitation programs varies across the province. There is a lack of access to programs and services that equip people with heart failure with self-management skills and mental health support.

Recommendation 4: Ensure that all echocardiography facilities are assessed by the Echocardiography Quality Improvement Program to confirm alignment with the *Standards for Provision of Echocardiography in Ontario* and implement the recommended improvements, if required, to achieve accreditation.

Action needed by:

CorHealth Ontario

Time frame for implementation:

Medium term (initiate within 2–4 years)

Quality statements:

1: Diagnosing heart failure

Gap:

Administration and use of echocardiography are not standardized in Ontario. As a result, clinicians' training and skills related to the appropriate use of this test are variable.

Appendix A: Programs and Initiatives

The following programs and initiatives can support the delivery of care outlined in the quality standard at the local level:

- Health care professionals and patients can leverage tools such as telehomecare, eConsult, and Medly to improve access to care; facilitate communication between patients and providers through remote monitoring; and foster improved self-management among patients.
- In some areas of southern Ontario, the Community Paramedicine Remote Patient Monitoring Program is being piloted, through which paramedics can provide remote patient monitoring to help people with heart failure manage their condition at home.*
  - Results are available following a Queen's University evaluation of the Community Paramedicine Remote Patient Monitoring Program to inform its potential for spread.
- Heart Wise Exercise–approved programs and classes are safe and appropriate options in the community for people with heart failure.
- The poverty screening tool is a resource to help address health inequities; it is intended to help primary care providers identify and provide solutions for patients affected by low incomes and other social determinants of health.
- eReferrals (in regions where it is available) and Ontario's Health Report Manager can support information sharing among providers, while ClinicalConnect enables the sharing of patient information.
- Each LHIN is implementing an electronic solution (either the Client Health and Related Information System [CHRIS] or the South East Health Integrated Information Portal [SHIIP]) by March 2020 to facilitate the development and sharing of the coordinated care plan.
- CorHealth is piloting the implementation of a spoke-hub-and-node model of care delivery in the South West, Champlain, and Waterloo-Wellington LHINs, which will support the adoption of this quality standard at the regional level with the intention of improving care coordination. Lessons learned from the early adopter sites will be used to inform the future implementation of the spoke-hub-and-node model throughout the rest of the province.

- There are various initiatives under review that are intended to improve access to appropriate care for people with heart failure:
  - The Institute for Clinical and Evaluative Sciences (ICES) is conducting the Comparison of Outcomes and Access to Care for Heart Failure (COACH) Trial to test a computer algorithm that performs risk stratification in the emergency department, informing physicians' decision-making about appropriate discharge planning and transition from hospital to the community.
  - McMaster University is sponsoring the DIVERT-CARE (Collaboration Action Research and Evaluation) Trial to evaluate the effectiveness and preliminary cost-effectiveness of a cardio-respiratory disease management model (using a case-finding tool called the Detection of Indicators and Vulnerabilities for Emergency Room Trips [DIVERT] Scale) in home care to manage symptoms and avoid emergency department use.
- The Rapid Response Nursing (RRN) program across the LHINs can be leveraged to support transitions between hospital and home for people with heart failure.*
- The eHealth Centre of Excellence has developed a standardized template that is aligned with the quality standard *Heart Failure: Care in the Community for Adults* (and includes the differentiation of heart failure patients by ejection fraction), which can be embedded into EMR systems to guide the diagnosis and management of heart failure.
- Health care providers can leverage existing programs, resources, and community-based initiatives that can support education and training around palliative care for health care providers, including:
  - Hospice Palliative Care Ontario's Health Care Consent and Advance Care Planning Community of Practice
  - Electronic Health Care Consent, Advance Care Planning, and Goals of Care Reference Guide e-learning modules offered by Hospice Palliative Care Ontario
  - The MOHLTC-funded Palliative Pain and Symptom Management Consultation Program (LHIN-wide)
  - Learning Essential Approaches to Palliative Care (LEAP) by Pallium Canada
  - Palliative Care Toolkit for Aboriginal Communities by Cancer Care Ontario
  - Aboriginal Relationship and Cultural Competency courses offered by Cancer Care Ontario
  - The Ontario College of Family Physicians Palliative Care and End-of-Life Care (PEoLC) Network
  - *When to Consider Implantable Cardioverter Defibrillator (ICD) Deactivation: A Guide for Patients and Family*, co-created by CorHealth Ontario and the Heart and Stroke Foundation

