# 11<sup>th</sup>ANNUAL HEART FAILURE UPDATE 2024

Friday May 24 - Saturday May 25 Marriott Chateau Champlain, Montreal, Quebec

Inc. Butters



Canadian Heart Failure Society Société canadienne d'insuffisance cardiaque

X @CanHFSociety #HFupdate



# **Plenary 1: Healing Hearts**



# Welcome and Congress Opening Remarks

Kim Anderson MD, FRCPC, MSc

### 11<sup>th</sup> ANNUAL HEART FAILURE UPDATE 2024

### Nous remercions du fond du **COEUR** nos commanditaires pour 2024. **HEART**felt thanks to our 2024 Sponsors



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We extend our respect to all First Nations, Inuit and Métis peoples for their valuable past and present contributions to this land we call Canada. We acknowledge the Indigenous Peoples of all the lands that we are each on today, and reaffirm our commitment and responsibility as individuals, to improving relationships between nations and to collaborating in a spirit of reconciliation.

# Faculty

### Co-chairs:

- Kim Anderson, MD, FRCPC, MSc
- Grace Chua, MD, FRCPC, FACC

### Presenters:

- Sean Virani, MD , MSc, MPH, FRCPC, FCCS
- Mena Gewarges, MD, MA, FRCPC
- Elizabeth Swiggum, MD, FRCPC, FCCS
- Stephen Greene, MD
- Wayne Sandvik

# Disclosures

	Dr. Anderson	Dr. Chua
Any direct financial payments including receipt of honoraria	Abbott Canada, Novartis, Servier, Takeda, Bristol- Myers- Squibb	Canadian Cardiovascular Society, Canadian Heart Failure Society, Canadian Society of Endocrinology and Metabolism, CPD Network, EOCI Pharmacomm, IiV Medical Agency, Meducom Health Inc, Sei-Healthcare, University of Toronto Heart and Stroke Richard Lewar Center of Excellence, Canadian Medical and Surgical Knowledge Translation Research Group
Membership on advisory boards or speakers' bureaus	No disclosures	Amgen, Astra Zeneca, Bayer, Boehringer Ingelheim-Eli Lilly Alliance, Bristol Myers Squibb, GlaxoSmithKline, HLS Therapeutics, Novartis, Novo Nordisk, Pfizer, Servier, CPD Network, Canadian Collaborative Research Network, University of Toronto, CHEP +
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# **Learning Objectives**

- 1. Employ novel treatment approaches and interdisciplinary collaboration to improve outcomes in patients living with heart failure.
- 2. Optimize therapies in individuals with heart failure and comorbidities.
- **3**. Diagnose patients living with heart failure with an aim to deliver holistic care.

# **Plenary Agenda**

ТІМЕ	ΤΟΡΙϹ
0.00  am $0.10  am$	Welcome and Congress Opening Remarks
9.00 a.m. – 9.10 a.m.	Dr. Kim Anderson
9:10 a.m. – 9:25 a.m.	A Call to Action: Gaps and Access to HF Care in Canada
	Dr. Sean Virani
0:25 a m 0:40 a m	Culturally Inclusive and Remote HF Care for Indigenous Persons
9.25 a.m. – 9.40 a.m.	Dr. Mena Gewarges
0:40 a m 0:55 a m	Language Matters and Resiliency Matters in HF Care
9:40 a.m. – 9.55 a.m.	Dr. Elizabeth Swiggum
0.55.2  m 10.10.2 m	Implementation Across a Continuum of EF
9.55 a.m. – 10.10 a.m.	Dr. Stephen Greene
10:10 a.m. – 10:15 a.m.	Lived Experience Commentary
	Wayne Sandvik
10:15 a.m. – 10:40 a.m.	Plenary Q&A
	All panelists

# Housekeeping

- To collect your MOC Section 1 credits, please remember to complete both the session evaluation and the congress evaluation
- The evaluation QR code can be found on your tables and will be displayed on the screen after the presentation

# A Call to Action: Gaps and Access to HF Care in Canada

### Sean A. Virani MD, MSc, MPH, FRCPC, FACC, FCCS

Vice-President | Medical and Academic Affairs | Provincial Health Services Authority Head | Division of Cardiology | Providence Health Care Physician Program Director | The Heart Centre | St. Paul's Hospital Associate Professor | Department of Medicine | University of British Columbia Vice-President | Canadian Cardiovascular Society Medical Director | HeartLife Foundation



