2006 Heart Failure Consensus Conference Recommendations Program

Terms of Reference for Clinical Practice and Health Outcomes Impact Working Group (IWG)

Table of Contents

Letter of Introduction……………………………………………………………...…...3

CCS HF CC Impact Working Group- Terms of Reference….…………………….4

CCS IWG Meeting Agenda/Minutes- 01/04/2006……..………….………………..9

CCS IWG Meeting Agenda/Minutes-02/10/2006………………………………..20

CCS IWG Meeting Agenda/Minutes-03/16/2006………………………………..27

Letter of Introduction

RE: CCS Heart Failure Consensus Conference – Impact Working Group Terms of Reference

We are pleased to offer the enclosed document which outlines the Terms of Reference for the Impact Working Group including a project summary and descriptions of roles, responsibilities, benefits and commitment.

As you know, CCS has made a substantial and long-term commitment to identifying best practices in Knowledge Translation. Since beginning this initiative in 2005,

The CCS Heart Failure Consensus Recommendations Program has experienced significant growth during this time and now includes participation of organizations and individuals who represent Canada's cardiovascular care community.

Over the past year, our 'closed-loop' approach to guidelines development has resulted in a number of innovative achievements including:

- CCS' first formal multi-disciplinary Primary Panel
- Establishment of the CCS Heart Failure Consensus Conference Advisory Roundtable
- Completion of CCS' first-ever end-user needs assessment
- Detailed program specifications for dissemination, implementation and evaluation
- Deployment of Core Development Teams
- Completion and publication of 2006 Heart Failure Consensus Recommendations in CJC January 2006
- Publication of 2006 Consensus Recommendations in four professional journals March 2006
- National program of regional workshops for the 2006 Consensus Recommendations scheduled for Lake Louise, Toronto, St. John and Montreal
- Creation of the multi-disciplinary and –organization Impact Working Group

Please feel free to contact John Parker (parker@ccs.ca) who will be happy to address your questions and comments on any aspect of this initiative.

We are genuinely grateful for your continued support and interest and look forward to completing this important next stage of this project with you.

Kindest regards,

Heather Ross MD
Chair CCS Consensus Conference Committee

Malcolm Arnold MD
Chair CCS Heart Failure Consensus Conference

John Parker MN
Director Knowledge Translation

Jonathan Howlett MD
Co-Chair CCS Heart Failure Consensus Conference

Impact Working Group – Terms of Reference

Purpose: The CCS Heart Failure Consensus Conference Clinical Practice and Health Outcomes Impact Working Group (IWG), which involves the highly collaborative efforts of CCS and a number of national health care organizations, has been struck to:

1. Develop a five-year strategic impact research plan for quantifying potential impact of the CCS Heart Failure Consensus Conference Program (includes the consensus and a number of dissemination and implementation strategies) on clinical practice patterns and health outcomes

2. Develop a five-year academic publishing/communication plan whereby the results of CCS' long-term commitment to identifying best practices in knowledge translation, as they apply to evidence-informed recommendations for heart failure care, are shared with CCS stakeholders and the broader national and international health care communities

3. Mobilize resources necessary to execute strategic research plan

Membership: The IWG currently consists of the following formally represented individuals and organizations (see Table next page):

Current CCS IWG Representation (February 2006)

Organization	Representative(s)
Canadian Cardiovascular Society	M Arnold P Liu H Ross J Parker
Heart and Stroke Foundation of Canada	Sally Brown/Designate
Canadian Institute for Health Information	G Webster
Canadian Institutes of Health Research	Elizabeth Stirling
Canadian Cardiovascular Outcomes Research Team	J Tu
Canadian Congestive Heart Failure Clinics Network	J Howlett A Ignaszewski
Quebec Heart Failure Society	N. Racine
Guidelines Standards and Evaluation (AGREE) Expertise	I Graham
Acute Care Nurse Practitioner	V Micevski
Mezzanine Business Consulting	M Healy

