HeartLife FOUNDATION

Heart Failure Policy Framework

A National Action Plan For Change

CONTRIBUTING AUTHORS

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ACKNOWLEDGEMENTS

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Summary

Heart Failure (HF) is on the rise, resulting in thousands of deaths annually among people in Canada. Despite the availability of diagnostic and management tools for heart failure, significant obstacles hinder the provision of effective, patient-oriented care.

The Heartlife Foundation developed the **Heart Failure Policy Framework ("The Framework")** to give us a clear road map on how decision makers take can action and work collaboratively toward a common **goal of improving the lives of people in Canada** living with HF, which in turn benefits patients, caregivers, and society as a whole.

In partnership with the Institute of Health Economics (IHE) of Alberta, The HeartLife foundation conducted extensive research and carefully examined the economic evidence related to improved diagnosis and management of heart failure.

The Framework serves as a national standard for provinces and territories to use on how to improve patient outcomes and reduce costs on our healthcare system. The Framework recommends policy recommendations to get us there and how we measure success, highlighting the economic benefits and how we fund implementation.

Three Pillars to Move Forward Change

DIAGNOSIS AND SCREENING
Detect early and diagnose accurately and effectively

MANAGEMENT & CARE
Improve the full circle of patient care and quality of life

PLANNING & EVALUATION
Address the data gap with patient-outcome driven performance reporting

ENDORSED BY

Canadian Cardiovascular Society
Société cardiovasculaire du Canada

Canadian Heart Function Alliance
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Conseil canadien des infirmières et infirmiers en soins cardiovasculaires

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Caregivers Alberta
CARING FOR CAREGIVERS

Medicines Access Coalition - BC

TRANSFORM HF

The Heart Failure Policy Network

BUILT FROM

Patient Charter Principles

01 Receipt of an accurate and timely diagnosis of heart failure

02 Availability of services and resources to support my mental health throughout my care continuum

03 Access to educational tools and resources, including a care plan, to empower me to effectively self-manage my health

04 Empathy and compassion from health care providers

05 Access to multidisciplinary care team throughout my journey that includes a heart failure specialist, a nurse, a pharmacist, mental health support, a dietitian, a cardiac rehab specialist, and my general practitioner

06 Timely access to the best standards of care and medical therapies that are currently available

07 Opportunities to provide input into decisions regarding future research into heart failure

In 2022 HLF developed a **Patient & Caregiver Charter** with 7 key principles to serve as a standard of care for patients and caregivers, providing guidance on what to expect during their care journey.

It empowers them to ask questions about important issues and understand their role in managing their health. The Charter highlights opportunities to improve heart failure care for healthcare providers, policymakers, and private payers.

750 THOUSAND

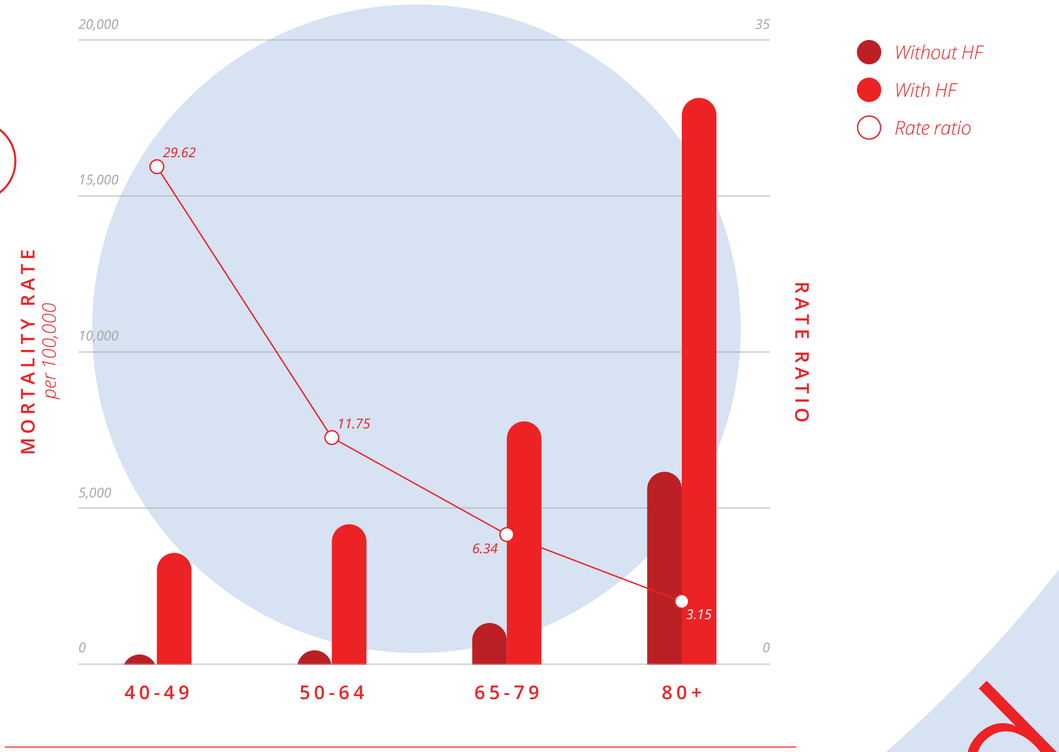
people in Canada live with heart failure and another **100,000 CASES** are diagnosed every year.[1]