# Disclosures

	Dr. Virani
Any direct financial payments including receipt of honoraria	No disclosures
Membership on advisory boards or speakers' bureaus	Hear tLife Foundation, Heart and Stroke Foundation
Funded grants or clinical trials	CIHR
All other investments or relationships that could be seen by a reasonable, well-informed participant as having the potential to influence the content of the educational activity	No disclosures



# **Learning Objectives**

- Identify gaps in quality of care and access to care for patients with heart failure in Canada
- Describe disparities in access and quality of care for different subgroups of patients with heart failure
- Support solutions to close care gaps and improve quality of care in an equitable manner

### **Common Barriers to Optimal Heart Failure Care**

### Lack of access to specialized care

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Limited availability of multidisciplinary heart failure clinics and specialists in rural or underserved areas.

### Poor prescription of GDMT



Multiple provider level barriers to prescription of guideline directed medical therapy have been identified and extend beyond therapeutic inertia

#### Socioeconomic factors

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Low income, lack of health insurance or transportation, and limited access to affordable healthcare and medications can hinder optimal care.

### Limited patient education



Inadequate understanding of the condition, treatment plan, and self-management strategies can lead to poor outcomes.

Addressing these barriers through improved access, patient support, education and policy has been the focus of most heart failure quality improvement strategies/programs

### Heart and Stroke Foundation of Canada National Heart Failure Resources and Services Inventory

- The national Heart Failure Resources and Services Inventory (HF-RaSI) was conducted from 2020 to 2021 by Heart and Stroke Foundation
- 629 acute care hospitals and 20 urgent care centres in Canada were surveyed
  - HF-RaSIs were completed by 501 acute care hospitals and urgent care centres, representing 94.7% of all HF hospitalizations across Canada.
- The HF-RaSI consisted of 44 questions on available resources, services and processes across acute care hospitals and related ambulatory settings.

### **Gaps in Care and Access**

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28.7% of hospitals lack access to BNP testing

Over a quarter of hospitals cannot perform this crucial diagnostic test for heart failure, impacting timely diagnosis and management.

#### Only 48.1% have on-site echocardiography

Less than half of hospitals have ready access to this vital imaging technique for assessing heart function in heart failure patients.



#### Only 12.2% of heart failure care at specialized centers

Most heart failure patients receive care from hospitals lacking expertise and resources dedicated to this condition.



#### 50.9% of admissions at centers with minimal capabilities

Half of all heart failure admissions occur at facilities illequipped to provide optimal care for this complex condition.

These gaps highlight significant barriers to accessible, high-quality heart failure care in Canada and serve as the foundation for our system redesign efforts.

### **Addressing Gaps and Disparities in Heart Failure Care**

Not all care gaps are realized equally



# **Disparities in Access and Quality of Care**

### A few subgroups of interest



#### Patients Hospitalized with AHF

AHF and hospitalization portend a poor prognosis and identifies a cohort of patients requiring early and aggressive treatment. Hospitalization is a recognized opportunity for intervention



#### Geographically Rural and Remote

Patients in rural and remote areas face barriers in accessing diagnostics as well as specialized heart failure clinics and multidisciplinary teams.



Factors contributing to disparities in outcomes include social determinants of health, access to healthcare services and systemic barriers routed in indigenousspecific racism

# **CAN-HF Registry**

**Consort Flow Diagram for Patients Admitted with Acute Heart Failure** 

Population: 7 sites across Canada, consecutive hospitalizations between 2017 - 2020



### Eligibility for in-hospital initiation of *Quadruple Therapy* in patients with HFrEF



# Eligibility for disease modifying therapies in hospitalized patients with HFpEF

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37.6 % በ

ARNI (PARAGON)

59.9 % Ш Ո Ո Ո 41

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# Gaps in Quality of Care

### **Converting Eligibility into Actual Prescriptions**



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### Only 6.6% of HFrEF patients eligible for ARNI received it at discharge

Even accounting for variability in drug coverage, rates of uptake remain extremely low despite robust evidence

#### 19%-56% prescription gap for BB, ACEI/ARBs and MRAs

Despite clear guidelines, a significant proportion of eligible patients were not prescribed key HFrEF medications.

### Less than 1.4% of eligible patients received ivabradine

Uptake of this recommended add-on therapy for HFrEF remains extremely low.

Substantial gaps exist in the quality of HFrEF care, with many eligible patients not receiving guideline-directed medical therapies *despite hospitalization for disease decompensation*.

### **Hospital Designation/Location in the HF RaSi**

A significant portion of our facilities providing HF care are in non-urban settings



### **Truth and Reconciliation Commission**

### **Call to Action 19**



We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

## Narrowing the Gap

### A step-wise approach to improving quality and reducing care gaps



# **Evidence-Based Strategies for Improvement**

Standardized Care Pathways	Self-Management Programs	Community-Based Support Systems
Implement evidence-based clinical protocols and checklists for consistent diagnosis, treatment, and follow-up across healthcare settings.	Provide structured education and support for patients to actively monitor their condition, adhere to treatment plans, and make lifestyle modifications.	Foster partnerships with community organizations to offer home-based care, social services, and peer support networks for patients and caregivers.
Multidisciplinary Care Teams	<i>Telehealth and Remote Monitoring</i>	Quality Improvement Initiatives

## **Subgroup-Specific Strategies**

A "one size fits all" approach does NOT work

#### Indigenous Outreach and Education

Collaborate with Indigenous communities to develop culturally-sensitive, anti-racist and decolonized educational materials and outreach programs addressing barriers to care, such as mistrust of healthcare systems and accessibility challenges.

#### Rural Telehealth and Mobile Clinics

Beyond Telehealth and remote monitoring, mobile clinics improve access to specialized heart failure care for patients in remote or underserved rural areas, addressing transportation and geographic barriers.

#### Language and Cultural Competency Training

Provide comprehensive training for healthcare professionals to enhance cultural competency, language proficiency, and sensitivity when caring for patients from diverse backgrounds, fostering trust and effective communication.

#### Community Health Worker Integration

Integrate community health workers from underserved populations into care teams to bridge cultural gaps, provide education, and support selfmanagement strategies tailored to specific subgroup needs and preferences.

#### Targeted Screening and Risk Reduction

Develop targeted screening and risk reduction programs for high-risk subgroups, addressing factors like higher prevalence of risk factors, language barriers, or socioeconomic determinants contributing to disparities in heart failure outcomes.

# Narrowing the Gap

### Virani's perspective on the Canadian "Dashboard"



# **Closing the Gaps: A Call to Action**



### Implement Evidence-Based Strategies

Adopt and scale up interventions proven to increase GDMT use such as CDST, transitional care programs, and prescription coverage. Leverage multi-disciplinary teams and enhanced interdisciplinary collaboration.



### **Tailor Solutions for Local Contexts**

Recognize diverse barriers across health systems, clinics, providers, and patients. Adapt evidence-based strategies to local settings through stakeholder engagement and pragmatic trials evaluating implementation outcomes.



#### **Coordinate System-Wide Approach**

Engage policymakers, health authorities, clinicians, researchers, industry, and patient advocates in a coordinated, multi-level effort to develop, fund, and operationalize implementation solutions.



### **Ensure Equitable Access**

Prioritize underserved populations and address socioeconomic determinants to guarantee all Canadians receive high-quality, guideline-concordant heart failure care regardless of background or circumstances.



#### **Engaging Patients as Partners**

Develop and implement culturally appropriate education, self-management support tools in collaboration with patients to improve adherence & address barriers. Focus on PREMS and PROMS that are meaningful to patients/families.



# Culturally Inclusive and Remote HF Care for Indigenous Persons

### Mena Gewarges, MD, MA, FRCPC

With special thanks to Dr. Heather Ross, Dr. Yas Moayedi, Anne Simard, Stella Kozuszko Toronto General Hospital



Weeneebayko Area Health Authority ・ムテンオームU9^bΓ 「\_\_へLハイ・ムートPL・ム・ムテ、



# Disclosures

• No disclosures

# **Learning Objectives**

- 1. Examine the needs of Indigenous population to access local and culturally inclusive HF care
- 2. Discuss the importance of patient and community satisfaction while ensuring improvement in morbidity and mortality
- **3**. Identify and develop key changes to provide inclusive and accessible care for the Indigenous persons

### Land Acknowledgement

I would like to begin by acknowledging that in our work, we are serving the Treaty 9 territory, the traditional territory of Mushkegowuk (Cree), Ojibwe/Chippewa, Oji-Cree, Algonquin, and Métis Peoples

### **Overview**

- 1. Examine the needs of Indigenous population to access local and culturally inclusive HF care
- 2. Discuss the importance of patient and community satisfaction while ensuring improvement in morbidity and mortality
- Identify and develop key changes to provide inclusive and accessible care for the Indigenous persons



# Setting: James and Hudson Bay Region of Northern Ontario

- JHB region home to diverse Indigenous communities
- Weeneebayko Area Health Authority (WAHA) is responsible for health services in the region
- Main hospital located in Moose Factory (accessible by boat/ice road/helicopter)
  - Nursing stations and smaller hospitals in other communities



• If you need cardiac care, high-risk surgery, glasses, braces etc... then you have to travel south.



Peawanuck to Toronto/Kingston 3-5 hrs + layovers and 1-6 stops



5 hours from Moosonee to Cochrane



Cochrane to Sudbury 6-9 hrs and 1-3 stops



Moosonee to Toronto 13+ hours and ONLY in winter


## **Cardiovascular Disease in the JBH Region**

#### **Importance of addressing heart failure:**

"Our community members were more likely to have a history of heart failure in Ontario overall in every age group...heart failure mortalities in these communities continue to climb, increasing by just under 10% between 1992 and 2014"<sup>1</sup>

#### The solution:

In 2022, WAHA and UHN HF Program leadership began clinical collaboration comprising in-person cardiology clinics in the region with remote management using Medly, a digital therapeutic program.

# Integrated Model to HF Care for JHB HF Patients

Co-developed model over last year - and continue to refine as we move ahead



In-person clinics (across 5 JHB communities)



Support through virtual clinics



Working closely with WAHA based Clinical Coordinator

## **Community In-person Clinics**



Moosonee: 3 clinics: Sept 2022, January + May 2023 Peawanuck: Sept 2022, Jan 2023 + May 2023





Fort Albany: February 2023

Moose Factory: Sept 2022, Jan + May 2023



#### **Medly Telemonitoring Program**



A Remote Patient Monitoring Platform for Multiple Chronic Conditions



Patient parameters are based on personalized thresholds and treatment plans, set by clinicians at time of enrollment.

Patient enters measures on daily basis: weight, blood pressure, heart rate and symptoms.

Thresholds can be adjusted by clinician at any given point through the clinician dashboard.

Actionable feedback is provided to patient immediately, such as:

- Parameters within normal range
- Record measures again later if you are feeling unwell
- Take a diuretic at a prescribed dose

#### WAHA Medly Program Overview



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#### Wali S et al, Int J Equity Health. 2021 Jan 6;20(1):8.

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**Blood Pressure Cuff** 





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#### Distribution of Alerts: November 2022 through March 2023



#### **Retrospective Chart Audit: GDMT**

- Guideline Directed Medical Therapy (GDMT) is the gold standard for HF management, and involves the titration of 4 drug classes:
  - 1. ARNIs, ACE inhibitors, or ARBs
  - 2. Beta Blockers
  - 3. SGLT2 inhibitors
  - 4. MRAs
- Total Percentage of JHB Patients on Optimized GDMT or being titrated for GDMT: 93%
- Medly has helped titrate GDMT for all reviewed patients



## Patient Survey – Key Results

- 15 completed surveys
- Patients were surveyed after using Medly for 1 month
- Responses anonymous to protect patients and solicit honest feedback

## Patient Survey – Key Results

1. The Medly Program allows me to access care close to home.



2. Would you recommend the Medly Program to others?



#### Patient Survey – Key Results

3. I found the Medly program easy to participate in.



4. Medly addresses a gap in care in the community.



#### **Patient Comments**

"I wish we had this program earlier in our remote communities, as I have lost loved ones as sudden cardiac arrest. Hopefully, it will continue as years to come. For me, I'm confident in my health and continue to feel positive with my lifestyle. It helped me a lot mentally, emotionally and physically."

"The program provided me with a quick response when having an episode..."

"Good program, excellent care! Just found it kind of difficult to keep it part of my daily routine."

"I am very happy with my Medly team which are very caring doctors and nurses they have called me on numerous times when my numbers are off and the weight, blood pressure and heart rate are so easy to do thank you for this team"

## **Early Lessons Learned**

- Shared governance and leadership model with supporting infrastructure are key
- Success relies on local capacity and linkages complement by UHN team
  - Hiring a Medly clinical coordinator based at Weeneebayko General Hospital familiar with the region has been invaluable
- Openness to self-referrals and responsive scheduling when in community allows for greater access and inclusion
- Outreach to WAHA clinicians facilitates referrals and communications

## **Early Lessons Learned**

- Great value in engaging community leaders
   and Elders
- Cree interpretation and translation allows for greater adaptation to community needs
  - Program material translated into Cree and available in different modalities (written, oral)
  - Use of interpreters during in-person clinics and OTN visits
- Mutual respect and support at core of partnership influences all actions
  - WAHA in driving implementation, UHN supporting as needed



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#### Looking Ahead: Future Directions for Equitable HF Care in JHB Region

- 5-year collaboration agreement signed!
- Expand to all communities to increase access to care and digital health tools
- Conduct quality improvement evaluation to inform approaches
- Sustain success with funding opportunities



#### Acknowledgements

- We recognize funding received from Ontario Health and Boehinger Ingelheim through the Healthcare Innovation Challenge 2022-2023 in support of our collaboration
- Thank you to WAHA executive, physician and nursing leadership as well as clinical leads who make this collaboration possible
- Acknowledge the respective Band Councils and communities who welcome us onto their Territory

## Meegwetch $\dot{\Gamma} \cdot 9^{L}$ Thank you



Weeneebayko Area Health Authority ・ムテレオームロタート 「エクトレロイ・ムートトレーン」





Words Have Power

#### Language Matters and Resiliency Matters in HF Care

#### Elizabeth Swiggum MD FRCPC FCCS

Medical Director | Heart Function Clinic | Cardiac Rehabilitation | Royal Jubilee Hospital Clinical Associate Professor | University of British Columbia Board member | Canadian Heart Failure Society Medical Chair | Heart Failure and Chronic Cardiovascular Disease | CSBC Board Chair | Doctors of BC

## Disclosures

	Dr. Swiggum
Any direct financial payments including receipt of honoraria	Boehringer Ingelheim, BI Lilly Alliance, Bayer, Canadian Medical & Surgical Knowledge Translation Research Group, Novartis, Servier, NovoNordisk
Membership on advisory boards or speakers' bureaus	Boehringer Ingelheim, BI Lilly Alliance, GSK, Novartis, Otsuka, Pfizer, Servier
Funded grants or clinical trials	Boehringer Ingelheim N/A for multi centre trials, Grants for QI Novartis, Pfizer, Servier, Bayer
All other investments or relationships that could be seen by a reasonable, well-informed participant as having the potential to influence the content of the educational activity	No disclosures

## **Learning Objectives**

Acknowledge	Acknowledge the longitudinal journey and transitions when caring for HF patients
Use	Use positive and understandable language to communicate and engage with patients and care partners
Apply	Apply methods to improve resiliency in patients and in health care practitioners

Acknowledge



## **Connection before Content**

# Grateful

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#### SO RESILIENT! A MODERN DEFINITION OF **RESILIENCE: "ADVANCING** DESPITE **ADVERSITY**" GOAL-ORIENTATION. BOTH LARGE AND WORK TOWARDS SMALL EVERYDAY BE PROACTIVE YOUR VISION CHALLENGES DON'T WAIT FOR **ADVERSITY**

#### dri⊄en



# "Even if I fall, I am moving forward

- Shirley Petten, Patient Partner

**Words Matter** 



## Resilience

**Words Matter** 



## Silence

#### **Patient-Physician Communication**



#### ORIGINAL RESEARCH Eliciting the Patient's Agenda- Secondary Analysis of Recorded Clinical Encounters

Naykky Singh Ospina, MD, MSc<sup>1,2</sup>, Kari A. Phillips, MD<sup>3</sup>, Rene Rodriguez-Gutierrez, MD, MSc<sup>2,4,5</sup>, Ana Castaneda-Guarderas, MD<sup>6</sup>, Michael R. Gionfriddo, