

Cardiac Care Network

MOVING FORWARD



ANNUAL
REPORT
07 | 08



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Moving forward

As we look forward to the coming year, the Cardiac Care Network of Ontario (CCN) will continue to work closely with member hospitals to provide leadership for monitoring and managing patient access to cardiac services in Ontario, using skills in information sharing, knowledge translation, and collaboration with key stakeholders at the hospital, regional and provincial levels to identify strategies for best practices and system improvements. In addition, CCN will focus on issues pertaining to quality, efficiency, access and equity of advanced cardiac services, with ongoing evaluation of specific metrics and indicators of system performance. CCN is pleased to continue to serve as an advisory body to the Ministry of Health and Long-Term Care in relation to the delivery of adult cardiac services in Ontario.



Who we are

The Cardiac Care Network of Ontario (CCN) is a network of 18 member hospitals providing cardiac services in Ontario. In addition, CCN serves as an advisory body to the Ontario Ministry of Health and Long-term Care. In addition to helping plan, coordinate, implement and evaluate cardiovascular care in Ontario, CCN is responsible for developing, maintaining and reporting on the provincial cardiac wait list registry for all patients waiting for selected adult advanced cardiac procedures in Ontario. In the role of monitoring and enhancing quality of cardiac services in Ontario, CCN develops strategies, based on best practices, to better manage cardiovascular disease across the continuum of care, including strategies to prevent acute hospital readmissions, decrease demand on emergency departments and decrease the need for initial and repeat procedures.

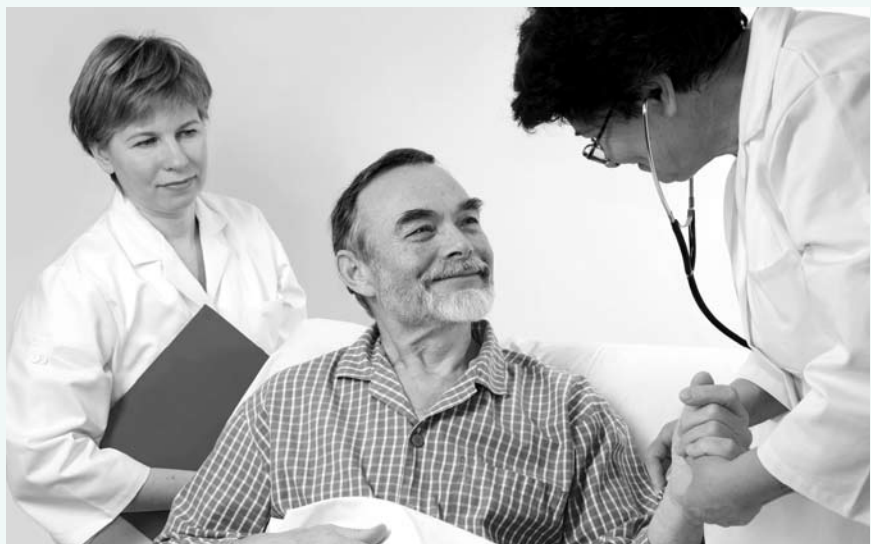
Vision

As a dynamic partnership between professional providers, institutions, community members, and government, providing advice based on data analysis and scientifically valid information, we will become an essential resource in improving the delivery of adult cardiac care in Ontario.

Mission

We are an advisory body to the Ministry of Health and Long-Term Care that is dedicated to improving quality, efficiency, access and equity in the delivery of the continuum of adult cardiac services in Ontario.

Using data and consensus-driven methods, we offer planning advice for the future of cardiac services and the provision of exemplary care in collaboration with the Ministry and others.



Member Hospitals

*Hamilton Health Sciences,
Hamilton*

*Hôpital Régional de Sudbury
Regional Hospital, Sudbury*

*Hôtel-Dieu Grace
Hospital, Windsor*

*Kingston General Hospital,
Kingston*

*London Health Sciences
Centre, London*

*Peterborough Regional
Health Centre, Peterborough*

*Rouge Valley Health System,
Toronto*

*St. Mary's General Hospital,
Kitchener*

*St. Michael's Hospital,
Toronto*

*Sault Area Hospital,
Sault St. Marie*

*Southlake Regional Health
Centre, Newmarket*

*Sunnybrook Health Sciences
Centre, Toronto*

*Thunder Bay Regional
Health Sciences Centre,
Thunder Bay*

*Toronto East General
Hospital, Toronto*

*Trillium Health Centre,
Mississauga*

*University Health Network,
Toronto*

*University of Ottawa Heart
Institute, Ottawa*

*William Osler Health Centre,
Brampton*

Board of Directors 2007–08

*Mr. Matt Anderson
University Health Network*

*Ms. Sarah Chow
St. Michael's Hospital*

*Ms. Patty Cochrane
Trillium Health Centre*

*Ms. Pat Daniels
St. Michael's Hospital*

*Mr. Ken Deane
London Health
Sciences Centre*

*Dr. Christopher Feindel
University Health Network*

*Dr. David Fell
Southlake Regional
Health Centre*

*Dr. Anthony Graham
Heart & Stroke Foundation*

*Dr. Charles Lazzam
Trillium Health Centre*

*Ms. Mary Catherine
Lindberg
Council of Academic
Hospitals of Ontario*

*Dr. Peter Liu
Canadian Institutes of
Health Research*

*Dr. John McCans
Kingston General Hospital*

*Ms. Collette Plourde
Hôpital Régional de Sudbury
Regional Hospital*

*Mr. Lonny Rosen
Gardiner Roberts*

*Ms. Heather Sherrard
University of Ottawa
Heart Institute*

*Mr. Don Shilton
St. Mary's General Hospital*

*Dr. Stuart Smith
St. Mary's General Hospital*

*Mr. Ken White
William Osler Health Centre*

Message from Chair/CEO



Ken White

Despite the availability of excellent health care, the demands for cardiovascular services will continue to increase as a result of the aging demographic of the population. The increasing prevalence of risk factors such as obesity, hypertension, and diabetes will also have a negative impact on the cardiovascular health of the population. We can do our part to ensure the sustainability of the cardiovascular care system for the future through innovation, transformation, and accountability.

Innovation

Innovation means a new way of doing. While the concept of change can be unsettling, it is impossible to be innovative without letting go of the past ways of doing things. CCN is launching a new innovation, replacing the former provincial cardiac registry *Cardiacaccess* with a new web-based software application to collect the key data variables to monitor access, quality and performance of the cardiac care system in Ontario. The new application leverages informatics technology and the highest standards for data quality and privacy encryption. This system also provides a new business intelligence strategy for reports.

Transformation

To transform means to change in form, appearance, or character. As an organization, CCN is transforming, evolving from monitoring and reporting on wait times to enhancing the system of active cardiac access management, and a new focus on best practices and strategies pertaining to other areas of cardiovascular care. CCN is now focussing on unique areas of subspecialty expertise by establishing new Working Groups for key areas to ensure trends in clinical care are followed, and the best metrics and quality indicators are used to track system performance. The creation of a new Research & Publications Committee will ensure that CCN leverages every opportunity to contribute to research and knowledge translation to inform practice.

Accountability

Finally, the sustainability of the health care system requires accountability. CCN has direct accountabilities to a variety of stakeholders, including the MOHLTC, LHINs, hospitals, partner organizations and every adult in Ontario who needs cardiovascular care: It is our highest priority to ensure these accountabilities are achieved.