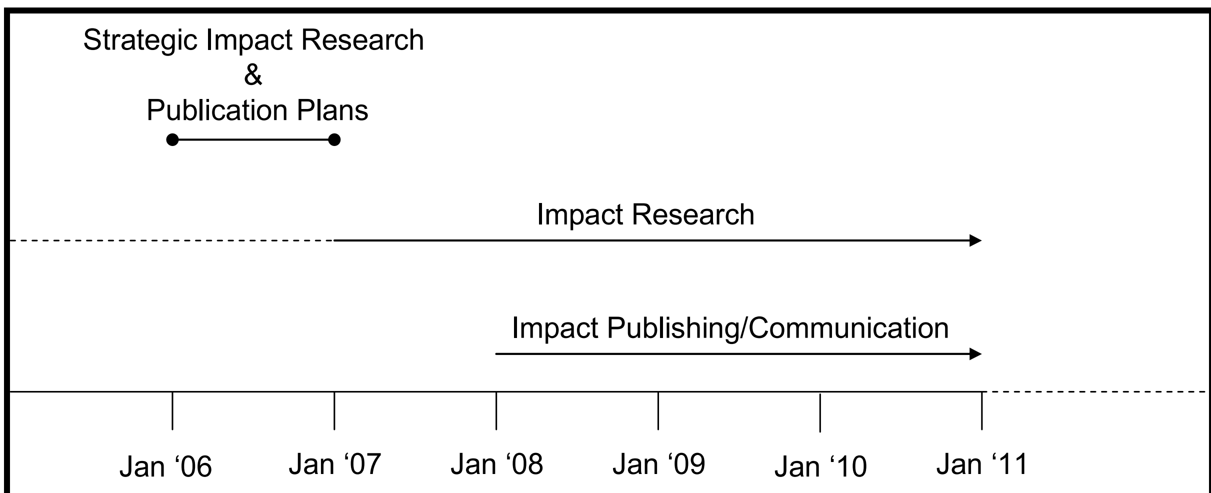
Membership will expand to include Health Canada and appropriate representation from the province of Quebec

Term: Given CCS has secured funding to evaluate three cycles of its closed-loop model of guidelines development, the term for membership on the IWG is similarly three years. At the

conclusion of the three year commitment, extending membership for additional three year intervals is possible.

The current Chair of the CCS Consensus Conference Committee serves as Co-Leader of the CCS IWG for a period of three years. The second Co-Leader of the CCS IWG will be chosen at the discretion of individual members of the IWG. IWG Co-leaders will be nominated thereafter and approved by CCS Executive.

Timeline: The IWG will focus on three parallel streams of activities:



The primary focus of the strategic research plan is quantitative data that relate to clinical practice patterns and health outcomes. These data could, for example, reflect diagnostic, treatment or hospital usage patterns or incidence, prevalence or mortality patterns. In addition, the strategic research plan will include detailed resource (human, financial, infrastructure) requirements.

The primary focus of the academic publishing and communication plan is sharing of findings which identify and quantify impact with project stakeholders as well as the broader national and international health care communities. In addition, the strategic academic publishing/communication plan will include detailed resource (human, financial, infrastructure) requirements.

Time Requirements: The IWG is a ‘virtual’ working group with the balance of communication conducted by electronic means, teleconference and surface mail. The inaugural meeting of the IWG is a face-to-face meeting to review proposed terms of reference, overall objectives and timelines. The need for future face-to-face meetings will be determined by the IWG on an as needed basis.

Participation on the IWG will require an estimated 20 hours per year. The balance of this commitment will involve ongoing correspondence and dialogue with the IWG’s members.

Resources: The IWG has access to CCS resources provided in the form of support staff and funding required to deliver both strategic research and publishing/communication plans. This includes as-needed access to the CCS Director Knowledge Translation and CCS Manager Knowledge Translation in addition to funds necessary to cover reasonable expenses incurred by individual IWG members during the strategic planning phase due to travel, accommodation, meals, communication and office supplies.

Once completed, both strategic research and publishing/communications plans will be used to secure funding and resources necessary to realize the third objective of the IWG – execution of both strategic plans.

Concurrent Evaluation: As a concurrent evaluation activity, the Core Development Teams responsible for implementation and evaluation stages of the project are conducting and reporting results of annual evaluations of qualitative variables known to affect end-user acceptance, uptake, allegiance and recurrent use of evidence-based recommendations including:

Value as Perceived by Target Users	• Relative advantage of new CC • Complexity of CC implementation into day to day care • Feedback integrated into CC development process • Magnitude of change in clinical practice of new CC • Representation of stakeholders during development • Does the CC save time and improve patient satisfaction
Development Process as Perceived by Target Users	• Transparency of development, dissemination and implementation processes • Quality of recommendations • Development involves systematic computerized review a grading of evidence • Rationale is provided for revising existing recommendations • Inclusively of development
Known Dissemination & Implementation Barriers Posed by Target Users	• Awareness and familiarity • Practicality of recommendations • Passive means of dissemination and implementation • Education/training requirements and implications of CC • Cost/equipment implications of CC • Potential liability/malpractice implications • Barriers in practice setting (i.e. policies, processes, social factors) • Means of evaluation and integration of feedback (quality improvement)

CCS IWG Meeting Agenda & Minutes 01/04/2006

CCS Heart Failure Consensus Conference
Clinical Practice Patterns and Health Outcomes Impact Working Group
Toronto, Ontario
January 4, 2006

Participants

H Ross, Co-Chair
M Arnold, Co-Chair
P Liu, Co-Chair
I Graham
G Webster
J Tu
V Micevski
J Howlett
VA Singh
M Healy

Regrets

A Ignaszewski

1300 – Welcome & Introductions H Ross/M Arnold

1315 – Summary of CCS Heart Failure Consensus Conference Project – J Parker

1345 – CCS Objectives of Impact Evaluation – H Ross, M Arnold

1400 – Open Discussion

1430 – Review Working Group Draft Terms of Reference – H Ross/M Arnold

1500 – Break

1530 – Summary of Professional/Institutional Interest (15 minutes/Participant)

