Heart Failure Shared Care Project Evaluation Report

June 2024

Surrey-North Delta

Division of Family Practice

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PROGRAM EVALUATION & RESEARCH

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Acronyms and Abbreviations

HFC	Heart Function Clinic
FP	Family Physician
NP	Nurse Practitioner
SND	Surrey-North Delta
DoFP	Division of Family Practice
CME	Continuing Medical Education
JPOCSC	Jim Pattison Outpatient Care and Surgery Centre

Introduction

This is the final evaluation report of the Surrey-North Delta (SND) Division of Family Practice (DoFP) 'Heart Failure' Shared Care Project. The overarching aim of the project was to improve collaboration and transition of care upon patient discharge from the Heart Function Clinic (HFC) so that SND Family Physicians (FPs) can deliver appropriate primary care and ultimately, help prevent re-hospitalization. The project operated between April 2022 and June 2024.

About the Project

Background

In the project proposal, it was outlined that patients with heart failure issues often end up in the emergency department and in acute settings, and that the period of time following discharge from these settings is often characterized as a period of high risk and instability. Heart failure patients receive care from multiple providers and facilities in the community, such as Family Physicians (FPs), Nurse Practitioners (NPs), Cardiologists, and, in SND, the outpatient Heart Function Clinic's health professionals. The seamless transition and integration of care between ambulatory and community partners can unite the care provision pathways and improve health outcomes for heart failure patient.

Prior to this project's development, a group of SND health providers hosted a 'visioning session' to discuss how heart failure patients can be better supported at the HFC. To address the needs and opportunities identified in the session, the HFC underwent a redesign to improve internal workflows that would improve the quality of care that heart failure patients were receiving at the clinic. The session also identified a need to improve how primary care providers (i.e., family physicians and nurse practitioners) engage with the clinic.

To better understand these needs and areas for improvement, the SND DoFP, conducted a survey in December of 2021 to collect data from FPs and NPs whose patients had been cared for at the HFC. The survey assessed their experience and perceptions working with the HFC (Box 1). This information was used to identify opportunities to support primary care providers with their heart failure patients as well as their interactions with the HFC.

Box 1. FP/NP HFC Survey: Of the 32 FPs and 2 NPs who responded to the 2021 survey, 88% (30 of 34) indicated that they were interested in more continuing medical education (CME) on heart failure. In addition, only one third (33%, 11 of 34) of survey respondents indicated that they were aware of who to contact at the HFC if they had questions about their patients and 59% (20 of 34) indicated that they felt that there was adequate transition of care at the time of patient discharge from the HFC. Some FP/NPs survey respondents also indicated that they wanted FP/NPs to have more active involvement in patient care while they were receiving care at the HFC. Others commented that direct lines of communication with the HFC team would be beneficial.

Project documents outline that the following gaps were identified:

- Undefined communication process between HFC & primary care
- Undefined coordination of care between specialist service and primary care
- Lack of relationship between Cardiologist, NPs, & FPs
- Lack of FP/NP awareness of services at the HFC

Project Activities

To address the gaps identified, the project proposed the following:

1. Pilot of integrated care pathway with Heart Function Clinic with 10-15 FPs, to include patient appointment with FP at 1 month post initial Specialist consult and 1 month before patient discharged from HFC.
    a. Assessment of current timeline achieved by HFC for patient Medication Optimization
    b. Assessment of current patient's compliance at HFC
    c. Assessment of patients' satisfaction with care received from HFC and FP following HF
2. Create a notification process that send notification to FPs when their patient is accepted into HFC.
3. Review and revise communication tools/documents currently used at HFC
4. Implement standardized communication on medication changes & adverse medication reactions – to be used by HFC & primary care providers.
5. Develop education sessions – CME heart failure and HFC service awareness to help primary care providers navigate HFC and direct appropriate referrals with an appropriate level of urgency.