In closing, we would like to express our thanks to the many individuals who volunteer their time and expertise with CCN, by participating on Expert Panels, Working Groups and Committees. The hours these volunteers give, combined with their dedication and commitment to continuously improve the system, is a significant factor in our success. We would also like to extend our appreciation to the MOHLTC for the opportunities, resources and support provided to the Cardiac Care Network of Ontario.

Yours truly,

A handwritten signature in black ink that reads "Ken White". The signature is written in a cursive, slightly stylized font.

Ken White
Board Chair

A handwritten signature in black ink that reads "Kori Kingsbury". The signature is written in a cursive, slightly stylized font.

Kori Kingsbury
Chief Executive Officer

Financial Summary

Financial Summary

March 31, 2008

	OPERATING FUND	SPECIAL PURPOSE FUND	TOTAL
Statement of Financial Position			
Total Assets	\$1,678,328	\$2,231,222	\$3,909,550
Liabilities & Deferred Amounts	1,459,597	2,231,222	3,690,819
Fund Balance — End of Year	218,731	-	218,731
Total Liabilities & Fund Balance	\$1,678,328	\$2,231,222	\$3,909,550

Statement of Operations and Surplus			
Revenue	\$2,373,919	\$75,078	\$2,448,987
Expenses	2,181,036	75,068	2,256,104
Excess Revenue	192,883	-	192,883
Fund Balance — Beginning of Year	25,848	-	25,848
Fund Balance — End of Year	\$218,731	-	\$218,731

How healthy will your heart be in the years to come?

According to statistics from the Heart & Stroke Foundation, every 7 minutes, someone dies from heart disease or stroke, and more people die from cardiovascular disease than any other disease in Canada—approximately 32% of all deaths (over 72,000 people per year). Are you doing what you can do to be heart healthy?

- Be smoke-free
- Be physically active
- Limit alcohol use
- Reduce stress
- Achieve and maintain a healthy weight
- Know and control your blood pressure
- Eat a healthy diet that is lower in fat
- Manage your diabetes



Prevention or Treatment: Finding the right balance

Eric Cohen MD

“An ounce of prevention is worth a pound of cure”—is this truly the case for cardiovascular (CV) disease? There is no doubt that various strategies are helpful for preventing and delaying the development of CV disease; despite this, there is also a sense that preventive strategies are under-utilized by cardiac care providers. Are we relying too much on complex and expensive treatment for acute CV events?

The answer lies in finding the right balance between preventive efforts and effective treatments. In the hospital setting, we have been focussed on drug and interventional therapy for acute coronary syndromes, heart failure, and heart rhythm disturbances. Advances in the treatment of these conditions have been substantial: in-hospital mortality rates of patients with acute myocardial infarction today are two- to four-fold lower than 20 years ago. The large increase over the past decade in the number of procedures for prompt revascularization and implantation of advanced rhythm management devices has been fuelled by accumulating evidence as to the value of these interventions in reducing various cardiac death, recurrent infarction, symptomatic heart failure and repeat admissions.

Over the past few years in Ontario (and in other jurisdictions), certain procedures such as percutaneous coronary intervention (PCI) and device implants such as implantable defibrillators have not continued to increase at the rates that were projected; that is, the rate of increase in these procedures has been slower than anticipated. At the same time, there has been definite progress in preventive efforts, for example, a recent report documented clear improvement in control of hypertension in Ontario. In addition, there are multiple reports on the links between smoking restrictions and reduction in adverse CV events. Among patients with established CV disease, the use of evidence-based drugs clearly lowers recurrence rates. While there is much more to be done with prevention, especially in light of disturbing trends in obesity and diabetes, there is no doubt that the success of preventive efforts to date play at least a partial role in accounting for recent observations regarding cardiac procedure volumes.

“The interplay between prevention and treatment may be more nuanced than the simple ‘more prevention equals fewer procedures’ equation.”

At the same time that procedure volumes have stabilized or declined, the complexity of the patient undergoing these procedures—measured by the level of risk, or the extent of co-morbidity conditions, has increased. Patients are, on average, older, and are more likely to have co-existing conditions such as diabetes, renal disease, and a history of cancer.

A detailed understanding of these trends will be essential to future planning of cardiac services. The existing focus on procedure volumes and capacity has been highly effective in improving access for the vast majority of patients. As we further expand and reinforce preventive efforts, we will need to pay attention to the resulting changes in the mix and complexity of patients and procedures in order to ensure that the access standards that have been established are maintained. CCN has a key role to play in these efforts by virtue of its infrastructure and expertise for data collection, interpretation, and planning advice. ■



CCN: Creating a Data Access Strategy

CCN has a well established reputation as a leader in tracking and reporting on access and quality performance for advanced cardiac services. This reputation is founded in part, on the merits of the CCN cardiac registry (*Cardiaccess*). For almost 18 years, CCN has collected clinical and administrative data on advanced cardiac procedures from Ontario hospitals. These data are used to report on metrics related to access, care delivery and quality, and includes hospital, regional and provincial reporting.

Over the past year, the CCN team has undertaken a major project to update the IT infrastructure, systems and processes to support the cardiac data strategy. This work has focussed on 4 key areas:

- 1) Updating the software application, WTIS-CCN, to capture procedure-based clinical and wait time information;
- 2) Creating a business intelligence strategy, CCN-BI, to provide stakeholders with direct access to their cardiac data in multiple formats;
- 3) Upgrading the physical hardware required to support the CCN-BI initiative;
- 4) Creating a sunsetting solution to retire the *Cardiaccess* application and database, while ensuring the data remains accessible in an archived format.

“I was really worried about how we would access our data. I have no concerns now, this is really great!” —RCCC

Achieving this vision required moving to a centralized web-based WTIS-CCN software application. From a best practices perspective, using a centralized data source for storing and accessing information is a key feature in data quality, however it limits the ability of hospitals to independently access their own data. In response to this challenge, CCN created a data strategy that provides hospital access to site-specific reports required for daily clinical and administrative operations, service planning and research. In addition, CCN-BI includes a flat file data transfer that can be customized by each hospital to meet their own unique requirements.

For the CCN-BI, all reporting functionality is accessed by end users through a web-based platform. The CCN team created a data-extract program, permitting scheduling of automatic daily downloads, including 66 complex standard reports and 43 statistical reports. Over the next several months the CCN IT group will transition their focus from the basics of providing technology support to enhanced business intelligence expertise to meet the needs of the end users.

As a final step, CCN is working with hospital technology departments to assist with the archival, storage and sunsetting of the *Cardiaccess* system. The new WTIS-CCN application and the CCN-BI, have been successfully developed, tested and are ready for implementation. CCN looks forward to continuing to provide leadership in the area of cardiac registry, wait list and data management systems, as our expertise takes on new dimensions with modernized information and business intelligence platforms. ■



Member Hospital

“Gone are the days when cardiologists had to hand-draw heart diagrams.”

William Osler Health Centre, Brampton brings Cardiac Catheterization home

On October 29th, Brampton Civic Hospital opened its cardiac catheterization lab. The Cardiac Procedures Unit is the only cardiac catheterization lab in the central west LIHN, one of the fastest-growing communities and serving a population of 720,000.

Prior to this, patients were referred to other cardiac centres around the GTA for coronary angiogram which caused long wait times and travel. With its own Cardiac Cath Lab, William Osler Health Centre (WOHC) has decreased the length of stay for patients requiring diagnosis and treatment of heart disease. Patients now undergo coronary angiography within 24 to 48 hours from the time of referral. A patient admitted to the ER department with a diagnosis of heart disease can be sent directly to the cath lab.