- VA Singh – Canadian Institutes of Health Research (CIHR)
- I Graham – Guidelines Standards and Evaluation (AGREE)
- A Ignaszewski/J Howlett – Canadian Heart Failure Clinics Network (CCHFCN)
- G Webster – Canadian Institute for Health Information (CIHI)
- J Tu – Canadian Cardiovascular outcomes Research Team (CCORT)
- V Micevski – Acute Care Nurse Practitioner
- H Ross/M Arnold/P Liu - CCS

1700 – Dinner

1800 – Definition of Working Group Goal – H Ross/M Arnold/P Liu

1815 – Inventory of Available/Required Resources – M Arnold/J Parker

1830 – Identify Short- & Long-term Timeline – H Ross/M Arnold

1930 – Future Meeting Dates/Format – H Ross/ M Arnold

1945 – Close

CCS Heart Failure Consensus Conference - Minutes
Clinical Practice Patterns and Health Outcomes Impact Working Group
Renaissance Toronto Hotel
Blue Jays Room
Toronto, Ontario
January 4, 2006

Attendees

H Ross, Co-Chair
M Arnold, Co-Chair
P Liu, Co-Chair
I Graham
G Webster
J Tu
V Micevski
J Howlett
VA Singh
M Healy
K Harrison

Regrets

A Ignaszewski

1. **Welcome & Introductions H Ross/M Arnold**

M Arnold welcomed everyone to the meeting. M Arnold also thanked everyone for agreeing to be part of this important working group.

2. **CCS Objectives of Impact Evaluation – H Ross, M Arnold**

Summary of Presentation by H Ross

Consensus Conference Guidelines – 2004 Member Needs Assessment

The Canadian Cardiovascular Society represents over 750 physicians and researchers in Canada. It is the national voice for cardiovascular physicians and scientists.

The mission of the CCS is to promote cardiovascular health and care through:

- Knowledge translation, including dissemination of research and encouragement of best practices through dissemination.
- Professional development and leadership in health policy.

In 2004, CCS members identified Consensus Conference (CC) Guidelines as the second most important offering of the Society. To strengthen this offering, CCS has undertaken an innovative initiative to improve its Consensus Conference Guidelines development and dissemination process.

History of CCS Consensus Conferences

- Long history of excellence with CCS Consensus documents
- Of critical importance to CCS membership
- Decision made at Council level to redress the purpose of Consensus documents
    - Do we want to be one more guideline?
    - Same old same old
    - OR - do we want to change uptake, practice and potentially patient outcomes

Decision Regarding CCS Consensus Conferences

- Re-evaluate the consensus process
- Long term changes - controversial
- Iterative
- Based on holes/gaps/reasons why health care providers do not use/uptake guidelines
- Based on needs assessment/reassessment
- Look at impact of changing the consensus process

CCS Heart Failure Guidelines - Results of a Multi-disciplinary Needs Assessment- Patient Related Findings

- 15% are aware of heart failure guidelines.
- 30% have heard of CCS.
- 0% are aware of CCS HF CC Guidelines.
- 95% desire a copy of the CCS HF CC Guidelines.
- 85% would like to have a copy of the CCS HF CC Guidelines in a simple, patient-friendly (e.g. Explaining why a doctor has prescribed beta blockers) one page summary format.

Recommendations

Development

- CCS should consider further expanding its representation of the Primary Health Model on the CCS HF CC Guidelines Primary Panel.

Dissemination

- CCS must coordinate dissemination of Guidelines to a much broader series of populations, through the heads of their respective organizations, including: GPs, Internists, Nurses, and Patients.
- CCS must increase the frequency with which the availability of the CCS HF CC Guidelines are communicated.
- CCS must improve its marketing of the CCS HF CC Guidelines.
- CCS should incorporate more process transparency into its communications with the five target populations.

Implementation

- The CCS HF CC Guidelines should prepared and distributed by these societies in the most appropriate format.
  - Cardiologists, GPs, internists, and nurses – a one-page, laminated, folding pocket card summary of the CCS HF CC Guidelines.
  - Patients – a simple one-page, patient-friendly summary, and access to a full text hardcopy version on the CCS website.
- CCS should support the written versions of the Guidelines with a training “road show” across Canada.

