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GWG Heart Failure Progress to Date

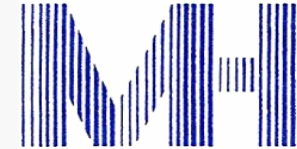
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Our Partners

CHAMPLAIN
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Friday, May 6, 2011



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The Heart Failure GAP Project

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Background

- HF is steadily increasing as a result of success in treating heart attack and other cardiac conditions. It is associated with significant morbidity, mortality and health care costs
 - HF affects 1% of people in Canada (over 350 000)
 - The average 1 year mortality rate for HF is 33%
 - It is the only major cardiovascular disorder that is increasing in both incidence and prevalence
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Facts

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- Hospital readmission rates are high, 8.7% at 30 days, 14.1% at 90 days and 23.7% at 1 year, the majority of readmissions are because of fluid problems.
 - Many are preventable
 - Problems with medication adherence
 - Problems with discharge management
 - Not enough follow-up in the community
 - Difficulty with ensuring adequate social support
 - Lack of knowledge about warning signs and symptoms
-



Goals

- To build on the regionalized approach to quality improvement in chronic disease prevention and management
 - To ensure all patients with HF receive best practice care when admitted to any Champlain LHIN hospital
 - To provide an organized process for delivering and documenting care
 - To improve utilization of resources
 - To improve and quality of patient care
 - To reduce practice variations and improve performance in delivery of evidence based care through data collection and feedback
 - To improve outcomes
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Strategy



- Establish baseline audit
 - Collaborate with health care providers at each institution to integrate best practices into usual processes and documentation tools
 - Focus on actively engaging the patient in understanding and participating in evidence based care
 - Collect data and provide feedback on adherence to guidelines
 - Enable the tailoring of tools and processes to suit the local context and needs
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Heart Failure GAP Tool!

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- Start the GAP tool at admission
 - Add the ejection fraction when (if) available
 - Diet – low salt, fluid restriction
 - Daily weights – do they have a scale at home
 - Medications: Yes, No, or Contraindicated
 - Quit smoking
 - Exercise
 - Heart Failure symptoms
 - Follow up with doctor
 - When to contact the doctor
 - Specific instructions
-



How are we doing?



Indicator	Target	To Date
# Hospitals signed commitment	16	16
# Hospitals first meeting complete	16	15
# Hospitals baseline audit complete	16	14
# Hospitals participated in Education	16	8
# Hospitals who have adapted tools	16	4
# Hospitals implemented	16	3
# Hospitals submitting data	16	1



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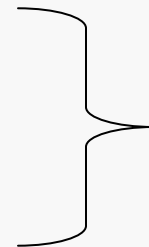
Baseline Audit Results

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- Number of hospitals: 12/16
 - Does not include UOHI or TOH
 - Audit tool based on Canadian Cardiovascular Outcomes Research Team (CCORT) process indicators for heart failure care.
 - Patient files identified using ICD 10 Heart Failure Codes
 - Number of patient files: 353
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- Diuretics
- ACEI (ARB if ACEI not tolerated)
- Beta Blockers
- Digitalis
- Aldosterone antagonists



Only recommended if still symptomatic despite optimized on best practice meds



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Guidelines- Risk Factor Management Education