DEATH RATE IS

30x higher

among **ADULTS AGED 40-49** with diagnosed heart failure vs. those without.[2]

This is at their most **productive years**, costing our healthcare system and making early diagnosis and management essential in younger age groups especially.



1 in 3

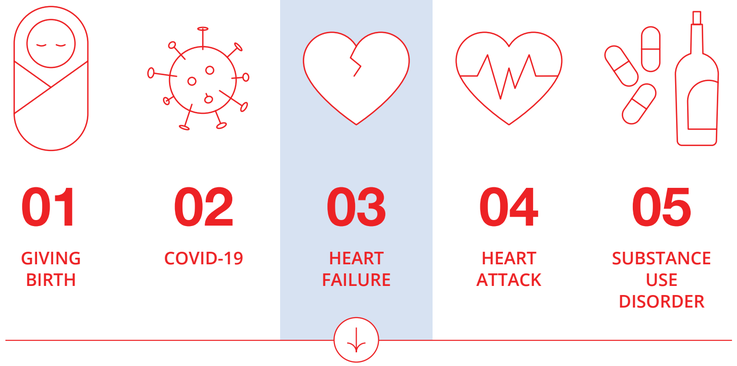
PEOPLE IN CANADA personally live with HF or have a family member or close friend with heart failure.[1]

Heart Failure is common and on the rise

The burden of the disease is substantial

Patients and their caregivers suffer from greatly reduced functional capacity and quality of life - **A BURDEN SIMILAR TO HAVING ADVANCED CANCER OR AIDS.**[3]

Leading causes of hospitalization in Canada



In 2019 alone, more than **71,000 HOSPITALIZATIONS** were due to heart failure.[1]

2016-17

575 MILLION

in hospital costs.[6]

It's costing our healthcare system

2030

2.8 BILLION

is the expected yearly healthcare cost associated with heart failure in Canada.[1]

Heart Failure is the second most expensive health condition in Canada accounting for $575.2 million in hospital costs in 2016–2017.

Simple interventions could save our healthcare system a fortune. Even just better testing implementation **could save $268-$347 million annually** based on projected healthcare resource reductions.[4]

Inequities in Care

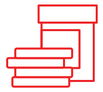
Many inequities exist in access to care and treatments for heart failure which substantially impacts the health outcomes and quality of life for people in Canada most in need.[1]

Rural and remote areas have reduced access to specialists

Language barriers make it difficult for others to access information about heart failure

Women have poorer heart failure outcomes than men

Heart failure prevalence and mortality rates are higher in Indigenous communities



Income disparity makes many individuals unable to afford the cost of heart failure medications

This results from a deficient healthcare system due to the following:

- **LACK OF KNOWLEDGE** of heart failure by public, patients and providers.
- Key **GAPS IN DIAGNOSIS** where proven technologies are available.
- **SYSTEMS OF CARE** are not well organized.
- Need for more defined **ROLES AND ACCOUNTABILITIES** for specialist and primary care teams.
- Unmet **NEED FOR PROACTIVE AND COORDINATED CARE** to reduce costs.