Evaluation

- CCS should consider conducting clinical practice audits at pilot sites starting in Cycle 2
- CCS should establish a Clinical Impact and Health Outcomes Working Group

Actions taken by CCS based on Recommendations

- CCS Core Development Teams for Dissemination, Implementation and End-User Satisfaction
  - Knowledge Translation Office
  - Microsoft Canada
  - Nova Networks
  - H3 Communications
  - Project Management

- End-User Identified Implementation Tools Development
  - Pocket Card
  - Practice Audit
  - Regional Interactive Workshops – Lake Louise, Toronto, Quebec, St. John

- CCS Guidelines Impact and Outcomes Working Group
  - Canadian Cardiovascular Society
  - Canadian Cardiovascular Outcomes Research Team
  - Canadian Institute for Health Information
  - Canadian Institutes of Health Research
  - Canadian Congestive Heart Failure Clinics Network
  - Guidelines Quality and Standards Expertise (AGREE)
  - Advanced Practice Nursing Expertise
  - Business Management Expertise

  Additional IWG membership was discussed, including Heart and Stroke Foundation of Canada, Health Canada and Quebec-based representation. J Parker will follow through with formal invitations

- Publishing
  - *Canadian Journal of Cardiology* – Canadian Cardiovascular Society
  - *Canadian Family Physician* – College of Family Physicians of Canada
  - *Canadian Pharmacists Journal* – Canadian Pharmacists Association
  - *Geriatrics Today* – Canadian Geriatrics Society
  - *Canadian Nurse* – Canadian Nurses Association

- Commitment
  - Three complete cycles of 'closed loop' guidelines development model

Discussion: M Arnold brought up the issue that CCS does not use the term "guidelines". Will try and have key words and linkage with the word "guidelines". However the term Consensus Conferences Recommendation(s) will be used.

I Graham discussed the fact that Consensus Conference is not thought of as evidence based, just best practices as identified by consensus of a group. So, regardless of what it is called and how it is branded, it must be clearly promoted as evidence-informed.

M Arnold circulated the Canadian CC recommendations on heart failure diagnosis and management 2006. J Howlett suggested that the title should be shortened to say CCS heart failure diagnosis and management 2006. In addition, I Graham will review this document using the AGREE guidelines.

3. Review Working Group Draft Terms of Reference – H Ross/M Arnold

Objective

- Charged with determining how to evaluate…….and then to evaluate if there is an <u>impact</u> of the new consensus process/efforts on healthcare provider practice/patient outcome

Purpose

- Develop a five-year strategic research plan for quantifying potential impact of the CCS Heart Failure Consensus Conference Program (includes the consensus and a number of dissemination and implementation strategies) on clinical practice patterns and health outcomes
- Develop a five-year academic publishing/communication plan whereby the results of CCS' long-term commitment to identifying best practices in knowledge translation, as they apply to evidence-informed recommendations for heart failure care, are shared with CCS stakeholders and the broader national and international health care communities
- Mobilize resources necessary to execute strategic research plan

Membership

- CCS – J. Parker, M. Arnold, P. Liu, H. Ross
- CIHI – G. Webster
- CIHR – A. Leury, VA. Singh
- CCORT – J. Tu
- Canadian Standards and Evaluation – I. Graham
- Canadian Congestive Heart Failure Clinics Network - J Howlett, A Ignaszewski
- ACNP – V. Micevski
- Mezzanine Business Consulting – M. Healy

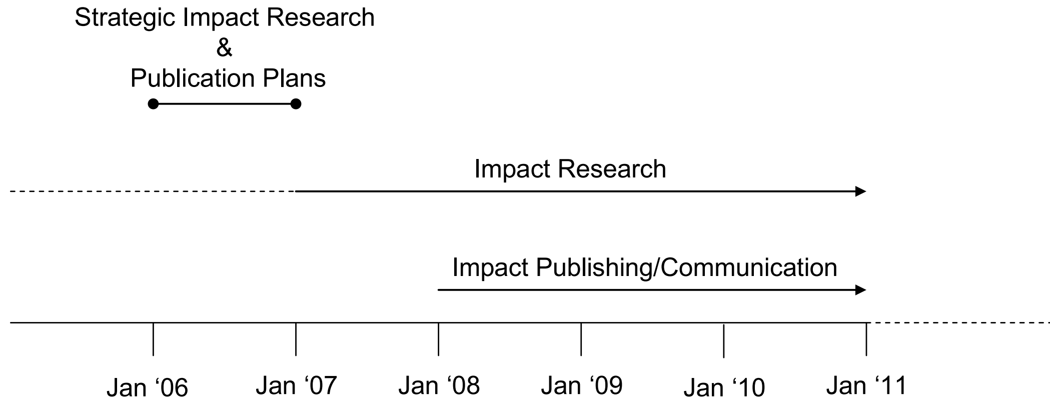
Term

- CCS has secured funding to evaluate three cycles of its closed-loop model of guidelines development
- Hence the proposed term for membership is three years
- At the conclusion of the term a three year extension is possible

Co-Chairs

- One Co-Chair of the IWG is the current CCS Consensus Conference Committee Chair
- The second IWG Co-Chair will be chosen at the discretion of the IWG members
- IWG Co-leaders will be nominated thereafter and approved by CCS Executive

