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HEART+LUNG Health
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Filling in the Pieces: Guideline Driven Care for Heart Failure






Catherine Clark RN, BSN, CCN(C)
Minette Walker RN, MSN, CCN(C)

Objectives

By the end of the session, participants will be familiar with:




- the work of the Vancouver Coastal Health (VCH)/ Providence Health Care (PHC) Heart Failure (HF) initiative
- the current state of HF care at PHC
- proposed tools used to implement guideline driven care
- the proposed implementation strategy for PHC
- measurement strategies for PHC and VCH

The burden of HF

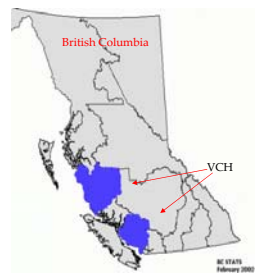
- **15%** of HF patients are readmitted within 30 days
- HF care costs this province almost **\$600 mill/yr**
- HF patients have a poor prognosis with the average 1-year mortality rate of **33%**

1. Tsuyuki RT, et al. Can J Cardiol 2003;19:436-438
2. Lee DS, et al. Can J Cardiol 2004;20(6):599-607 3. BC Ministry Data, 2010

Development of a Regional HF Strategy




- Cardiac Services BC devoted funding to improve HF care across the province
- BC's 5 HA received funding to support local improvements
- Regional HF team: CNS, 2-coordinators, telehealth nurse
- VCH/PHC plan to address needs/gaps in 5 key areas



British Columbia




VCH

BC HEALTH February 2009



VCH/PHC Plan

1. Outreach to special populations
2. Telehealth
3. GP support
4. Support 2-HFC's in VCH/PHC
5. **Seamless transitions and implementation of guideline driven care**

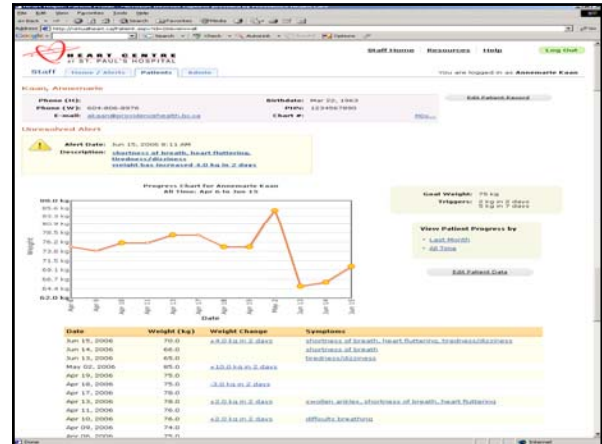
1. Outreach to special populations

- Bella Bella and Bella Coola – Aug 2011
 - * Cardiology consults
 - * nursing/allied health education for HF
 - * Portable echo, stress testing
- Elders luncheon – Prevention talk

2. Telehealth

- Telehealth nurse
- Information and communication technologies for teaching and learning
 - ie., web based education for nursing
- Technical support for video conferencing
- Virtual Heart Function Clinic



3. GP Support - RACE

- **R**apid **A**ccess to **C**onsultative **E**xpertise
- GP's receive telephone advice and support from specialists
- enhances primary care physicians' ability to manage patients in their offices and increase access to specialist knowledge
- provides learning opportunities, including a .25 CME credit for every call
- specialists receive MSP remuneration for participation

4. Heart Function Clinics

- VGH and SPH
- Work towards a regional HF Clinic program
 - Improve communication
 - Similar pathways
 - Joint teaching using the same tools
 - Interclinic transfers

5. Support Seamless Transitions

What: Improve heart failure care across the continuum from hospital to home by implementing guideline driven for HF

How: Implementation of tools, ie order sets, discharge transition, education checklists, etc

Progress to date

Acute care

Developed and implemented tools at LGH, PRH, Sechelt, BB

Next sites PHC and VGH

Community

Clinical Practice Guidelines for Home and Community

Residential Care

- The “hidden” population of HF patients
- High burden on ER and hospital admissions
- Working to improve staff awareness
- Working on frail elder specific order set