The Framework

Governments are crucial in promoting public health and reducing the burden of heart failure and other cardiovascular diseases.

Policy-level changes are essential to reduce hospitalization, lower mortality rates, and use resources more efficiently. Early detection and effective management can significantly reduce the burden of illness, but the real challenge lies in implementing these strategies at regional, provincial, and national levels.

Scaling up successful initiatives and spreading effective approaches at local and provincial levels are critical to building on what has already been accomplished and further improving heart failure care.

North Star

PATIENT AND CAREGIVER CENTRED: Informed by the HLF Patient Charter, solutions are built from the needs and rights of patients and caregivers across Canada.

FOCUSED ON EQUITY: There is equitable access for all people in Canada, regardless of gender, age, ethnicity, or region of residence.

CULTURALLY APPROPRIATE: To ensure that healthcare services respect and address the diverse beliefs, values, languages, and customs of patients, leading to more effective and equitable care.

Three Pillars of the Framework

01 Diagnosis and Screening:
Detect early and diagnose accurately and effectively

02 Management & Care:
Improve the full circle of patient care

- Guideline Directed Medical Therapy
- Multidisciplinary care
- Mental health support
- Technology and Virtual Care

03 Research & Evaluation:
Address the data gap with patient-outcome driven research, planning and performance reporting

PILLAR 01

Diagnosis & Screening

Why it matters

Early diagnosis and screening for heart failure are crucial as they can significantly improve patient outcomes and quality of life. Heart failure is a progressive condition that often develops gradually, and its symptoms can be subtle at first. Early detection allows for timely intervention and the implementation of appropriate treatment strategies, which can slow the progression of the disease, reduce hospitalizations and system costs, and extend life expectancy.

Goals

Detect early and diagnose accurately and effectively

01

Heart failure is detected and diagnosed early and accurately, regardless of gender, age, ethnicity, or region of residence (province, region, urban, rural).

02

Patients, healthcare providers, governments, and the general public are aware of and educated on what heart failure is and risk factors, and best practice guidance to detect and manage heart failure and support patients along their journey.