Brampton Civic is one of the country's most technologically advanced hospitals. Gone are the days when cardiologists had to hand-draw heart diagrams and then dictate a report that had to be typed and sent to referring physicians. The newly implemented information system allows cardiologists to generate reports and diagrams instantaneously. Referring physicians now receive results within 30 minutes of an angiogram being completed, thus allowing patients, if required, to be referred to other cardiac centres for angioplasty within 24 hours.

A large part of Brampton's community is of South Asian descent. Research shows that South Asians are at higher risk of developing heart disease than any other ethnic group. Our cath lab staff is able to provide service in Hindi, Punjabi and Urdu.

A five-month study of follow-up patient care phone calls showed that patients were 99.9 per cent satisfied with the pre- and post-catheterization education and care. Less than 1 per cent of patients experienced any complications.

—Inderjit Sahota RN BSCN
*Regional Cardiac Care Coordinator
William Osler Health Centre*

“During each step of the way, staff made sure I was prepared for the procedure, comfortable and well cared for in a compassionate manner. I am confident that your hospital will become a world-class facility.” wrote a satisfied patient.

“External Code STEMI enables us to extend care beyond our doors, reaching more people in the area that we serve.”

St. Mary's Sets a New Gold Standard for Primary PCI

The evidence is clear: when treating patients suffering an acute heart attack, every minute counts. In the case of an ST-Segment Elevated Myocardial Infarction (STEMI), the international benchmark for best care is to provide primary angioplasty within 90 minutes of arrival to hospital. St. Mary's Regional Cardiac Care Centre, (Kitchener) has established a protocol with patients in Waterloo Region receiving access to emergency angioplasty within as little as 36 minutes from when the ambulance first arrives on the scene.

The protocol is the result of a partnership with Waterloo Region Emergency Medical Services (EMS) and was launched in October, 2007. Known as "External Code STEMI", it sees advanced-care paramedics wirelessly transmit the results of a 12-lead electrocardiogram (ECG) from the field directly to a BlackBerry carried by interventional cardiologists at the Centre.

What separates the St. Mary's program from other programs in Canada is that the interventional cardiologist provides an ECG diagnosis immediately, and if appropriate, the patient bypasses the hospital's emergency department, proceeding directly to the cardiac catheterization lab.

"We were consistently beating the 90-minute hospital to balloon benchmark internally," said Dr. Suzanne Renner, an interventional cardiologist with the Centre. "External Code STEMI enables us to extend care beyond our doors, reaching more people in the region that we serve. We are thrilled with the outcomes we've seen thus far."

Since launching the program, the average first point of medical contact to balloon time has averaged 58 minutes. "We have redefined the gold standard for cardiac care in our community and as a result, our patients are having better outcomes. Further, we are able to provide access to life-saving care to more people in our region," Dr. Renner said. "We are lucky to live in a community where a common passion for excellence and a commitment to innovative thinking has led to better patient care."

St. Mary's credits the success of the protocol to a strong partnership with Waterloo Region EMS, commitment from cardiologists and staff, and invaluable information technology support.



Dr. Suzanne Renner reviews an ECG on a BlackBerry in the Cardiac Catheterization Lab at St. Mary's Regional Cardiac Care Centre in Kitchener.



Committee reports

CCN Hospital Administrator Committee

Each hospital providing advanced cardiac services in Ontario is represented on this committee. The focus of this group is on strategic thinking and planning to address high level operations and systems issues to ensure the delivery of advanced cardiac care services based on the standards established for best practices, quality, equity and access.

Regional Cardiac Care Coordinators

This committee is key to CCN's core efforts in Active Cardiac Access Management, by providing a forum to define, promote and support the clinical processes and best practices to ensure the effective management of patients waiting for adult cardiac services. The RCCCs serve an important role in helping patients and families navigate through the health-care system, as well as ensure the appropriate information is available for clinical decision-making and data-gathering.

Clinical Services Committee

This committee serves a clinical advisory role to the CCN Board of Directors focussing on strategies for planning, delivery and enhancement of advanced cardiac services. With broad representation from various cardiac hospitals and programs, this group is tasked with the responsibilities for preparing key reports and recommendations, or reviews of specific areas of clinical practices relevant to cardiac care.

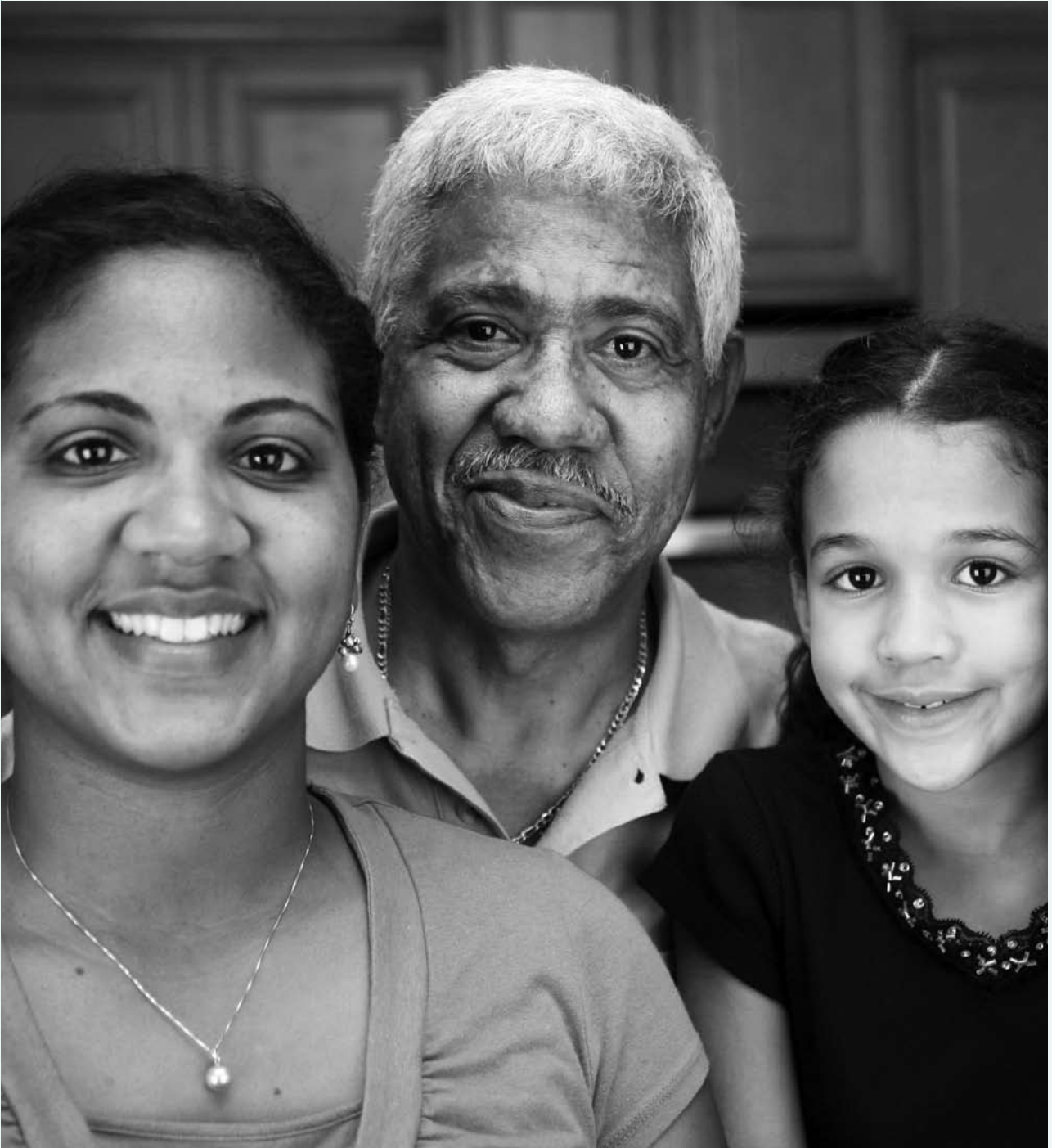
Cath/PCI Working Group

The focus of this working group is interventional cardiology, specifically on standards and issues related to cardiac catheterization and percutaneous coronary intervention (PCI). With the emergence of primary PCI (PPCI) as a key treatment strategy for acute myocardial infarction, the main priority over this past year has been the creation of a subgroup focussed specifically on PPCI—identifying best practices and standards, and developing a coaching document to share key learnings in this area.