Timelines: IWG focus - three parallel streams of activities



Plan

- Jack Tu:
  - Focus on one or two of the recommendations as opposed to all of them
  - Ensure dissemination, and media to help in dissemination (medical post/star, globe etc) Key issue: That people are not aware
  - Include use of the HF awareness week Feb 14th
  - Get message out multiple times
  - Aim at GP in terms of target and measured outcomes audience - note most difficult to reach
  - Measurable and changeable within the target audience and time
  - Create incentives for change - audit data, feedback and potentially make it public (as a way to change practice)
  - KOL's from industry/hospital involved in knowledge translation
  - Target pharmaceutical: BBL, spironolactone, including monitoring of therapy
  - Target non-pharmaceutical options as well

  - Comments/Suggestions from the committee members:
    - I Graham
      - Prioritize these important messages while being very clear who is the target audience
      - Communicate with the knowledge translation group
      - System issues e.g. - short visits, may not be because they don't know or believe in recommendations but what are the system issues that may be blocking implementation of guidelines. Take the recommendations to small group/AGREE reviewed
      - Tailor the recommendations to fit local context - includes involvement of key opinion leaders - hence try to facilitate the adaptation process at local level

- Innovation decision process:
  1) awareness is first step,
  2) persuasive (change)
  3) Use (intention – do you intend to use them)
  4) Sustainability (on going use – three types
     a) Use it, doesn't work, abandon it
     b) Use it, works, implements it
     c) Use it, partially works, adapt it

- M Healy
  - Dissemination – uptake -implementation
  - Must measure at discrete points in time

- J Howlett:
  - Morbidity and mortality,
  - hospitalization and death
  - what is the penetrance of heart failure clinical usage
  - ACEI/ARB (though Jack's point well taken – may well be saturated
  - EOL
  - Lifestyle
  - device therapy
  - BNP

- V Micevski
  - Indicators of self-care practice – daily weights, adherence to their prescribed therapy

- M Arnold
  - Symptoms of HF- awareness at GP and public level

- J Tu
  - Ontario laboratory data bases to be 'linked' in the near future
  - 2004 calendar year, approx. 9000 patient hospitalizations for HF audit
    1) Will review – recommendation and case report form to ensure that issues that we have are included on their case report form

Specific Variables

- Beta Blockers – most promise
  1) prescription rates, hospital BBL use discharge rate, hospital/clinical BBL use at admission rate, long term compliance prescribing, pharmacy fills
  2) Provincial databases – ICES, ICONS and the Heart Failure Clinic Network
  3) Target doses or % of target dose
  4) Compare between different health care providers

a) Potential need for focus groups, survey to find out why they aren't using it (part of knowledge translation group)

- Disease Management Program
  1) Get hospital to report if patients will be enrolled into or are currently in DMP program – longer term goal – are hospitals paying attention to the importance of DMP (number needed to treat 5), and increasing the number of programs/access
  2) Use HF clinic network – enrollment rates pre and post CCS recommendations – specifically are the high risk patients getting referred to established DMP (shorter term)
  3) Attitudes toward DMP – GP – diagnosis, management and timely referral - can also use as a method of dissemination
  4) Patients Self knowledge and awareness, post discharge or HFC visit mailed questionnaire
  5) Public Awareness – Health Promotion and prevention general awareness, prevention
  6) CIHI – special project fields – have specific centers enter data into the specific fields and then you can get the data at the end
  7) have clinical team develop a basic check list, get health records to enter that minor data, then can access later
  8) Need info in by fall to get info back by next year.

  a) Variables:
     - have they been discharged to a disease management program
     - Discharge education
     - Where they on BBL before admission to hospital
     - Are they on BBL at discharge

- Review of discharge summaries/strategies to assess patient education effectiveness

____ CIHI

____ ICONS, ICES (BBL)

____________________________________ Hospitals (BBL)

______________________________ HF Clinics (BBL)

______________________________ Clinical Studies (Targeted Sampling)

____________________________________ GP Offices (BBL) –

____ HF Patients (Survey)
(nested study with knowledge translation, survey then implantation different between groups, focus group)

____ Population

ACTION: Minutes to be sent out ASAP. Members are to send J Parker a half page/proposal outlining what they would like to be involved in along with any additional ideas they may have.

Will create a small executive group and get individuals together. Need to start very quickly and getting some names tied to get some broad objectives together.

J Parker proposes to outline a business plan that will outline the necessary resources that is required, including a full time project manager.

Face to face meeting in another 2 months. If no dates feasible at the beginning of March, then Lake Louise at the end of March might be an option – L Hodgson to arrange

Teleconference call in 3 weeks – L Hodgson to arrange

Meeting adjourned at 7:30pm.

CCS IWG Meeting Agenda & Minutes
02/10/2006

PARTICIPANTS

Malcolm Arnold-Co-Chair
Heather Ross- Co-Chair
John Parker
Mark Healy
Greg Webster
Peter Liu
Jonathan Howlett
Andrew Ignaszewski
André Leury
Normand Racine

Regrets:
Jack Tu
Sally Brown
Vaska Micevski

Welcome:

Heather welcomed everyone to the call. Malcolm and Heather will co chair.