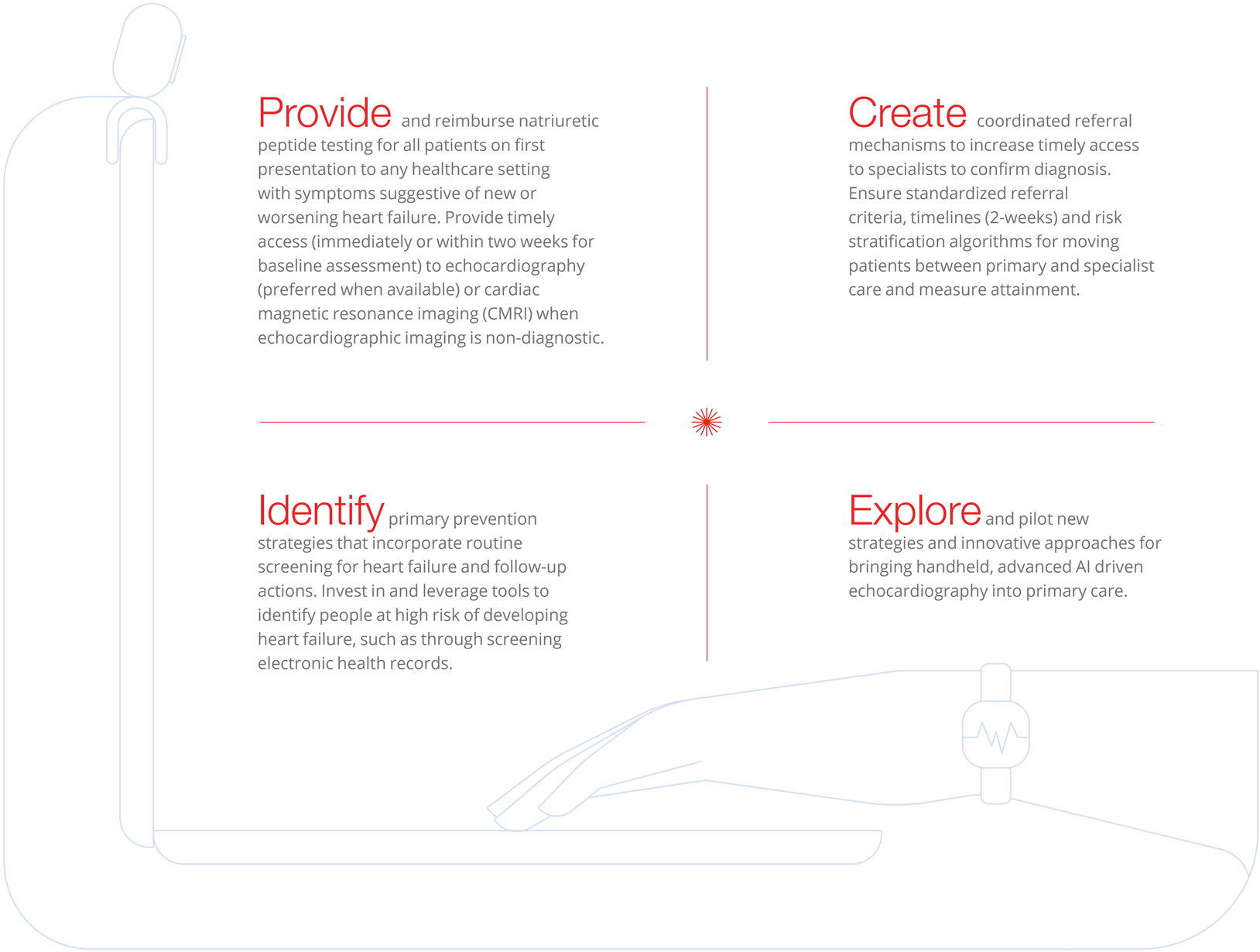
Advice

Provide and reimburse natriuretic peptide testing for all patients on first presentation to any healthcare setting with symptoms suggestive of new or worsening heart failure. Provide timely access (immediately or within two weeks for baseline assessment) to echocardiography (preferred when available) or cardiac magnetic resonance imaging (CMRI) when echocardiographic imaging is non-diagnostic.

Create coordinated referral mechanisms to increase timely access to specialists to confirm diagnosis. Ensure standardized referral criteria, timelines (2-weeks) and risk stratification algorithms for moving patients between primary and specialist care and measure attainment.

Identify primary prevention strategies that incorporate routine screening for heart failure and follow-up actions. Invest in and leverage tools to identify people at high risk of developing heart failure, such as through screening electronic health records.

Explore and pilot new strategies and innovative approaches for bringing handheld, advanced AI driven echocardiography into primary care.



Impact

Overall, improving access to NT-pro-BNP testing has shown in multiple studies to both **improve patient outcomes and reduce costs on the healthcare system** in Canada, via reduced resource utilization, fewer echocardiograms, fewer initial hospitalizations, fewer cardiology admissions, fewer ICU admissions, fewer emergency readmissions and fewer hospital readmissions.

NT-pro-BNP testing implementation in Canada could

save up to

347 $ MILLION

annually

based on projected healthcare resource reductions.[4]

Measuring Success

Increasing the percent of patients who receive natriuretic peptide testing (BNP or NT-proBNP) and an echocardiogram within 2 weeks of presenting with symptoms suggestive of new HF.

PILLAR 02

Management & Care

Why it matters

Timely access to the right treatment is essential for optimal outcomes preventing disease progression and minimizing healthcare burdens, ultimately saving lives and money for our healthcare system.

Goals

PATIENTS RECEIVE and participate in individualized, appropriate, equitable, culturally appropriate, and timely access to evidence-based and guideline-directed medical therapy (GDMT).

01

TECHNOLOGY SOLUTIONS are used to optimize communication and information sharing across healthcare providers and settings, remotely monitor patient outcomes, and provide greater access to specialist care via virtual healthcare visits, where appropriate.

04

Improve the full circle of patient care

02

CARE IS PROVIDED from a multidisciplinary team of providers, including heart failure specialist, nurse, pharmacist, mental health support, dietitian, cardiac rehabilitation specialist, and primary care provider.

03

PATIENTS AND CAREGIVERS receive mental health support throughout their HF Journey.

