FAMILY PRACTICE RENEWAL PROGRAM

myQ Quality in Family Practice

Practice Improvement: Good News Stories

TRANSFORMING HEART FAILURE CARE: STREAMLINING THE REFERRAL PROCESS TO IMPROVE ACCESS

Situation/Problem

A quality improvement project was launched between a primary care physician, cardiologists, and staff from the Heart Failure Clinic to improve the care of patients with a diagnosis of heart failure. The group of physicians, nurse practitioners, managers and office staff came together to address what they thought could result in a better patient experience of care by:

- Reducing significant delays in obtaining echocardiograms for a definitive diagnosis,
- Improving the sharing of clinical information about patients and status of referrals,
- Reducing uncertainty of patient need for cardiology referral,
- Improving the ability of primary care providers to adjust heart failure medications following treatment in the Heart Failure Clinic.

Over the course of six months the team members met 7 times to discuss and test changes using the existing available resources within the teams.

What did the team accomplish

The team achieved 3 important improvements in the Heart Failure (HF) referral process:

1. A direct referral to the Heart Failure Clinic was tested for an approach that improves access to the clinic while avoiding referrals that are less likely to benefit from the expertise of the clinic. Using an out-out-province BNP lab test and evaluating patient readiness to participate in the HF clinic, using a scripted conversation tool, the primary care physician is able to refer appropriate patients to the HF clinic for an appointment in approx. 2 weeks. They have also avoided a duplicate consultation to a cardiologist in this process creating more capacity for cardiologists to see other patients.
2. A common referral form for cardiology to improve clarity around important information to exchange was developed. Additionally, use of the upcoming appointments in the MedAccess EMR is now being used to track scheduled appointments to the HF clinic. These changes resulted in more effective communication without increasing the overall amount of information exchanged.
3. Discussed important discharge report information on how to manage heart failure medication changes. This discussion may inform the HF clinic's future communication to primary care on the order for titrating or changing medications in response to patient condition.

Facing system barriers like: wait times for echocardiography, special authorizations required for diagnostics, and access to therapeutics, this team made meaningful changes to improve care for patients needing a referral to general cardiology or the heart failure clinic.

What's next

The team is going to continue testing and refining tools developed in the Navigating Care Coordination Series. The team plans to revisit their care coordination agreement in 6 months to assess the improvements and identify further opportunities for changes. Please send any questions or requests for a copy of the care coordination agreement to: Nancy.Dillon@myqnl.ca

"Sharing the referral status minimizes work for everyone and creates a better experience for the patient"

– Family Physician