Arrhythmia Management Working Group

The scope of this group pertains to all aspects of clinical care related to cardiac arrhythmia management, including device implants such as permanent cardiac pacemakers (PPMs); implantable cardioverter defibrillators (ICDs), loop recorders, diagnostic electrophysiology studies (EPS) and interventional procedures such as catheter and complex ablations for recurrent arrhythmias. In addition, the AMWG is focussed on the process and system enhancements that will be required to meet demands for services in the future.





Project reports

Validation of Valve Surgery Urgency Rating Score / Recommended Maximum Waiting Time

The CCN Urgency Rating Score (URS) for coronary artery bypass patients has been widely accepted. Recognizing the differences and complexities with the heart valve patients, CCN has developed a wait times prioritization scheme to determine the urgency and recommended maximum wait times for patients with valvular heart disease requiring surgical intervention. The next step in this project is to validate the URS for Valve Surgery and determine if revisions are required prior to full implementation.

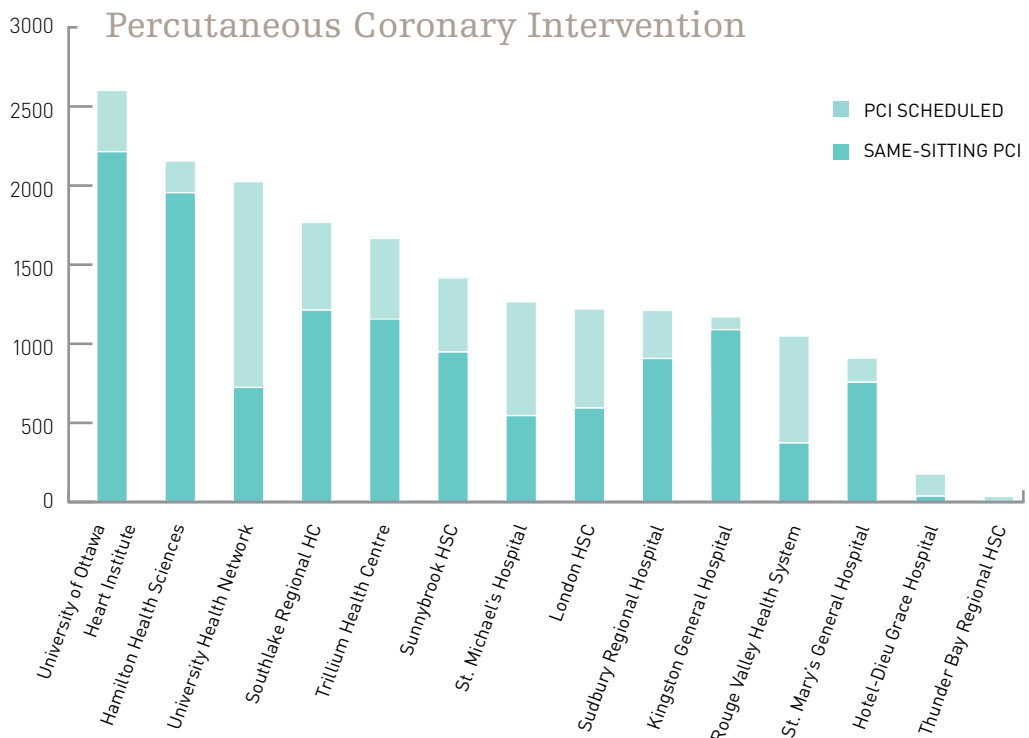
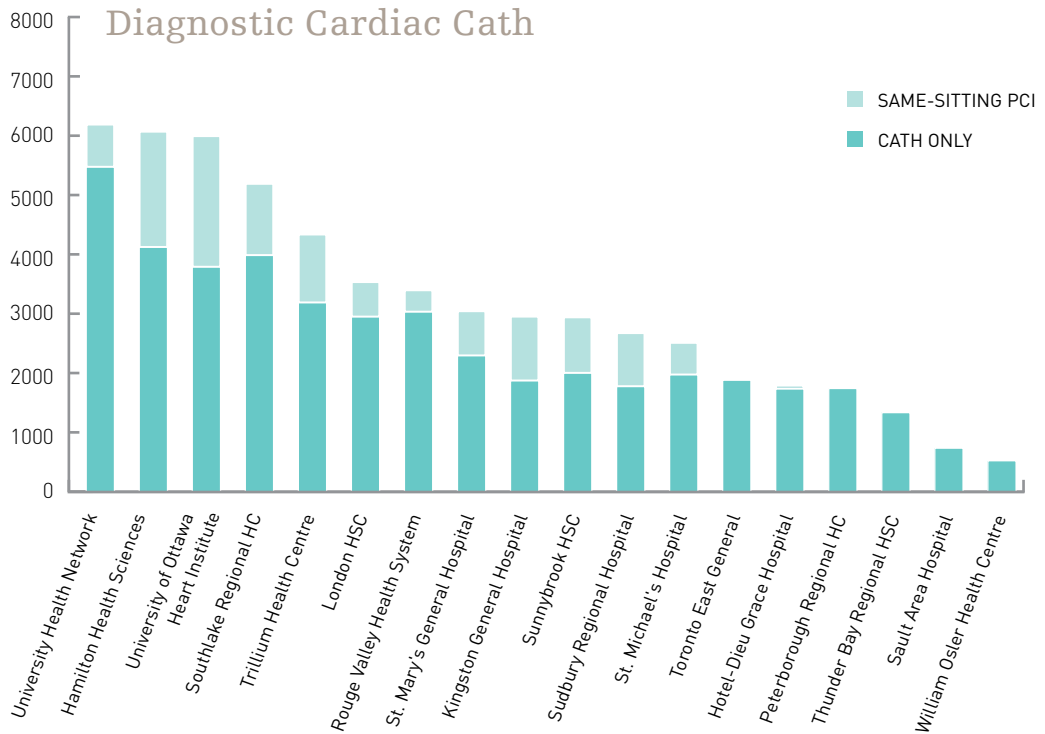
Acute Coronary Syndrome