Advice

The Right Treatment

TIMELY ACCESS TO THE RIGHT TREATMENT enhances the likelihood of optimal outcomes.

- Patients with heart failure should be on all 4 guideline-directed medications, at a maximally tolerated dose for them, within 3 to 6 months from their initial diagnosis.[5]
- Use standardized regional or provincial processes and protocols, (e.g., acute admission order sets, discharge protocols, cardiac rehabilitation referral process, continuity of care protocols) to ensure consistency and quality of care.

Multidisciplinary Care

MULTIDISCIPLINARY CARE ENSURES A COMPREHENSIVE understanding of the patient's physical, emotional, and social needs, leading to individualized treatment plans and better management of the complex aspects of heart failure.

- Fund, facilitate, and incentivize care through collaborative, multidisciplinary teams that include a heart failure specialist, nurse, pharmacist, mental health support (such as psychologist), dietitian, cardiac rehabilitation specialist, and primary care provider that partner with the patient. Care may be provided in-person or virtually, as appropriate, to address geographic challenges.
- Standardize discharge planning and routine follow up within 30 days to ensure care team is set up and disease management is underway.

Advice

Mental Health Support

MENTAL HEALTH SUPPORT IS INTEGRAL for heart failure patients and their caregivers as the condition often brings about significant emotional stress, anxiety, and depression due to its chronic nature and impact on daily life.

- Provide access to mental health and psychological services and support for individuals with heart failure, those around them, and caregivers, including access to mental health professionals and peer-led support groups to help them understand the journey and connect with the heart failure community (in-person or virtually). Services and supports should be provided upon diagnosis and regularly throughout the care continuum.
- Include mental health providers (e.g., psychologists, psychiatrists, social workers) as part of heart failure multidisciplinary teams from the outset, either through the heart failure model (e.g., cardiac rehabilitation, heart failure clinics) or through referral to general mental health services.
- Incentivize primary and specialist care providers to regularly screen for depression and anxiety at all follow-up appointments or at least quarterly every year.

Technology and Virtual Care

TECHNOLOGY AND VIRTUAL CARE are beneficial for heart failure management due to their capacity to remotely monitor patients' vital signs, medication adherence, and symptoms, allowing for early intervention and personalized adjustments to treatment plans; particularly in rural and remote areas, where access to specialized medical facilities may be limited.

- Investing in patient-forward, standardized and consistent virtual care platforms and electronic medical record technologies to improve care coordination.
- Over-invest in remote monitoring and virtual care in remote or rural communities with less access to in-person solutions.
- Invest in cost-effectiveness assessments of new technologies to ensure a clear sense of resource needs to support new tools and to demonstrate the value of tools to improve care while providing incentives for use of emerging technologies.

Impact

EFFECTIVE AND TIMELY ACCESS to GDMT has been proven to improve patient outcomes and quality of life, reducing disease progression, complications and hospitalizations. Using all 4 GDMT medications together **could help patients 5 to 8 years longer.**[5]

MULTIDISCIPLINARY CARE and access to the right providers is essential to improving disease management and enhancing collaboration, reducing complications and hospital visits. By addressing medical, lifestyle, and psychosocial factors, multidisciplinary care optimizes patient outcomes, reduces hospitalizations, and enhances overall quality of life.

INTERNATIONAL STUDIES HAVE SHOWN remote monitoring following hospital discharge and support from a multidisciplinary team reduced emergency department visits by 75%, heart failure-related readmissions by 89%, and costs by 63% compared with usual care, with **an estimated cost savings of US$4,583 per individual** over the first year after hospital discharge.[6]

A STUDY IN BRITISH COLUMBIA found significant cost savings associated with home telemonitoring compared to usual care, with a reduction of $1,631/individual with heart failure of the 90-day study period.[7]

THE ECONOMIC CASE for investment in mental health is strong: for every $1 invested in scaled-up treatment for depression and anxiety, there is a $4 return in better health with the Mental Health Commission of Canada reporting mental health problems or illness cost the economy well in excess of $50 billion. For patients with heart failure, access to support is crucial, improves their ability to manage their symptoms and has been proven to improve health outcomes generally for patients with HF.[8]

In Canada, a similar reduction in hospital admission would translate to a cost saving of almost 600 million dollars annually just for newly diagnosed patients.