Project Goals

As per the project funding request, the overall intent of the HF project was **to improve collaboration and transition of care upon patient discharge from the HFC so that SND FPs can deliver appropriate primary care.** Ultimately, this project aims to prevent re-hospitalization and improve the health outcomes for heart failure patients in the community of SND.

About the Evaluation

Evaluation Approach

The evaluation is intended to provide feedback on the implementation, operation, and outcomes of the project. The evaluation was designed to be participatory and developmental. The following questions guided the evaluation:

Process Questions

1. To what extent was the project implemented as planned?
2. To what extent was the project able to identify and engage the necessary stakeholders?

Outcome Questions

3. To what extent did the project achieve its planned results?
4. What lessons does the project provide that could be used to improve patient care and efficiencies in other populations or locations?
5. To what extent are the outputs/outcomes sustainable?

Methods

The evaluation team incorporated the following data collection methods:

- **Document/Admin Data Review |** The evaluation team reviewed relevant project documentation including the project planning documents (i.e. funding proposals, meeting minutes, etc.) and project administrative data (i.e. event attendance, HFC data).

- **Key Stakeholder Interviews |** A total of seven semi-structured video/telephone interviews were conducted with team and working group members. These interviews gathered information on what was implemented, project team challenges and successes, overall project impacts, project sustainability, and next steps. In addition, four semi-structured interviews were conducted with FPs to assess their experiences communicating with the HFC after the pilot project was implemented (i.e., integrating FPs into the HFC patient journey).

- **Surveys |** Post-event surveys were administered following all 3 project education and engagement sessions to assess attendees' perspectives on the event and on their achievement of the learning objectives (Table 1).

Table 1. Project Education and Engagement Sessions

Education Name & Information	Date	# Post-Event Surveys
CME: Demystifying the Heart Function Clinic – Partner with your Heart Team for Life	June 28, 2023	37 FP responses *(100% response rate)*
CME: Demystifying Heart Failure Management – Practical Tips	September 14, 2023	30 FP responses *(100% response rate)*
Lunchtime Learning Series - JPOCSC HFC	May 28, 2024	32 FP/NP/MOA responses *(80% response rate)*

- **Contextual analysis |** All evaluation information was analysed within the context of the program's stated goals and objectives.

Limitations

A potential limitation of using semi-structured interviews is that participants may not be able to accurately recall all experiences. To mitigate this limitation, participants were sent the interview guides in advance of their interview date, allowing them to review questions and reflect on their experiences. By doing this, it was less likely that participants were caught off guard or surprised by any questions that were asked within the interview itself. The evaluation also used multiple lines of evidence, including administrative data and surveys, to mitigate the impact of response bias in interviews.

Evaluation Findings

Project Operation

The project received direction from a working group, with members including a local FP and Specialist Physician, Fraser Health representatives, HFC providers and leadership, and a SND Division of Family Practice Project Manager.

Based on the needs assessment and planning and gaps identified, the following objectives were decided by working group members as they began implementation:

- Improve communication and coordination of care between FPs/primary care and the HFC
- Improve FP/NP knowledge and understanding of heart failure care, the HFC, and HFC services
- Improve FP/NP confidence in supporting patients with heart failure
- Improve collegiality between FP/NPs and HFC staff/providers
- Improve care experience for patients with heart failure issues

Based on the objectives chosen by the WG, and the capacity of the project, the activities were refined. The following activities were conducted to address the above objectives:

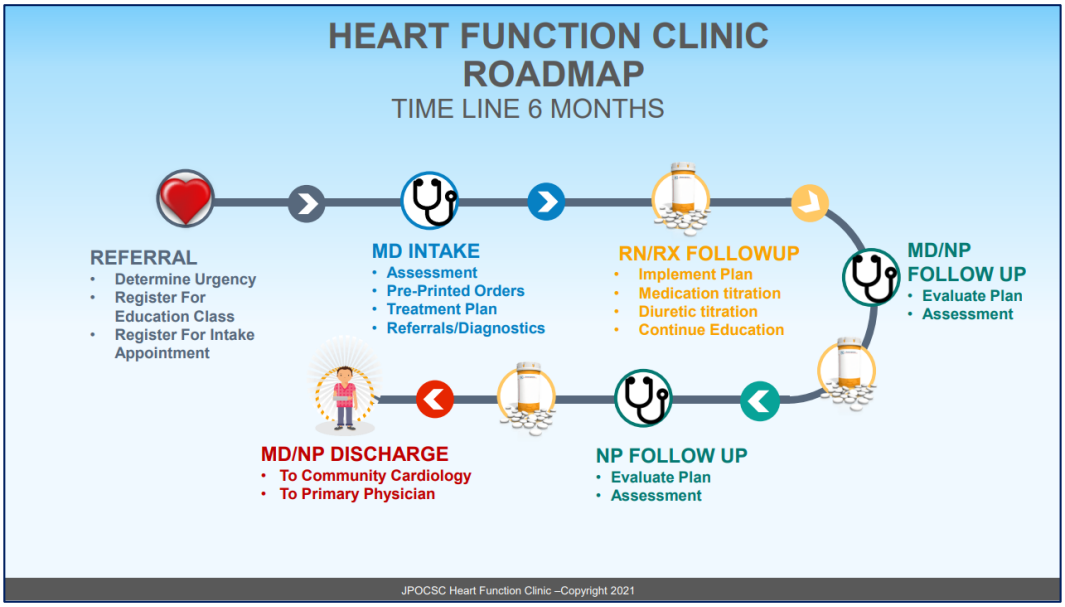
1. **Heart Function Clinic Pilot Project Trial:** Integrate FP/NPs within the HFC patient roadmap (i.e., improve primary care provider engagement with the HFC and their heart failure patients while they received care at the clinic).
2. **FP/NP Education and Engagement Sessions:** Host education sessions for primary care providers to improve their awareness and understanding of the HFC, as well as to support their knowledge and confidence managing heart failure patients.
3. **Resource Development:** Develop resources to increase FP/NP awareness of the services available and how to refer patients to the HFC.

Project Activities and Outcomes

1. Heart Function Clinic Pilot Project

The goal of this pilot project was to improve communication and coordination of care with FP/NPs who have patients attending the Heart Function Clinic. To facilitate this, an updated roadmap was created, that outlined 2 timepoints (approximately 1 and 4 months into the patient journey after they had completed intake with the clinic) for patients to have follow up appointments with their FP/NP (Figure 1).

Figure 1. Heart Function Clinic Patient Journey Roadmap



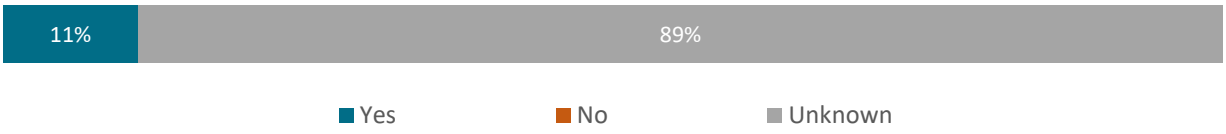
Evaluation findings indicate that there were **unanticipated challenges in integrating FP/NPs into the patient journey at the HFC**. HFC staff/providers who were interviewed reported that initially, efforts were made to remind FPs that they should meet with their heart failure patients at approximately 1 month after their initial appointment at the HFC and 1 month before discharge. However, FP/NPs notified the HFC that this approach wouldn't work as calling patients to schedule a visit with them was not a part of their usual workflow or practice. To mitigate this challenge, patients were then told, by the HFC team, to book a visit with their FP at each of the two time points (1 month after initial appointment, 1 month before discharge).

Based on data collected by the HFC, **71% (22 of 31) patients who were referred to the HFC** between October and December of 2023 (i.e., during the recruitment period for the pilot project) **did have an appointment with their FP approximately 4-6 weeks after their initial intake at the HFC**, and only 6% (2 of 31) did not. Data was not available for the other 7 patients (Figure 2).