- Speak Up Ontario is an initiative of Hospice Palliative Care Ontario, providing patients with information, tools, and resources related to Health Care Consent and Advanced Care Planning in Ontario.
- Existing programs and resources that can support patients, families, and caregivers in building self-management skills include:
  - The Ontario Telemedicine Network remote chronic disease management program, which uses technology to provide remote coaching in symptom management, medication management, and behavioural change.*
  - *Living with Heart Failure*, a resource created by the Heart and Stroke Foundation in collaboration with the BC Heart Failure Network, which can be shared with patients and families to support the building of self-management skills.
- The French Language Health Services Planning Entity in each LHIN region can be leveraged to support local planning, delivery, evaluation, and improvement of French-language health services. Community Health Centres and Aboriginal Health Access Centres may be able to support the development and provision of culturally informed programs and self-management resources in multiple languages.

Note that the organizations, programs, and initiatives referenced in this document are examples for consideration. They do not reflect all the organizations, programs, and initiatives doing work in this area.

* Programs and services that can be leveraged to support the management of multiple chronic diseases.

Appendix B: Common Recommendations for Adoption

There are a number of recommendations that support the adoption of quality standards across a range of topics. These will eventually be outlined in one reference document. Health care organization and providers, system administrators, and professional bodies are encouraged to look to these recommendations as a way to support adoption of the quality standards and reduce gaps in care. The common recommendations applicable to the quality standard for heart failure are listed below.

Common Recommendations	Lead(s)
Quality Improvement	
Assess the care being provided against the quality standard using Health Quality Ontario's *Getting Started Guide* and refer to the action plan template and measurement guide for this quality standard as tools to support quality improvement.	Health care providers and organizations
Sub-Region Planning	
Consider equity issues when addressing disparities in accessing services in each region of Ontario. The Health Equity Impact Assessment (HEIA) tool can help embed an equity lens in decision-making processes and should be used by analysts and planners to inform service planning and provision.	LHINs
Education and Training	
Embed the quality standard into health curricula and continuing professional development and credentialing programs for providers.	Educational institutions, accreditation programs, continuing education programs and colleges

Appendix C: Process and Methods

The development of the recommendations for adoption involved extensive consultation with stakeholders across the province, from a variety of professional roles and perspectives.

The following organizations and groups were consulted:

- CorHealth Ontario
- The Ontario Ministry of Health and Long-Term Care
- Ontario Association of Cardiologists
- LHIN/Health Quality Ontario Regional Clinical Quality Leads
- Ontario Telemedicine Network (OTN)
- Heart and Stroke Foundation
- eHealth Centre of Excellence
- The South West LHIN
- The Central East LHIN
- Hamilton Paramedic Service
- Ontario Physiotherapy Association
- Various cardiac rehabilitation programs across Ontario
- OntarioMD

Along with engaging the organizations mentioned above, the Heart Failure Quality Standard Advisory Committee, which includes individuals with lived experience, also provided feedback on the adoption of this quality standard.

Note: Between February and October 2018, Health Quality Ontario received feedback from 69 individuals and groups, including family physicians, cardiologists, registered nurses, allied health professionals, and administrators from various care settings across Ontario, as well as individuals from LHINs, health care organizations, and system partners. Information was gathered through one-on-one interviews, presentations at committee meetings, and public consultation, and was used to further inform gaps between current practice and quality care as outlined in the quality standard.

The Ontario Quality Standards Committee (OQSC) is a sub-committee of Health Quality Ontario's Board of Directors. It is tasked with reviewing and approving the quality standards at each stage of the development process. The OQSC will continue to assess impact of this quality standard, working with patients and the public, clinicians, organizations across Ontario's health system, and the Ministry of Health and Long-Term Care for a more centralized, integrated, and systematic approach to quality health care.

[i] Huitema AA, Harkness K, Heckman GA, McKelvie RS. The spoke-hub-and-node model of integrated heart failure care. Can J Cardiol. 2018;34:863-70.

[ii] Cardiac Care Network. Strategy for community management of heart failure in Ontario. Toronto (ON): The Network; 2014.

Quality Standards

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