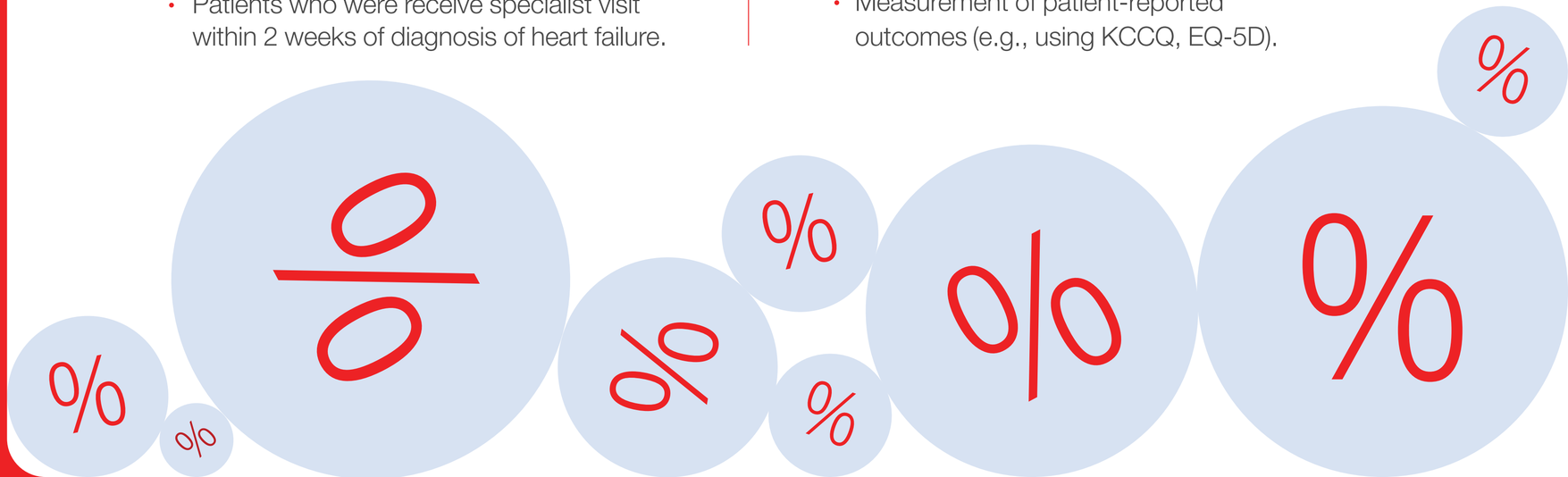
Measuring Success

Percent of...

- Patients who received guideline-directed medical therapy within 3 to 6 months from their initial diagnosis.
- Patients who receive and follow a personalized, multidisciplinary discharge plan.
- Individuals with HF who receive a referral for and are seen by a specialized, dedicated, multidisciplinary team to manage their care.
- Patients who were receive specialist visit within 2 weeks of diagnosis of heart failure.
- Individuals with HF who are routinely screened for mental health (e.g., anxiety, depression) and wellbeing at regular follow-up appointments.
- Patients with HF, those around them, and caregivers who report having accessed mental health services and support.

And:

- Availability of cardiac rehabilitation for individuals with heart failure living in remote, rural, and Indigenous communities.
- Measurement of patient-reported outcomes (e.g., using KCCQ, EQ-5D).