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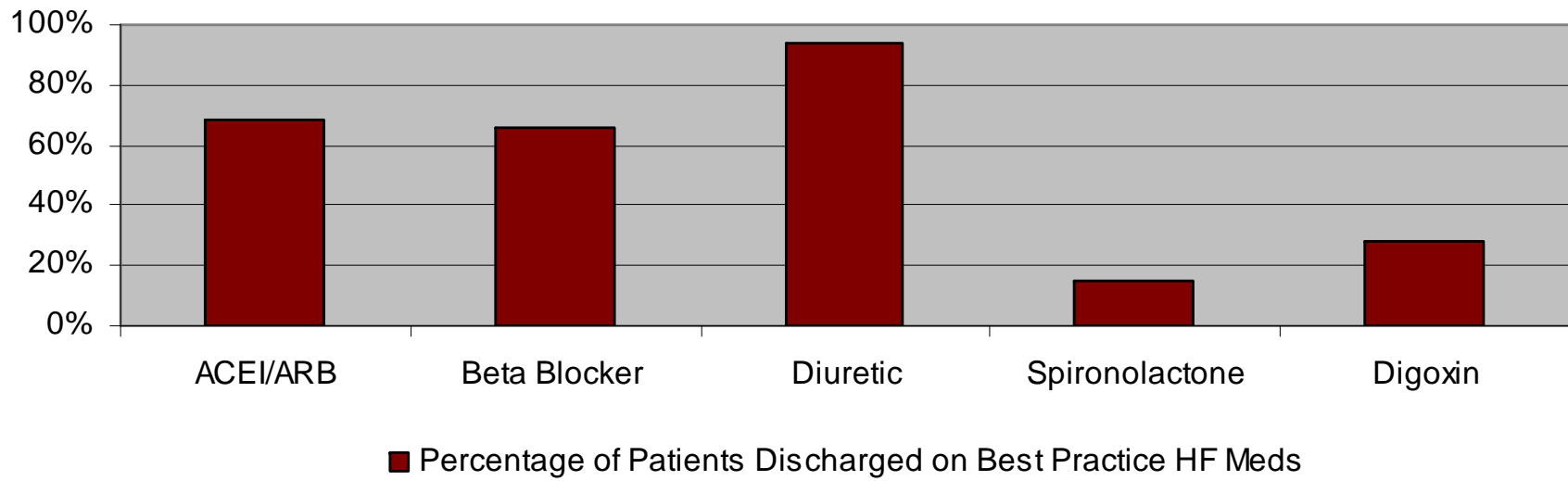
- Educate about early warning signs of decompensation and how to respond
 - Discuss salt (2000mg/day) and fluid intake (1.5-2L/day)
 - Educate about smoking cessation
 - Encourage regular exercise
 - Track daily morning weights with a diary and report 2 lb gain in 24 hrs or 5 lb gain in 7 days
 - Stress the importance of taking medications
 - Follow up after discharge
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Preliminary Baseline Audit Results