Review of past minutes:

Malcolm moved them to go forward. Hearing no opposition and no changes, Heather accepted the minutes.

John noted that this teleconference is being recorded and notes will be created based on the recording.

Review/Approval IWG Business Plan:

John circulated draft of the business plan; Peter, Heather, Malcolm and Jonathan have reviewed it. Their feedback has been incorporated into the version that the group has received.

John tested the model and proposal with two industry partners who are currently part of the investor pool for the Heart Failure project, Sanofi and Boehringer Ingelheim. The feedback that we have received is essentially positive. Based on the feedback, we learned that the information that is needed for the investors to make the decision internally to support this project is contained in this document, the amount we are asking for are perceived to be reasonable, that there is a clear return on investment and they said that if this document was on their table formally the would have no problem supporting this project for 3 years.

This proposal is an extension and a mirror of original business proposal. It is a multi investor, pooled, 3-year commitment. The money comes directly to CCS, CCS pools the money and allocates based on need over the duration of the project.

We are seeking $750,000 unevenly spread over 3 years. There is some upfront one time investment costs for year 1. One of those proposed is money that is directed to upgrading and stabilizing the current database within the Heart Failure Clinics Network and the second is that money goes towards the development of a Heart Failure specific Website. There are reoccurring costs from one year to the next including a full time Program Manager, it is suggested that recruiting begin as soon as possible.

We are looking for a minimum of 6 investors; we are offering the original 6 investors first right of refusal, they are aware of this and they know this is coming.
John would like to get the information to them by Monday with the group's input and approval.

The expectations per investor for the first year (Fiscal 06/07) investment is $45,100 and for year two and three $38,500 for a total of $ 122,100 for the 3 year investment. The investors will sign a commitment of investment form to be submitted by March 17th, which is two weeks prior to our fiscal year.

All companies that we have spoken to are in the position where they are planning and allocating funds for the coming fiscal year and feel the timing is right for investing in this project. John requested comments and feedback.

Heather felt it was a great document. One of the people who comes to mind as a project manager is Marcella Shouldice. She is great at organizing people and holding them to timelines. Malcolm felt she was also a good suggestion. Some of her projects are winding down so it might be a good time to approach her.

John agreed that Marcella was worth every penny and that they have had positive experiences working with her. Heather noted from an administrative point she has the history, experience and track record with us and we know what we would be getting.
It was agreed that John should approach her and make an offer.

Mark mentioned that they should look for an individual who has health care experience, good with long term planning, deadline management and strong communication skills. Heather agreed and confirmed that from working with Marcella on the Access to Care that she is confident that Marcella would be an excellent candidate.

Mark asked if the candidate would be involved with the financials. John said the financials would most likely remain in his scope. The candidate would look after execution.

Ian noted that he didn’t see a budget line for an analyst, so who is actually going to analyse the databases. John said that each organization at the table represents significant infrastructure; part of our strategy is how we could economically tap into those infrastructures with the meat of this project. If that is not possible then we need to allocate the money for an analyst would likely be full time. Ian noted Jack Tu has a number of analysts but in order to shift their priorities money does magic. In the business case, there is money allocated to database usage, John thought that the $65,000 could be used towards the salary for an analyst.

Ian mentioned that getting the analyst to get the data into the formats that we can use and then we have to pay them to do the analysis. As long as we have the resources it is will be ok.

Peter noted that as the project moves we will have a better idea of the financial allocations needed.

John agreed and that there would be some play with the financials for allocating to areas that need it. The total fiscal requirement for fiscal 06/07 is $45,000, which is just under the $50,000 mark, and our experience has been once you meet that threshold it becomes a different conversation with the Pharma companies and involves higher-level approval. By staying under it or around it we reduce the number of people involved in the decision of supporting the project.

Heather mentioned that having Peter around the table should help provide some guidance as he is currently in control of a large budget.

Mark questioned whether Marcella would come for $75,000 per year? Heather wasn't sure but John thought that was reasonable and that he felt it was within a range she would consider.

John would like to finalize the document and with the group's approval send it to our potential investors and would ask that once this document is released that we (the group) take this back to our contacts through our networks, create some excitement and buzz regarding this work group and the importance of the work we are achieving.

Peter suggested that we look at what is required and who is accessible and who are yet the potential accessible candidates and divide it up as we may each have preferred candidates that we are more individually affective at communicating with.

John has put together a web site for this project and we will be testing it with the primary panel and working group at the beginning of next week. The intent is for this to become a focus of activity and information sharing for this project. The website will be very rich with information and will become an important centrepiece of this project.

Heather requested group agreement on making a formal pitch to securing Marcella as a project manager. The group agreed. John will put forward an offer to her on Monday.