Figure 2. Percentage of patients who had an appointment with their FP **4-6 weeks after their initial intake** at the HFC (n=31)

18 of the 31 patients who were a part of the pilot project, were discharged from the clinic between January and April of 2024. However, **data was not available for 16 of the 18 patients**. Data collected for the other two patients indicated that both had another appointment with their FP prior to their discharge from the clinic (Figure 3).

Figure 3. Percentage of patients who had another appointment with their FP **before their discharge** from the HFC (n=18)



Half (2 of 4) of FPs who were interviewed indicated that their level of communication with the HFC had not noticeably changed since the implementation of the pilot project, however, both indicated that they **are receiving enough communication from the clinic** and are **satisfied with the HFC provider notes they received.**

One FP interviewee indicated that **the communication he received from the HFC had recently increased.** Specifically, this FP indicated that he **had been informed that his patients had started at the HFC as well as received a reminder to book an appointment with the patient in two months time.** In this case, the FP's administrative staff was often able to get a hold of the patients and schedule in these appointments. This FP noted that, **as a result of this added connection and communication, the patient was satisfied with the continuation of care that was facilitated by the HFC.**

"Previously, we were only able to see the patients once they were discharged and even after that the patient would wait a couple of months when they needed a refill and sometimes at that point we would figure out that they had gone through that clinic, and if we had some concern or some clinical questions, that could remain unanswered… But this way there is more collaboration, and the patients also feel more supported…I felt that the this is a new way. [The patient] feels that I'm also part of that and they are a lot less stressed closer to discharge… they are happy to continue with us afterward… they feel that once they're stabilized, I would be able to help them. So, it's been a good experience."
– Family Physician

All (n=4) FP interviewees noted that **more frequent contact with the HFC and HFC providers is helpful and necessary for patients with more complex heart failure issues.**

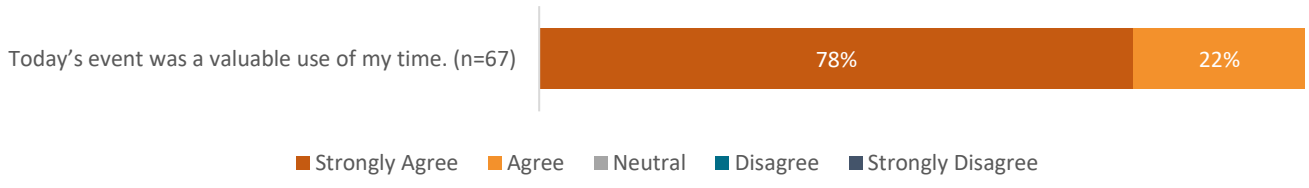
2. FP/NP Education and Engagement Sessions

Three education sessions were facilitated as part of the project. The aim of these sessions was to improve FP/NP knowledge and understanding of the HFC, improve FP/NP confidence managing heart failure patients and interacting with the HFC, and improve familiarity and collegiality between FP/NPs and HFC staff and providers.

Event Satisfaction

All (n=67) FPs who attended a CME session indicated that they 'strongly agreed' or 'agreed' that the event was a valuable use of their time (Figure 4).

Figure 4. FPs satisfaction with the CME session they attended



Attendees of the May 28, 2024 virtual lunch learning series reported that they **found the session helpful and informative.**

Generally, event attendees identified the following as highlights or most valuable parts of the sessions:

- Engaging in group discussions
- Having the opportunity to meet with HFC staff and providers face-to-face
- Doing case scenario reviews

"I find this is an excellent topic and I'm always happy to hear more cases" – Event Attendee