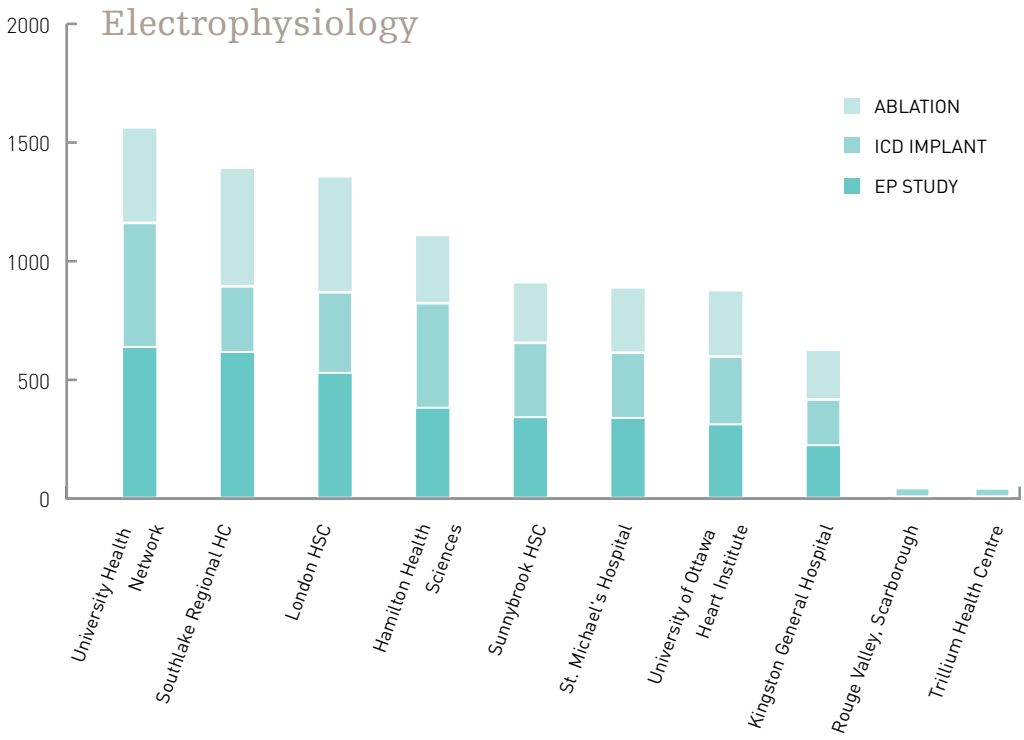
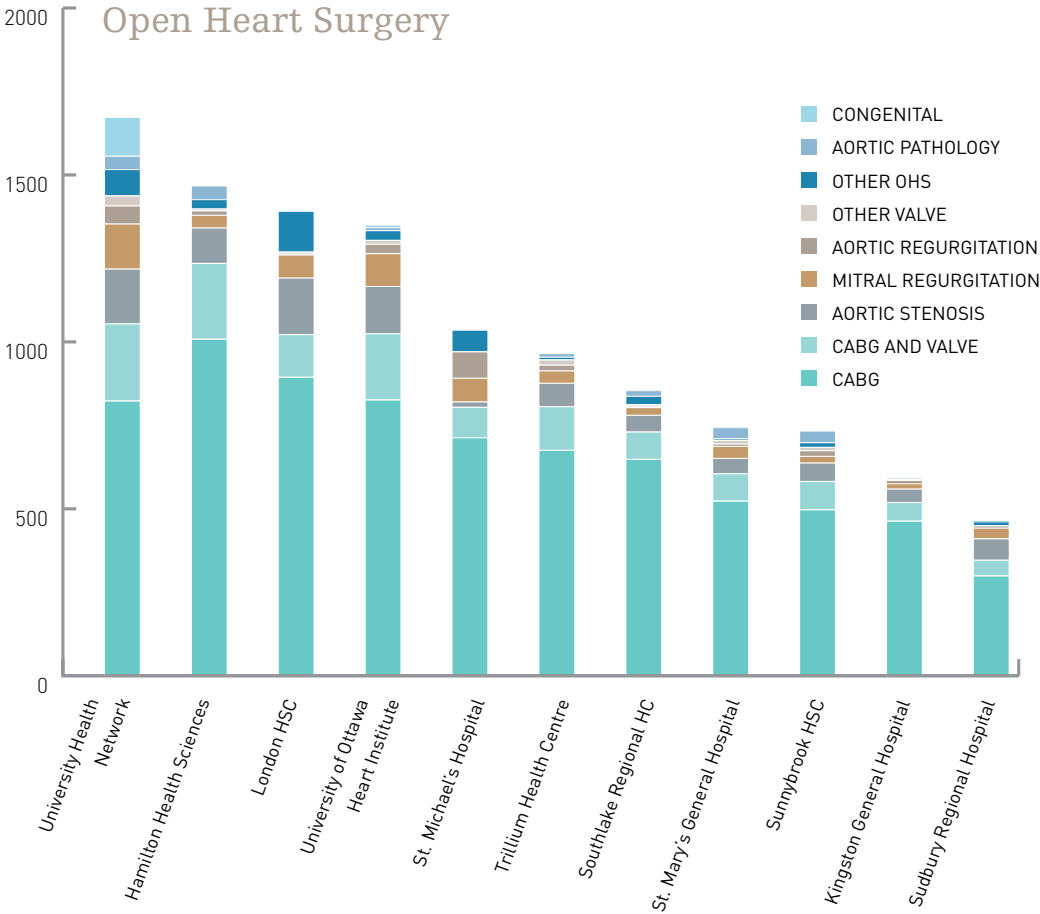
The Acute Coronary Syndrome (ACS) Project was developed to support hospitals in implementing and reporting on ACS best practices, defined by published clinical guidelines. It is well established that this approach to ACS care, using standardized clinical care tools and processes, improves patient outcomes. The majority of hospitals in Ontario have established ACS protocols, however there is some variability in the measurement and reporting of performance. This project supports the standardization of care between hospitals and promotes reporting of metrics at the level of the hospital and LHINS.

Heart Failure

The purpose of the CCN Heart Failure Project is to identify the heart failure management clinical resources available in Ontario, and promote an integrated and collaborative approach to heart failure disease management. At the Canadian Cardiovascular Congress (October 2007) CCN hosted a workshop on heart failure management. The workshop, *"Addressing Heart Failure in the Community: a Forum on Options for Management"*, focussed on established models of heart failure management in a variety of clinical and regional settings.