Finalization of Research/ Publication Projects
Heather noted that at the last meeting, all the members were to send John a half page proposal outline what they would like to be involved in and outlining any other comments or ideas. We have not received any to date. We really need to move this piece forward.

This is meant for open discussion. Everyone has received the minutes and Malcolm has done a really nice diagram looking at it in it's entirety.
She mentioned that it all falls under the title "Who is going to take what and what time frame?"

Identification of Project Champions/Roles & Responsibilities

Malcolm noted that the project champions and identification of them would probably help to drive the outlines required and specifics also the projects and the type of research that needs to be done.

The problem with items 4,5 & 6 is we haven't finalized what our research question is. We have identified potential resources to address a question that we haven't formalized.

We have identified a number of research questions and outcomes that we think would like to measure, the flip side of that is the feasibility and cost and timeframe of measurement and the energy and expertise of enthusiasts and project champions.

Malcolm suggested Heather and himself prepare a draft of a document that might beginning to identify things we missed or better practices.
Heather agreed. There has been excellent discussion around the table since the meeting but there has been no follow thru from there to today's call on what the specific research projects should be. Heather felt that the suggestion was an excellent one.

Malcolm noted that the group would have to commit to the time to critically reviewing the document with criticism and suggestions that we would build on. It will not be final or comprehensive. It would represent our discussions to date.

Over the next two or three weeks we might be able to identify our current plan of action and have a clear objectives, hypothesis, initial timelines and champions. The champions identified would then be responsible for taking each project and plan and outline for their particular project providing objectives, measurement outcomes, strategies and timeframes. The group agreed to this.

Milestones and Timelines:
It is going to be hard other than to put a timeline for the end of February, to identify the research projects and identify the champions for these projects.
We need a strong working document that would be the platform for project champions to build on. Then the project champions can come back with more detailed documents and ideas that can be integrated into a subsequent document by the end of March early April.

- Strong document commitment by February 28th 2006-02-20
- Feedback from call by February 24th.
- Lise to organize Teleconference for March
- Lise to organize Face to Face late April early Ma

Face to Face:
John suggested an alternative to the initial March recommendation.

Heather suggested a teleconference in March. Once we have the project champions identified and a project manager in place a lot of this can be managed electronically and then follow up with a Face to Face in April-May.

Other Business:

Normand Racine committed to the 3 year project officially.
John asked Normand how we should designate him, Normand is a member of the CCS and a representative of the Quebec Heart Failure Society
Normand suggested a monthly recurring call in order to block off the individuals schedules.

Summary/Close:

- The group accepted the minutes
- Normand Racine officially committed to the 3 year commitment
- John presented the Business plan
- John will approach Marcella as a project manager
- 'Straw dog' document by end of February
- Group will send comments and feedback to Heather and Malcolm by end of week
- By March we will identify projects and project champions
- Face to Face late April or early May
- John will send a summary (to do list) to all those not available for today's call.

CCS IWG Meeting Agenda & Minutes 03/16/2006

CCS Impact Working Group
Teleconference
Thursday March 16th 2006
11:am EST

Participants: **Malcolm Arnold, Chair**
Jonathan Howlett
Sally Brown
Malcolm Arnold
Vaska Micevski
Normand Racine
Peter Liu
Greg Webster

Regrets: Ian Graham
Heather Ross
Andrew Ignaszewski
Jack Tu

1. **Welcome- M. Arnold**
2. **Review of Minutes – M. Arnold**

   Malcolm suggested the minutes from the last meeting be accepted. John agreed. The minutes were accepted.

3. **Summary of Research Questions – M. Arnold**

   Jonathan is leading the Heart Failure workshops, there are four across the country aimed at high-level internists/specialists and is hoping to determine some degree of impact, outcomes and change of practice - the details are yet to be defined. In principal the work that will take place at the workshops will target people who can learn from the opinion leaders themselves.

Heather and Vaska, are interested in taking a look at clinicians both academic and in community institutions. It would include specialists as well as trainees and nurse practitioners. The emphasis is on education and adherence to guidelines.

Vaska noted that the purpose of our study was to take a look at how the educational intervention would be affected. One thing that we were looking at implementing was expert clinicians or opinion leaders presenting at rounds. As we are having more discussions around methods, she wondered if there was an opportunity to do two different things, her group could take a look at using web-based learning.

Malcolm has spent time developing a slide kit, and is interested in the continuity of care - the care gap or breakdown of care that exists when a patient comes to emerge with Heart Failure and then is sent home, looking at what happens in the emerge, what information they are sent home with, what follow up happens in the GP's office and how the emerge doctors communicate with the GP's.

Peter will look at the broad base community cluster randomization that would involve GPs and the change in care and the impact of incentives on that. Academic and industrial detailing. Randomization will be based on clusters or groups as it is hard to randomize individuals.

John to draft minutes and send to Malcolm. Malcolm will summarize what accurately reflects each proposal and see where we can have some degree of separation between the projects. Then look to see where each project overlaps or complements the other projects then identify specific interventions, hypotheses and outcomes that would be unique to each project but would complement what the other projects are looking at. Determine at the next conference call based on the feedback, prioritizing what needs to be done first or can they be done in parallel and what data is required for each project and what may be useful for one or two projects so that duplicate data is not being collected.

If the minutes can be turned around relatively quickly then each of the group members should still have a memory of our discussions and each of the group can fine tune and have another conference call and move this forward. If we have a project manager to help in the near future then this would work extremely well.

Sally asked Normand to expand on his comment "that family practice physicians are not interested in following congestive heart failure patients because they are too sick" and asked if others on the call share this view. Sally noted that if that holds true then that is a huge barrier to knowledge translation.

Normand noted that in Quebec they are currently working on trying to desensitize physicians to not be intimidated and to understand that these patients are not that sick. In Quebec, about 20% of GP's do hospitalization and will also follow up outside of hospital, Many do just hospitalization and do very little clinic follow-ups. So the physicians who are sensitized to the hospital follow ups are not the same physicians receiving the patients for follow up care.

Normand went on to describe how we can get physicians excited about heart failure; we are holding two workshops one on the April 7th and one on the 28th. One in Montreal one in Quebec. The afternoon session will be on Heart Failure and in the morning we will be looking at the global cardiovascular risk factors ramifications. We hope to attract more physicians.

Peter noted that while we are putting the projects together we should submit to the CIHR knowledge translation program for funding. They won't fund the entire project but certain aspects of the project would meet the qualifying criteria.

Peter will look into the deadline and process for submitting to CIHR for funding and whether there is a cap on budgets for anyone individual project. The average grant size is approximately $120,000 per year.

Malcolm asked that Peter provide this information to be included into the minutes.

4. Open Discussion/Additional Suggestion – M. Arnold

5. Priority Ranking of Questions – M. Arnold

6. Business Plan Update – J. Parker

John gave an updated on the business plan. The plan was finalized and distributed to the six investors. John has heard responses from two of the original six, Biovail and Merke. They wish to continue their support of phase I of this project (meaning identification of best practices and knowledge translation) but they are both unable to support the activities of the Impact Group. Informally John has heard from both Sanofi and AstroZenica and both are extremely interested in supporting the work of the impact group but John has not received a formal signed off commitment. John is following up with them.

John remains positive and optimistic in receiving the support needed to get the project going for the first year and starting to develop some momentum and then continuing to raise funds for year two and three.

Malcolm asked what resources are needed to move forward. Most pressing right now is to get a project manager on board on a near full or full time basis. The project requires a project management skill at this time. Malcolm asked if there has been any progress with the individuals whose names have been brought forward as project managers. Marie Josie Martin has been approached and the CCS knows her. Marie Josie is here on the call today in Ottawa, to discuss her interest in joining the team.

Marie Josie stepped out of the office so that the group could openly discuss her candidacy.

Malcolm asked John what type of position he would like to offer Marie Josie and how that would be funded. John said he would like to engage Marie Josie full time for the term of one year with the possibility of extension for two to three years.

This project needs a lot of work in terms of establishing a detailed process and that will require someone's full time concentration and attention. John will continue to broaden the search for funding and support to ensure the resources are there to fund this position.

Malcolm asked if the group was in favor of using the funds to hire a good project manager even though that would take from funds that could have been put towards the individual projects. The group all agreed that this was a good idea

John will start expanding the search from the original six investors. He was in Atlanta where he met with different Pharma representatives around this project and there was a huge interest and excitement surrounding this project.

CCS has submitted an abstract for the family medicine forum that takes place in Montreal in November. The abstract is a jointly presented workshop (CCS and the College of Physicians) around the Heart Failure Consensus Recommendations. That might be an opportunity for that aspect of Knowledge Translation to be investigated further.

7. Next Steps/Face to Face Meeting – M. Arnold

   A date has been chosen. It is May 12th in Toronto.

   It was noted it would be beneficial to have a teleconference before the May 12th meeting. If John and Malcolm can work on the wording of the minutes and then get them out to you within a week and then give another week or two for feedback, then having a conference call the 3rd week of April would be beneficial. John noted that he would resend the meeting information with dates and time out to the group.

8. Conclusion

   Vaska just wanted to bring to everyone's attention that the CIHR knowledge grant that Peter discussed; the full nomination package must be couriered out and received by May 15th. And the decision is November 2006. There appears to be one competition with three different levels of impact.

Based on this information Malcolm suggested that we need to tighten the timelines for returning feedback and move up the conference call up sooner than a month. Some people might have more time, energy and experience to put such a grant together within a short timeframe but it would certainly require dedication for several weeks to make that happen.

Malcolm thanked everyone for attending, and special thanks to Greg for attending because they will be looking to him for help with some of the outcomes and measurements that some of these projects would necessitate. Malcolm also thanked Sally noting we are excited to work with Heart and Stroke and see a lot of opportunities for drawing on your expertise.