Process

- **Assessment**
 - Steering committee
 - Chart review
- Planning
- Implementation
- Evaluation

Chart Assessment

PHC Cardiology, Medicine & MSJ

Assessment Process

- CCS guidelines – recommended care
 - ACE I/ARB
 - Beta Blocker
 - Anticoagulation for Atrial Fib
 - Documented Ejection Fraction (EF)
 - Fluid, salt and daily weight practices
 - Discharge preparation
 - Teaching

Chart review

- 30 charts from each area
- 2010 discharges with HF as a primary diagnosis
- Inclusions:
 - Systolic HF EF <45% for cardiology and IM
 - All EF for MSJ
 - Transfers to LTC facility
- Exclusions:
 - Preserved EF HF at SPH
 - Transfers out to another acute care facility
 - Death
 - Transplanted cases

Demographics

	Cardiology	Medicine	MSJ
Average age	65.8	71.7	79.7
Age range	31-88	24-90	66-94
Sex	m= 67% f= 33%	m= 60% f= 40%	m= 57% f= 43%
LOS (days)	9.7	7.7	8.9
LOS range	1-28	2-45	2-53
New diagnosis	5	2	5

Canadian Cardiovascular Society 23
Leadership. Knowledge. Community.

Transition from Hospital to Community

Recommendations

- Patients and caregivers should be educated while in hospital and soon after discharge on
 - Warning signs and symptoms of worsening HF
 - Self management skills
 - Factors that may aggravate HF
 - Reasons for and appropriate use of medications (Class I, Level C)
- Effective means of communication and collaboration between patient, caregiver and health care providers should be identified (Class I, Level B)

Arnold JMO, Howlett JG, Ducharme A et al. Can J Cardiol 2008;24(1):21-40.

Transition from Hospital to Community

Recommendations

- A written summary should be provided to the patient at the time of discharge and to the primary care physician within 48 h of discharge. It should include:
 - Diagnoses
 - Significant interventions in hospital
 - In-hospital complications
 - Medications at discharge (including prescriptions and explicit instructions for adjustment)
 - Plans for follow-up, including delineation of the respective roles and responsibilities of each caregiver (Class IIa, Level B)

Arnold JMO, Howlett JG, Ducharme A et al. Can J Cardiol 2008;24(1):21-40.

Discharge Prescription and Transition Tool

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Transition from Hospital to Community

Practical Tips

- The goals and directions of care should be shared and openly discussed among the patient's health care professionals; any differences in perspective/opinion should be identified and a best solution agreed upon
- In appropriate cases, personal contact with the referring or primary care physician should be considered at or before discharge
- Where available, RN/APNs with training and expertise in enhancing patient and caregiver HF management skills may assess the patient in hospital and then follow them at home as part of a transitional care program

Arnold JMO, Howlett JG, Ducharme A et al. Can J Cardiol 2008;24(1):21-40.

Teaching record

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Regional Heart Failure Strategy Patient Education Materials

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Evaluation

- Remains ongoing at pilot site
 - 6 month post chart assessment
- Clinical Care Analysts
- Reported on a monthly basis
- Currently only one measure used

Clinical Guidelines Initiative

- Heart Failure is one of the CGIs
 - Ministry mandate to provide guideline driven care
 - Requires identification of indicators for regular reporting to Ministry of Health
 - * 28 day unscheduled readmission
 - Hopes of other indicators to be added

Anticipated Success Factors

- Implementation completed at other sites
- Presence here at PHC
- In-servicing for nursing and allied health
- Change enthusiasts
- A well established level of HF care

Potential Barriers/Challenges

- Not knowing the culture of the hospital
- Not knowing “who’s-who”
- Competing initiatives
- Resistance to change/ standardization
- Fear of increased workload
- Cost of travel

Nursing Implications

- Launching initiative
- Sustainability
 - Ownership
 - When to review

“ when order sets are inadequately maintained, they become templates for efficiently practicing outdated medicine on a widespread basis ” Bobb et al.

JAMIA v14, pp. 41-47

Summary

- Reviewed the burden of Heart Failure
- Reviewed the VCH/PHC HF Strategy
- Outlined the process used in Acute care
- Demonstrated the tools
- Measurement and sustainability