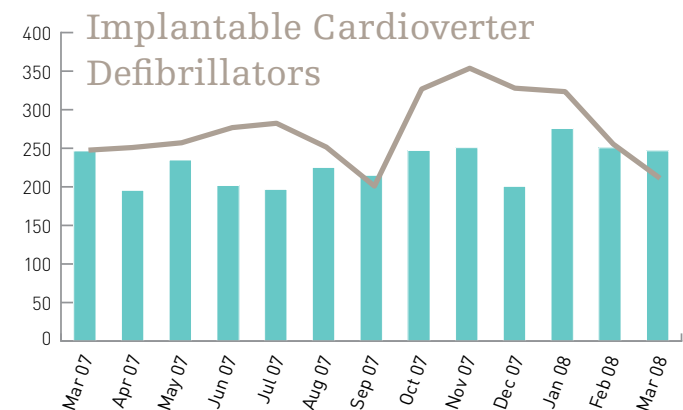
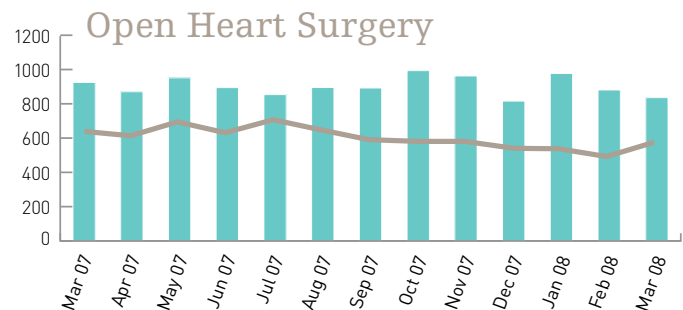
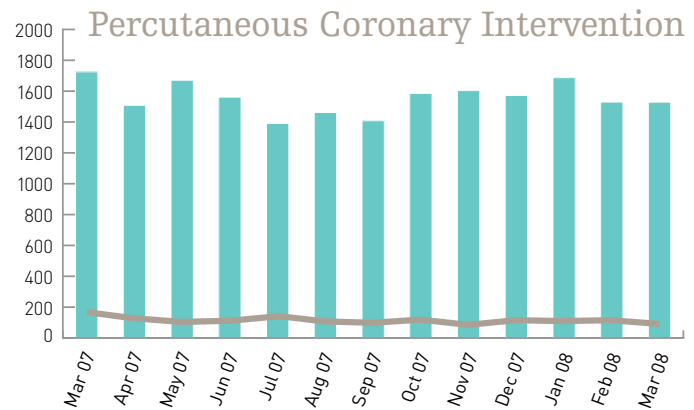
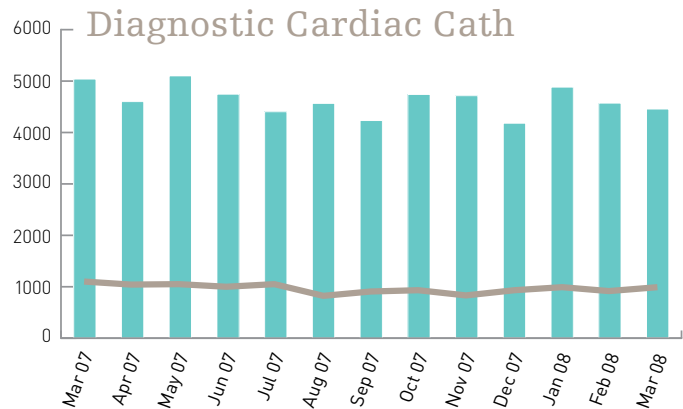
Ontario Procedure Volumes by Hospital 2007–2008





Wait List Provincial Trends

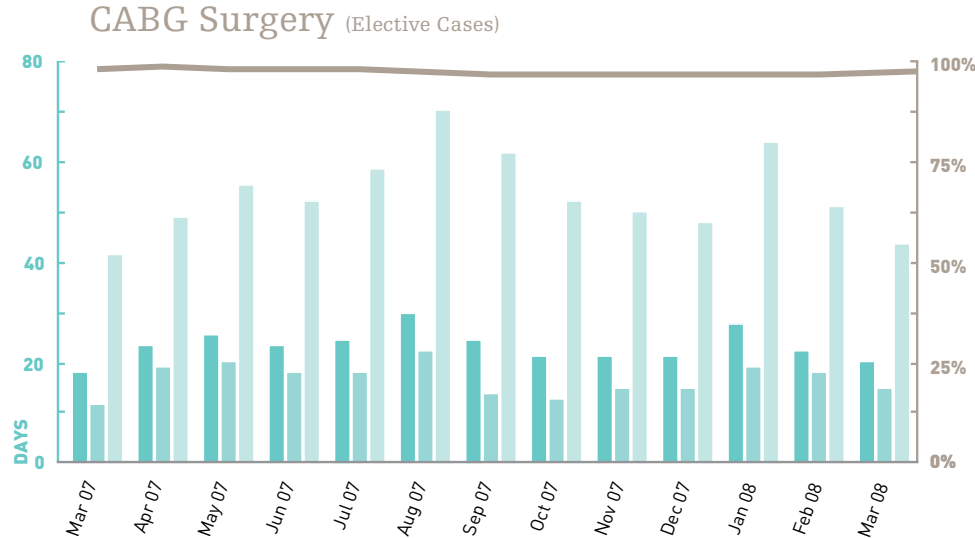
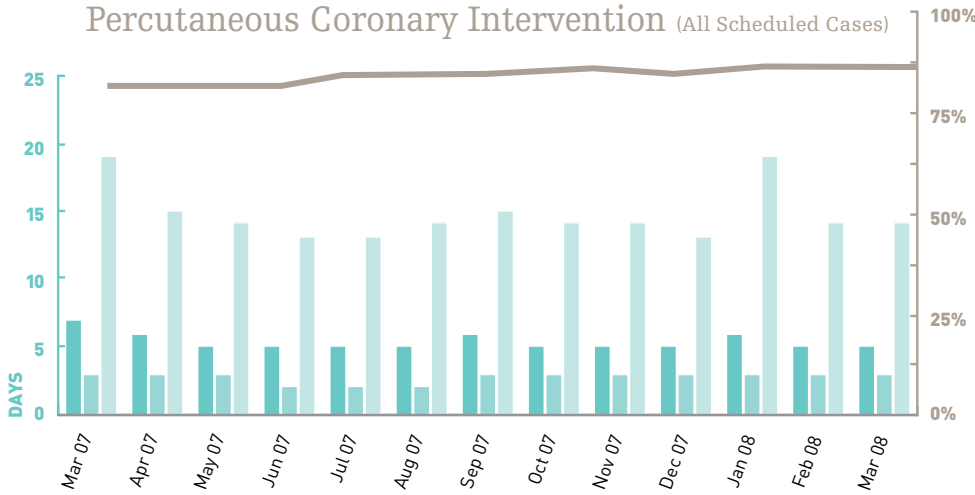
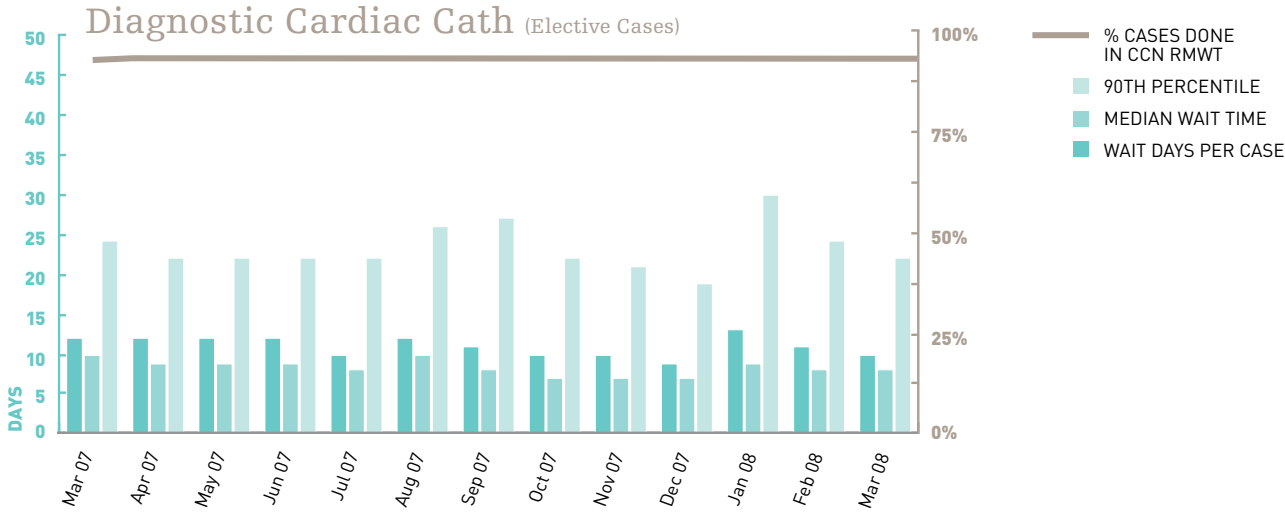
■ PATIENTS WAITING
■ PROCEDURES COMPLETED



Trends in wait lists and wait times for 2007–2008 have been stable. Over 90% of elective procedures are done within recommended maximum wait time and 100% are within MOHLTC-defined access targets.