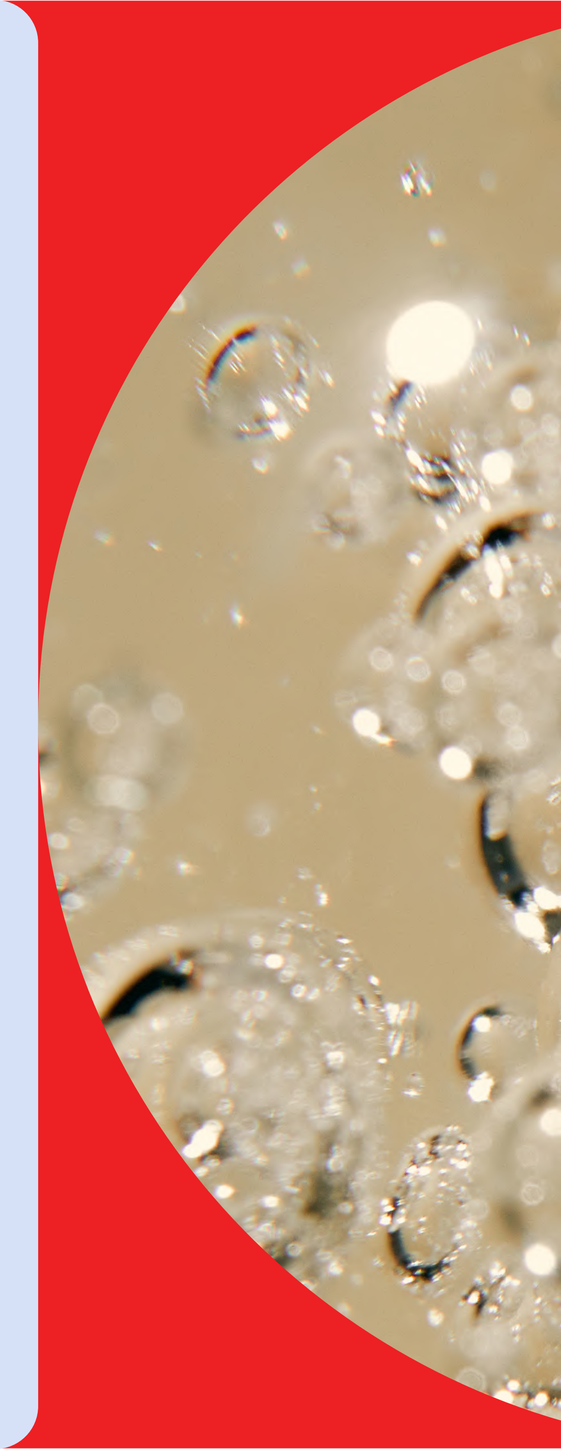


PILLAR 03

Research & Evaluation

Why it matters

The patient voice is crucial in research as it provides valuable insights that lead to patient-centered outcomes. By considering patients' experiences and preferences, research becomes more relevant, leading to effective interventions and improved healthcare results. Engaging patients in research also builds trust and empowerment, enhancing the overall quality and relevance of research findings.



Goals

Address the data gap with patient-outcome driven research, planning and performance reporting

01

Key knowledge gaps to advance heart failure prevention, diagnosis, treatment, and care delivery are addressed through inclusive research initiatives and by building and leveraging health data infrastructure.

02

Implementation and planning of key policy interventions are centered around patients and caregivers, and aligned with the HLF Patient Charter.

03

Progress toward achieving system-level goals is routinely evaluated.

Advice

Research

The patient voice is crucial in research as it provides valuable insights that lead to patient-centered outcomes. By considering patients' experiences and preferences, research becomes more relevant, leading to effective interventions and improved healthcare results. Engaging patients in research builds trust and empowerment, enhancing the overall quality and relevance of research findings.

- **CONSTRUCT ROBUST HEALTH DATA INFRASTRUCTURE,** such as establishing a national heart failure registry and optimizing the Canadian Community Health Survey, to guide care delivery, to monitor outcomes and adherence to guideline-directed care, and for resource planning.
- **ENGAGE PATIENTS,** healthcare practitioners, and health systems to participate in heart failure research. Formalize and actively support a role for patient partnership in research through establishing funding initiatives to promote patient engagement and prioritization of ideas (i.e., patient-driven, patient-led research).
- **FUND RESEARCH INITIATIVES** that examine new and affordable therapies (e.g., value-based agreements), assess the cost-effectiveness of treatments, evaluate healthcare performance measures, and explore new care delivery pathways (e.g., end-of-life care, advances in hospice care). Study enrollment should consider equity, diversity, and inclusion.

Evaluation

Ensuring the success of the framework centered on patient outcomes requires active measurement and evaluation of each strategy.