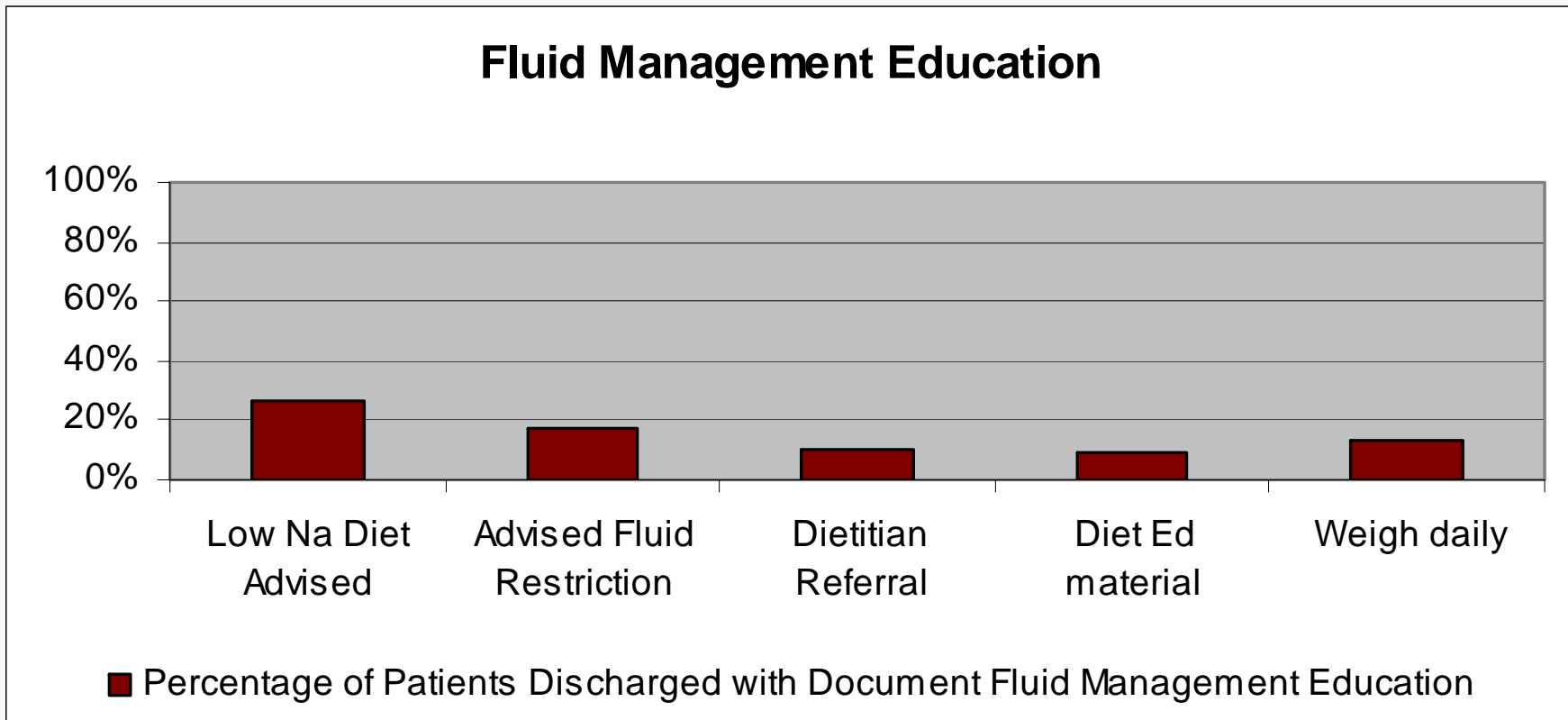


Heart Failure Medications





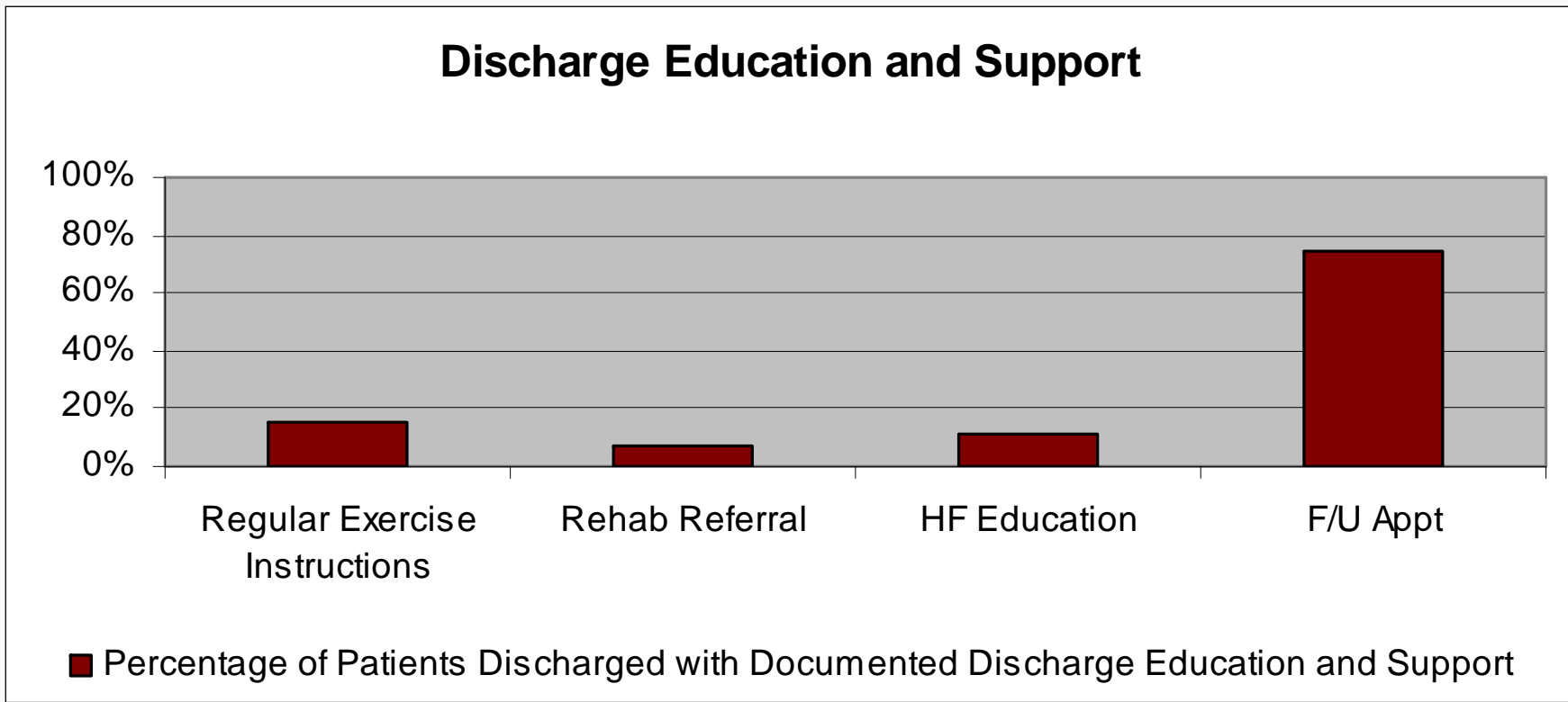
Fluid Management Education





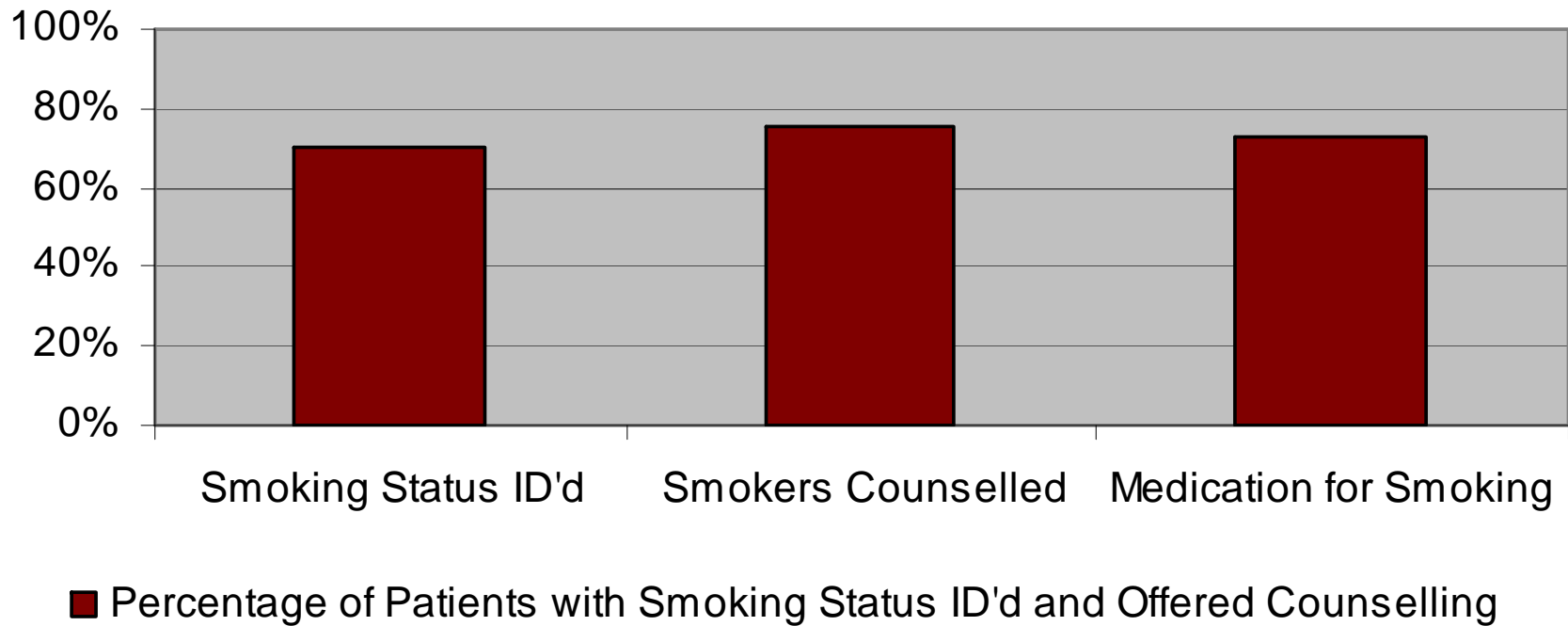
Preliminary Compiled Baseline Audit Results

Discharge Education and Support





Smoking Cessation





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Patient Outcomes



Every 10% increase in guideline adherence

Equals

A 10% decrease in patient mortality

QUESTIONS?