Active Cardiac Access Management

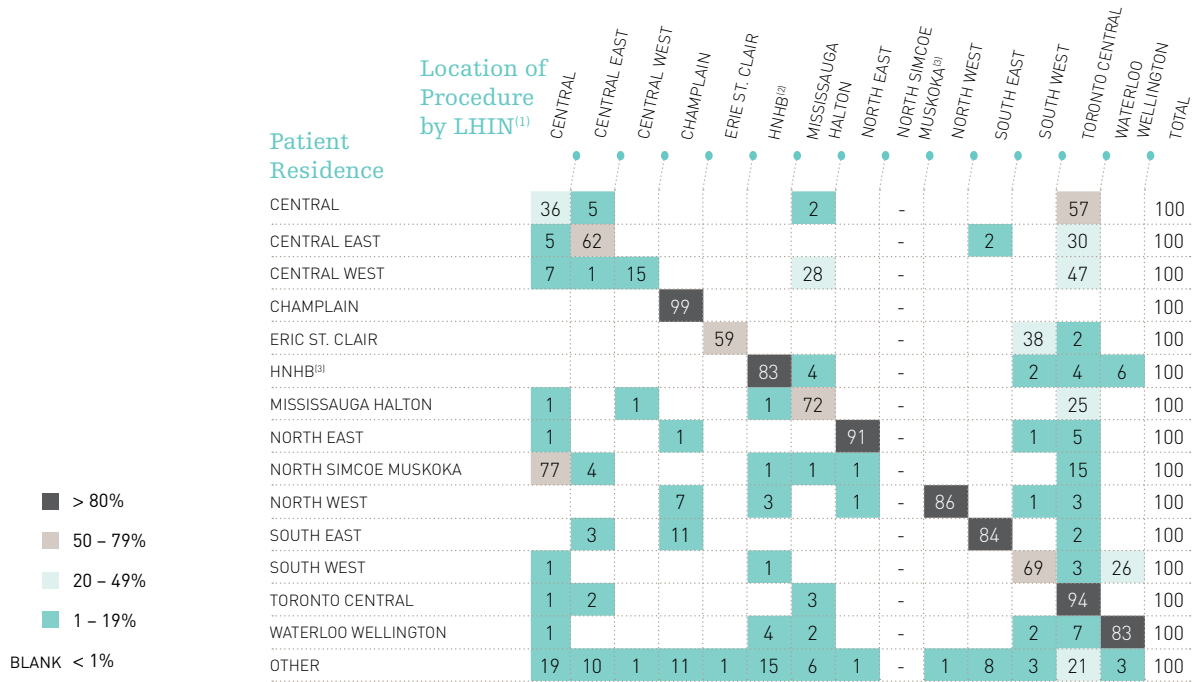
Wait times and Access Performance Indicators



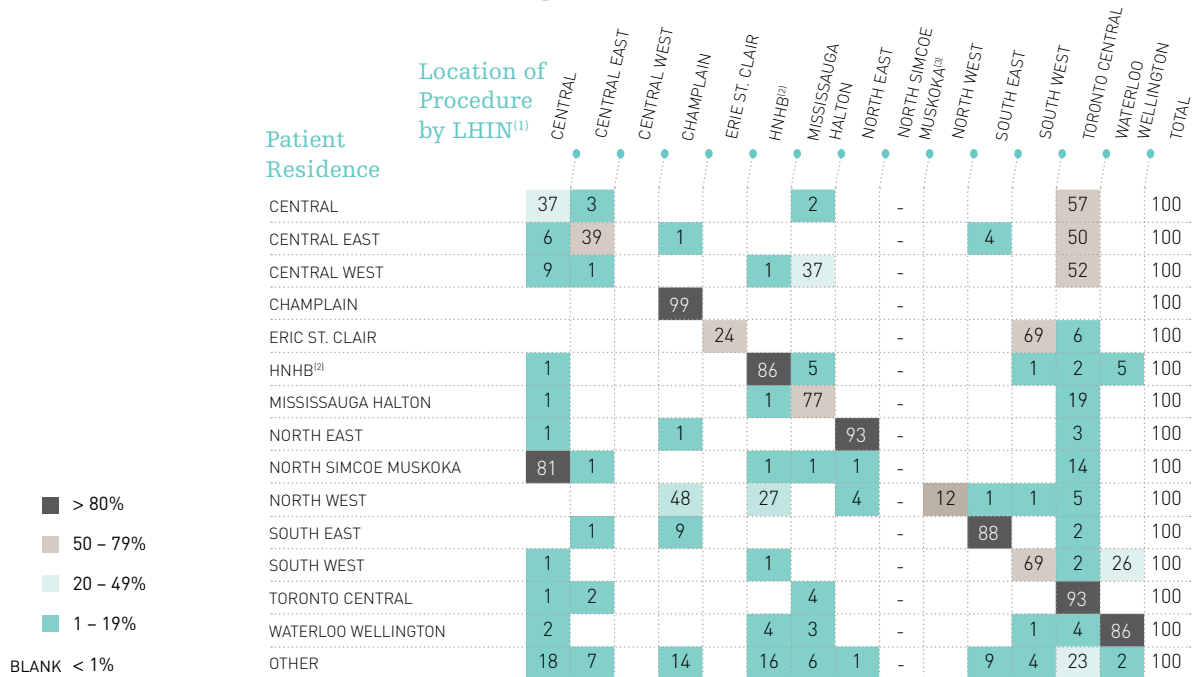
Market Share — LHIN

Advanced Cardiac Procedures

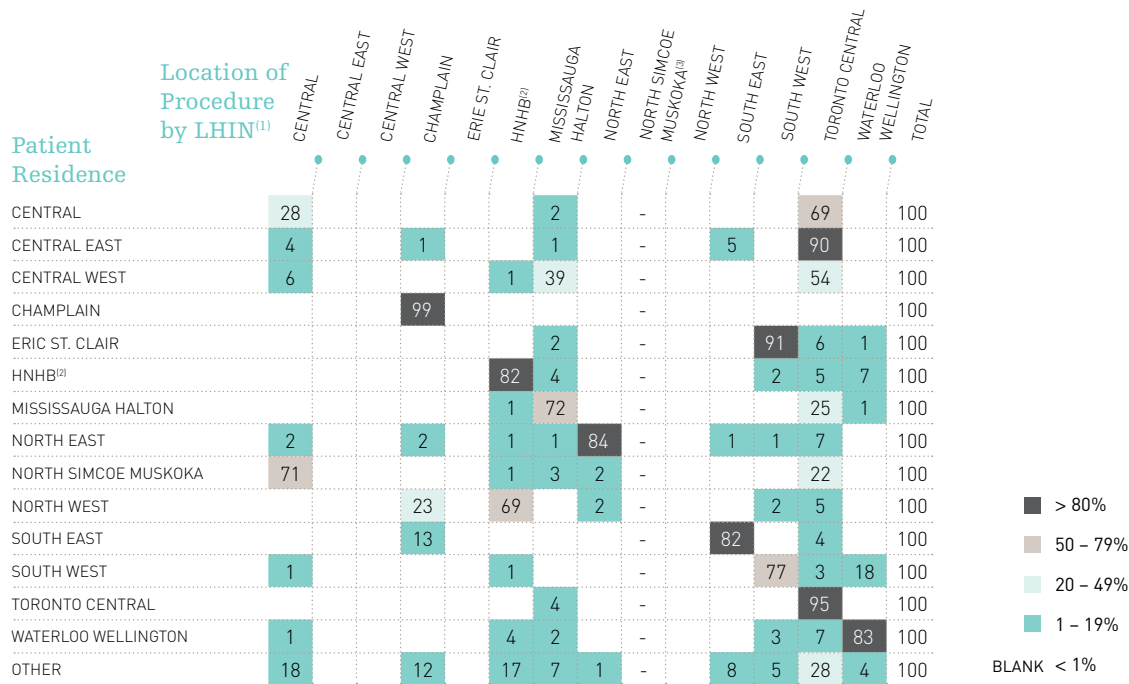
Distribution of Diagnostic Cardiac Cath Cases According to Patient Residence — LHINs (%)