- **DEFINE NATIONAL**, healthcare system-level key heart failure performance indicators, including patient-reported outcome measures, to evaluate performance informed by the framework recommendations.
- **MANDATE PERFORMANCE REPORTING** to establish accountability. Measure performance at baseline and establish clear progression goals. Routinely measure and evaluate progress achieved and follow-up with an action plan to address any unmet targets.
- **ROUTINELY COLLECT AND REPORT** on patient reported outcome measures (PROMs) and patient-reported experience measures (PREMs) through administrative databases. Include PROMs, such as improvement in quality of life and functional status, in guideline recommendations.

Impact

Healthcare

ENHANCED TRANSPARENCY and accountability in healthcare delivery.

MORE RESPONSIVE and tailored healthcare services to meet patient needs.

ACCELERATED DEVELOPMENT of medical knowledge and advancements.

Patient

INCREASED RELEVANCE OF RESEARCH outcomes to real-world patient experiences.

ENHANCED PATIENT TRUST and engagement in healthcare research.

PATIENT PERSPECTIVES integrated into research priorities, design, and outcomes.

OPPORTUNITIES FOR PATIENTS to contribute to improved treatments and interventions.

Funding Strategies

Alternative funding models are essential to effectively implement the framework and prioritize accurate and timely diagnosis, optimized care, and improved patient outcomes.

Accurate and Timely Diagnosis

- **INVEST IN DIAGNOSTIC INFRASTRUCTURE FOR ACUTE AND PRIMARY CARE:** Allocate funding to enhance diagnostic capabilities by updating and expanding medical imaging equipment such as hand held echocardiograms, diagnostic tests such as NTproBnP, and point-of-care testing technologies. This can lead to quicker and more accurate diagnoses, enabling timely interventions.

- **SUPPORT CONTINUING MEDICAL EDUCATION:** Provide funding for healthcare professionals to attend training and workshops focused on the latest diagnostic techniques and advancements. This can improve their ability to accurately diagnose heart failure.

Access to Guideline-Directed Medical Therapy

- **SUBSIDIZE GDMT:** Provide equitable access to treatment through funding essential drugs and new effective therapies (including research to address the limited data on pharmacological therapy of heart failure with preserved ejection fraction [HFpEF]). Allocate funding to subsidize or reduce the cost of heart failure medications that are part of evidence-based treatment guidelines for prevalent conditions. This ensures that patients have affordable access to necessary GDMT, increasing adherence to treatment plans.
- **SUPPORT CLINICAL DECISION SUPPORT SYSTEMS:** Provide funding for the development and implementation of platforms to educate and remind clinicians about guideline-recommended treatments and alert them to potential drug interactions.
- **PROVIDE AUTHORITY:** for the members of multidisciplinary care team to safely and effectively prescribe and up titrate GDMT.

Mental Health Support

- **EXPAND MENTAL HEALTH SERVICES:** Allocate funding to increase the availability of mental health services for patients and caregivers living with heart failure, including therapy, counseling, and psychiatry, particularly in underserved areas. This can help address the growing demand for mental health support.
- **VIRTUAL AND TELETHERAPY:** Invest in virtual mental health platforms to provide remote access to mental health professionals. This can improve access to care, especially for individuals in rural or remote areas.

These funding recommendations aim to address the specific challenges and opportunities for heart failure including a timely and accurate diagnosis, access to guideline-directed medical therapy, mental health support, and the integration of virtual care and technology into healthcare systems. As with any policy recommendations, ongoing evaluation and flexibility are key to ensuring that the funding strategies remain effective in achieving the desired outcomes.

Use of Virtual Care and Technology

- **TELEHEALTH INFRASTRUCTURE:** Allocate funding to establish robust heart failure telehealth infrastructure, including reimbursement for virtual appointments, ensuring that patients can access medical care remotely.
- **DIGITAL HEALTH TOOLS:** Provide funding for the development and deployment of digital health tools, such as heart failure education platforms, mobile apps and wearables, that empower patients to manage their health conditions and monitor progress. These tools can enhance patient engagement and facilitate remote monitoring.

HeartLife FOUNDATION

It’s time to take action

This is just the beginning.

The Heartlife Foundation will be using this framework to advocate for change across Canada.

Visit our website for updates on how to participate in advocacy initiatives and to donate as we push for a better life for people in Canada with heart failure.

It’s about life, not failure.

FRAMEWORK

DONATE

End Notes

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