

P3 - CCN PROVINCIAL HEART FAILURE STRATEGY: ADDRESSING BARRIERS TO HEART FAILURE MANAGEMENT IN LONG-TERM CARE

Kira Goodman, Anne Forsey. Cardiac Care Network of Ontario.

Contact: kgoodman@ccn.on.ca

Brief Description of Research or Project: With an aging population, the prevalence of heart failure (HF) is rising in people living in the community and in long term care (LTC) facilities. HF affects over 20% of LTC residents and is associated with increased mortality and frequent hospital admission. Despite clinical guidelines, HF management in LTC in Ontario is suboptimal as a result of resident complexity, suboptimal resources, and a fragmented and disorganized provincial health care system. In response to the increasing burden of HF in the aging population, the Cardiac Care Network of Ontario (CCN) assembled an interdisciplinary HF Working Group in 2011 and drafted The Provincial Heart Failure Strategy (PHFS) that will be formally launched in February 2014. The PHFS highlights the need for standardizing HF tools and resources for patients, caregivers, and interprofessional teams; building capacity within the health care team; and improving organization of care in the context of a hub-and-spoke model of HF care that can be adapted to a local context. This poster will review the current literature describing the challenges to delivering optimal HF care to LTC residents and highlight how implementation of the PHFS will support improved care in this complex and dynamic population. **Why is this research important to profile at the Research Day 2014?** Management of heart failure in the community and long term care facilities In Ontario is suboptimal as a result of resident complexity, suboptimal resources, and a fragmented and disorganized provincial health care system. The challenges for managing HF are experienced by patients and their family members, health care providers, care leaders, and policy makers. The Provincial Heart Failure Strategy (PHFS) was developed by an interdisciplinary team at the Cardiac Care Network to help address gaps in the current system and will be formally launched in February 2014. Key priority recommendations identified in the PHFS are of interest to attendees at this conference and include: 1) standardizing tools and resources for patients, caregivers and clinicians, 2) improving organization of care, and 3) enabling measurement and improvement on HF related care processes. This poster will review the current literature describing the challenges to delivering optimal HF care to LTC residents and highlight how implementation of the PHFS will support improved care in this complex and dynamic population.