Distribution of Percutaneous Coronary Intervention Cases According to Patient Residence — LHINs (%)




Distribution of Open Heart Surgery Cases According to Patient Residence — LHINs (%)



CCN tracks patient residence to assist LHINs in service planning. However, LHIN boundaries for cardiac services in major urban centres are fluid as patients move based on choice in accessing services. Hence, a patient living in one LHIN may receive service in another.

⁽¹⁾ LHIN: Local Health Integration Networks ⁽²⁾ HNHB: Hamilton Niagara Haldimand Brant ⁽³⁾ There are not member hospitals for this procedure in this LHIN



Member Hospital
Neil Fam MD

“What could be better than coming in at night and saving a life?”

St. Michael's Hospital—The Heart and Vascular Program

Neil Fam is part of a mission. He's working on a project designed to get heart attack patients needing emergency treatment to angioplasty and stenting, considered the optimum standard of care, no matter what the time of day and despite the obstacles. The project is called 24/7 Primary PCI (percutaneous coronary intervention), which means angioplasty for the patient that needs it, no matter what the time of day or day of the week.

Everyone acknowledges that someone having a heart attack needs help fast. Time is muscle in the treatment of these events: every minute saves heart muscle. However, getting the patient to the best treatment in the shortest amount of time is challenging, particularly in a city like Toronto where traffic gridlock is legendary. And there can be a myriad of steps along the way, including time spent just waiting to be seen in emergency departments. Not all hospitals offer the same treatment. St. Michael's and other heart centres have coronary catheterization labs, and can perform angioplasty and stenting while others such as most community hospitals, lack these facilities. In a large number of cases, clot-busting drugs are used as the first line emergency treatment, a default that recognizes the logistical difficulties of performing angioplasty, given the obstacles. The clot-busting treatment does get results, but can have side effects. “Clot-busting drugs fail in a quarter of cases and can cause bleeding in the brain,” Dr. Fam explains. “But because of the perceived difficulties getting patients to angioplasty and stenting, clot-busting drugs are widely used.”

In other cities throughout the world 24/7 Primary PCI is the standard. “In Europe and in many major cities in the United States, this is the treatment,” Dr. Fam points out. “Ottawa too is ahead of us in this respect. But we are doing better now. Since November, St. Michael's has been able to offer this service. Our median door-to-balloon time is 82 minutes which is in keeping with published guidelines for the standard of care.”

Training for EMS personnel & special protocols

24/7 Primary PCI will work because of several important changes to the protocols of how heart attack patients are treated when they call 911 for help. A key factor is the training of emergency service workers, so that when someone reports chest pain, they can administer a twelve lead ECG right away in that person's home. Then, they whisk the patient directly to the catheterization lab, completely bypassing the stop at the emergency room. In the case of St. Michael's this has meant using personnel, nurses in the CCU, who are on duty during nights and weekends. When the call comes, these nurses gown up and get to the cath lab, ready to work alongside the doctor who will be doing the angioplasty. "It has been proven in studies that primary angioplasty decreases the chance of damage and the size of the heart attack," Dr. Fam notes. "Previously, the way it worked was a patient who came in during the day got angioplasty, but that patient would have received clot-busting drugs at night or on weekends. That was partly because, while doctors might live close to the Hospital, the rest of the team did not. Utilizing available staff already at the hospital saves about 45 minutes! The success of the project is a team effort."

Since November, patients who report chest pain in the St. Michael's catchment area have been part of the new 24/7 Primary PCI protocol and at the end of May this was expanded to include patients in the St. Joseph's Health Centre area too. By summer, all teaching hospitals in the City of Toronto will be on board. "No one hospital can serve the entire city," Dr. Fam points out. "This is a co-ordinated approach, and it is relying on high-level administrative support for its success."

And the success does rely on the physicians, doctors like Neil Fam, who are part of the organizing committee and who come and perform the emergency angioplasties. "I'm a positive and practical person," Dr. Fam says. "I could never just accept the status quo. I don't mind if I have to come in at night and perform an angioplasty. What could be better than coming in at night and saving a life?"

Toronto, led by the St. Michael's Hospital Heart and Vascular Program, is well on its way to becoming world-class in a category that matters: saving and enhancing the lives of heart attack victims. The city has its own difficulties (traffic!) to contend with, but with a concerted effort by all concerned, it will make the grade. "Toronto will have a home-grown solution," Dr. Fam points out.

—Kathy Flaxman



“Prior to a stand-alone Angioplasty Program, more than 600 patients and their families had to travel to London, Toronto and Detroit.”

Hôtel-Dieu Grace makes stand-alone angioplasty available closer to home

History was made in Windsor Essex in May 2007 when Dr. Rajen Chetty, a local Cardiologist performed the first stand-alone angioplasty procedure at Hôtel-Dieu Grace Hospital (HDGH).

Operating under the supervision of London Health Sciences Centre’s Dr. Bill Kostuk, the new angioplasty program has provided service to more than 200 patients in its first full year of operation.

Last spring, HDGH hired Dr. Amr Morsi, an Interventional Cardiologist, as its permanent Medical Director. With Dr. Morsi’s appointment it is anticipated that the number of procedures HDGH are able to perform annually will grow to 600 in 2008.

Prior to establishing a stand-alone Angioplasty Program at HDGH, each year more than 600 patients and their families had to travel to London, Toronto and Detroit for this therapeutic intervention. Having the procedure available has made a huge difference in the lives of people in the community who need this life-saving treatment and it represents a tremendous improvement in cardiac care services for Windsor & Essex County.

As a stand-alone site, HDGH has established a mentor relationship with London Health Sciences Centre (LHSC). As our mentor centre LHSC works closely with HDGH with the selection of appropriate PCI patients who meet the criteria for a stand-alone service.

Staff



Back Row (l to r)

Kori Kingsbury
Chief Executive Officer

Mirjana Ilic
Data Manager

Jim Pagiamtzis
*Director Operations and
Stakeholder Relations*

Darko Mazalica
*Manager, Information
Technology*

Charles Senior
Communications Specialist

Susanne Hinds
Administrative Assistant

Front Row (l to r)

Rose Obien
Clinical Data Entry Clerk

Lisa Burlacoff
Clinical Practice Consultant

Joan Zarbatany
Executive Assistant

Caroline Rafferty
*Director of Quality
and Performance*

Al Yoshiki
Report Developer

Lucy Li
Decision Support Analyst

Not shown

Daniela Marinova
Administrative Assistant

Lee Norbeck
*Manager, Finance and
Administrative Affairs*

Michelle Thornley
Clinical Practice Consultant

Eric Cohen MD



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