"Great talk, great engagement, good job" – Event Attendee

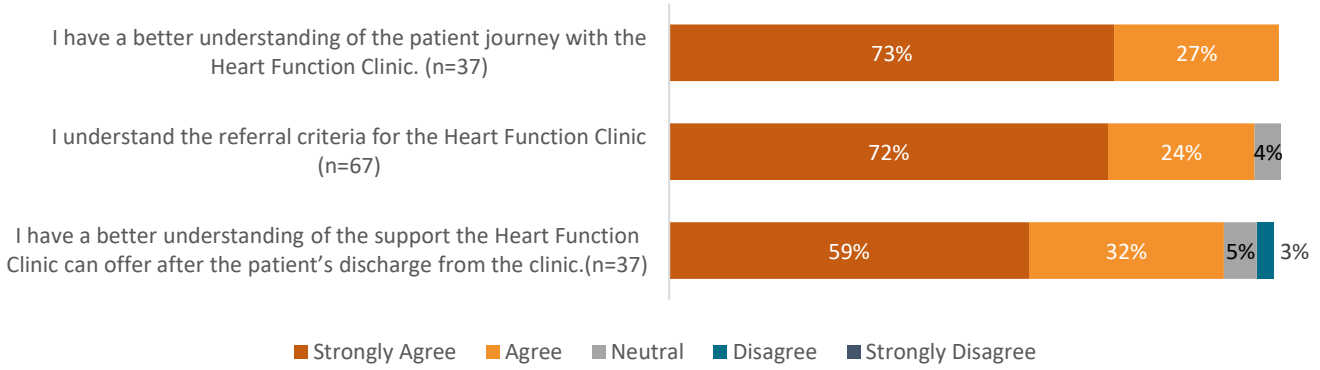
"Great topic! I have learned a lot about how to send patients to this clinic and how the appointment processes work." – Event Attendee

Impacts and Outcomes of Physician Education & Engagement

➢ *Improved FP/NP Awareness, Knowledge, and Understanding*

Evaluation findings suggest that after attending an education session, **FPs had an improved level of understanding of the HFC**. Attendees agreed that after attending a CME session, they **understood the referral criteria of the HFC** (96%, 64 of 67) and **that they had a better understanding of the patient journey within the HFC (**100%, 37 of 37) (Figure 5).

Figure 5. FPs reported knowledge and understanding of the HFC after attending CME session



Similarly, all attendees (n=32) of the May 2024 learning session indicated that after attending the presentation, they had a better understanding of the overall HFC processes, of the clinic's referral processes, and the patient inclusion criteria to make a referral to the HFC.

"Once we did the teaching sessions, there was an uptake of referrals that we were getting directly from the Family Physicians" – Heart Function Clinic Staff Interviewee

Attendees of the September 2023 CME session also reported that after attending the session, they had an **improved understanding of the treatment options for patients who have heart failure** (100%, 30 of 30).

Working group interviewees who attended one or more educations sessions reported that the sessions allowed for FPs and HFC staff/providers to meet face-to-face, have engaging discussions, and answer one another's questions.

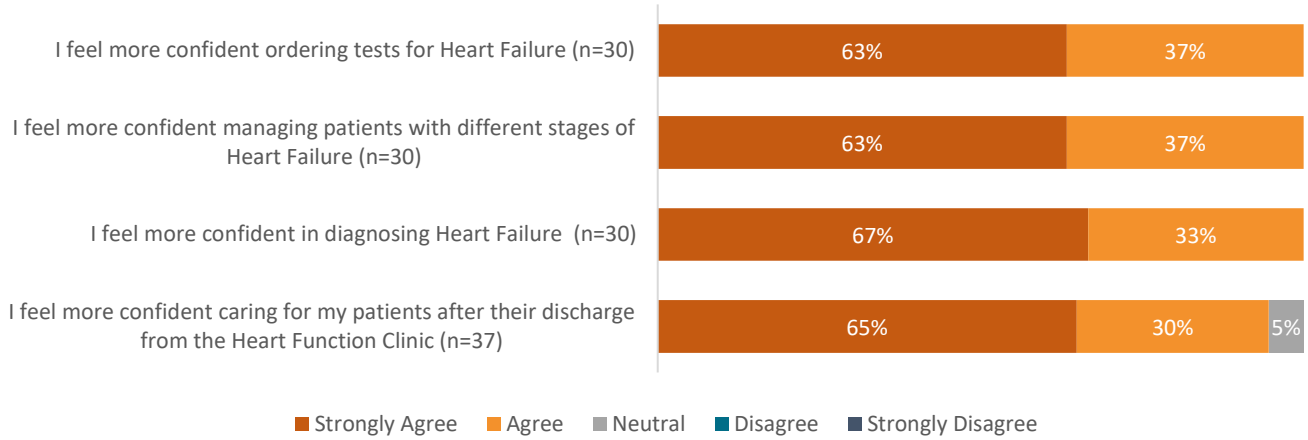
"Those primary care physicians that showed up, I think they got a lot out of it. I think their understanding of the Heart Function Clinic, the patient journey through it, was a lot clearer." – Working Group Member

"I think some of some of those logistical issues were answered face to face and I felt that that information was retained better. The GPs naturally felt that they understood the Heart Function Clinic a lot better and as a group we talked about it"– Working Group Member

➢ *Improved Family Physician Confidence*

Evaluation findings suggest that FPs who attended a CME session reported an **improvement in their overall confidence supporting patients with heart failure**. For example, all September 2024 session attendees (30 of 30) reported that they **felt more confident managing patients with different stages of heart failure** and nearly all (95%, 35 of 37) June 2023 session attendees reported that they **felt more confident caring for patients after their discharge from the HFC** (Figure 6).

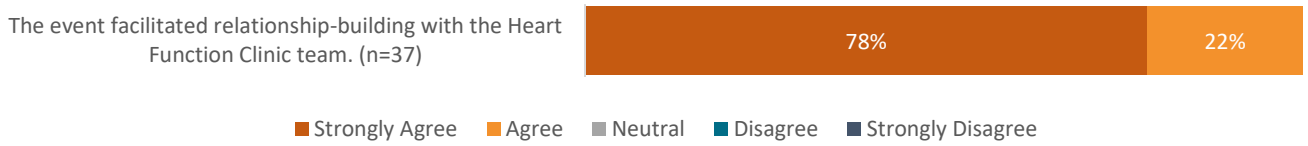
Figure 6. FPs reported changes in confidence after attending a CME session



➢ *Improved Collegiality Between FPs and the HFC team*

All FPs who attended the June 2023 CME session attendees[1] (37 of 37) reported that **the session facilitated relationship building with the HFC team** (Figure 7).

Figure 7. FP education session attendees perception that the event favilitated relationship building with the HFC team



[1] This question was only asked of DATE session attendees

Other Project Outcomes

HFC interviewees noted that as a result of the project, **HFC staff and providers are now more aware of the challenges primary care providers experience when supporting complex patients including those with heart failure.** They shared that this knowledge helps them better understand how they can work towards improving their own internal processes to support primary care providers better.

3. Development and Promotion of Resources

An infographic describing the HFC at JPOCSC was developed to promote the HFC further and to inform primary care providers of HFCs processes and services. This infographic was shared with within the Division Newsletter, at one of the project's CME events and has also been posted on Pathways (https://pathwaysbc.ca/ci/8132).

In addition, a short, animated video (https://www.youtube.com/watch?v=YfyikiXS28o&t=21s) providing an overview of the HFC services and criteria for referral was developed was uploaded onto Pathways in June of 2024.

Impacts and Outcomes of Development and Promotion of Resources

Interviewees noted that the infographic and video will be an important part of continuing to share information about the HFC with SND primary care providers.

Lessons Learned

What worked well?

Evaluation findings indicate that the following were facilitators of project progress and success:

- **Project Team and Partner Dedication |** Project team and working group interviewees indicated that the dedication of everyone involved in the project was a primary contributor to the project's progress and successes. Having the consistent support and engagement of the HFC and their staff was appreciated by the Division members, and HFC staff and providers reported the same appreciation of Division staff.

> *"The fact that everybody made a lot of effort in staying committed, to joining the meetings and collaborating and just really doing the work behind the scenes… we had a lot of various life challenges for some of the folks in the group, and they still managed to bring it in and just maintain their engagement. I think that worked really well. The fact that you had people's commitment and dedication to this project. That is actually the biggest success to me." – Working Group Member*

- **Strong Project Management |** Several interviewees indicated that the project and its successes would not have been possible without the project managers. They indicated that the management successfully supported the team in focusing project objectives and provided them with a "sense of team".

What were the challenges?

Evaluation findings indicate that the following challenges were experienced by the project team:

- **Project Team and Partner Turnover** | Interviewees indicated that turnover in project management, as well as project partners, resulted in project delays and loss of momentum.

> *"Naturally, when one project manager leaves and another one takes over, there's generally some drop off… So that kind of caused a little bit of slowing of the project." – Working Group Member*

> *"Then we had to kind of revisit what had been done so far. Catch everyone up as to what was done. So yes, that did present a challenge for sure. And naturally, when you get new people into the group, some of the ideas take a different turn because only people that have been there from the beginning understand how we got here." – Working Group Member*

- **Logistical Challenges** | The planned integration of FP/NPs into the HFC patient journey, was not fully realized due to unforeseen logistical challenges as well as capacity related constraints experienced by HFC staff and providers. For example, while patients were reminded to book an appointment with their FP/NP approximately 1 month after their initial intake at the HFC and 1 month before their discharge, interviewees indicated that tracking whether patients were connecting with their FP was challenging. They also indicated that it was unclear whether patients were meeting with their FP to discuss their heart failure or for other reasons. In addition, trying to track this data added to HFC staff's already heavy workload. Thus, evaluating the success and impacts of this pilot project was challenging.

Sustainability

Project team and working group members noted that the **project was successful in laying a foundation for future work done in this area**, however, there were **some concerns expressed around the sustainability of the project outcomes**. For example, while evaluation findings suggest that the education sessions successfully improved FP knowledge of the HFC, several interviewees indicated that it's unclear if this information will be retained by session attendees. They also noted that further efforts are needed to continue engaging and educating SND primary care providers about the HFC.

Some interviewees also noted that it was unclear if there is infrastructure in place to maintain communication and collaboration happening between the HFC and primary care long-term, particularly without exceeding workload capacity of HFC staff and providers. However, **project partners were generally optimistic that there is potential to fine tune these processes and maintain communication and collaboration between the two groups, over time**.

One project output which interviewees described as a facilitator of project sustainability was the **development of the HFC infographic and video**. These resources were described an important tool to sustain the continued education and spread of this information.

Interviewees noted several recommendations to support the sustainability and spread of this work, which is highlighted further under the 'Recommendations for Next Steps' section below.

Summary

Project Objectives	Progress Made Towards Intended Objective
The objectives in blue are related to Shared Care Shared Measures and Outcomes that the project intended to address.	
Improve communication and coordination of care between FPs/ primary care and the HFC[2]	• • • Evaluation findings suggested that due to unforeseen logistical challenges, FPs were not successfully and consistently integrated into the HFC patient journey, and therefore **the evaluation was not able to identify if improvements in communication and coordination of care between FPs/primary care and the HFC was fully realized**. However, evaluation findings indicate that 71% (22 of 31) of patients who were a part of the pilot project did connect with their FP 4-6 weeks after their initial intake at the HFC. FP interviewees (n=4) indicated that they generally have an appropriate amount of contact with their heart failure patients while they are the HFC. HFC staff and providers are optimistic that there may be future opportunities to explore how communication and collaboration of care between HFC providers and FPs can be improved.
Improve FPs' overall knowledge and understanding of heart failure care, the HFC, and HFC services.	↗ Evaluation findings suggest that the education and engagement session improved FPs' overall knowledge and understanding of managing their heart failure patients as well as the HFC. For example, all (30 of 30) September 2023 FP CME session attendees indicate that they had an improved understanding of the treatment options for patients who have heart failure. In addition, all attendees of the CME sessions and the virtual lunch and learn series reported that they understood the referral criteria of the HFC and nearly all (100%, 37 of 37) attendeess of the June 2023 CME session indicated that they had a better understanding of the patient journey within the HFC.
Improve FPs' confidence to better support patients with heart failure	↗ Evaluation findings suggest that the education and engagement sessions improved FP confidence in supporting their heart failure patients. For example, 95% (35 of 37) felt more confident caring for patients after their discharge from the HFC and all (n=30) attendees reported feeling more confident managing patients with different stages of heart failure.

[2] *SCC3 Improvements in physician and other health provider coordination, flow of care and communication: M0005 – Improved coordination of care between physicians, M0007 – Improved care communication between physicians, M0010 – Improved care communication between physicians and other healthcare providers*

Improve collegiality between FPs and HFC staff/ providers[3]	All (n=37) FPs who attended the June 2023 education and engagement session reported that the session facilitated relationship building with the Heart Function Clinic team.
Improve care experience for patients with heart failure issues	Due to project timeline and budget restrictions, the evaluation was not able to prioritize collecting patient data at this time. Team and working group interviewees indicated that collecting patient feedback would be an important consideration for future work in this area.

Recommendations & Next Steps

The evaluation solicited recommendations for next steps from project and working group interviewees. The following ideas are shared here for the consideration of the project team. As mentioned above, interviewees indicated that to ensure sustainability of project outcomes, intentional efforts are necessary. Therefore, project team members and partners indicated the following as considerations for future related work:

- **Continued Education and HFC Promotion |** Several interviewees indicated that continued yearly education sessions should be hosted for existing and new to practice SND FPs to sustain and spread awareness and knowledge of the HFC and other JPOCSC services. Similarly, one interviewee noted that engagement and education of MOAs was important as they are an important part of facilitating the connection between primary care providers and the HFC. Another interviewee indicated that continuing to develop and share resources related to this work would be important to support promotion of available heart failure resources, service, and supports amongst primary care providers.

> *"The hope is that they [FPs] will retain that information, and then they'll share with their colleagues and then that just becomes a usual workflow…So that's the hope."*
>
> *"We thought that maybe doing this once a year or even once every six months might be more than expected, but at least once a year would be totally reasonable as a means of refreshing this for new GPs and old GPs. And, you know, repetition is going to be the best way for us to have an enduring effect."*
>
> - *Project Team and Working Group Interviewees*

- **Facilitating Communication Streams between Primary Care and the HFC |** Continuing to explore opportunities to support communication between FPs and the HFC was mentioned by interviewees. For example, FP/NPs do not have access to the HFC EMR and therefore cannot read HFC provider notes, particularly HFC nurse and pharmacist notes around medication changes being made. One interviewee noted that there was some discussion and early exploration done by project management around finding ways to provide FP/NPs with access to these EMR notes through UCI or Care Connect, however, ultimately

[3] SCC5 – Improvements in GP access to Specialist consultations: M0011 – Increased collegiality between family physicians and specialist physicians

no progress was made around this. One interviewee noted that it may also be beneficial to leverage the RACE app to further connect primary care providers and specialists, beyond the scope of this project.

- **Gathering of Patient Feedback |** Two interviewees noted that gathering feedback from patients regarding their experiences at the HFC would be beneficial to further understand how current processes and the changes that have been made up to now, are impacting patients' perception of the care that they are receiving as well as gather ideas on how processes and care can be further improved.

Conclusion

While not all of the Heart Failure project's intended objectives were fully realized, the project was successful in bringing together partners to explore and address existing gaps in care for SND heart failure patients. In particular, key successes of the project were building connections between primary care and HFC, increasing FP understanding of the HFC, and improving their confidence to manage their heart failure patients. The project has created a foundation of collaboration between primary care and the HFC that can continue to benefit providers and patients in SND into the future.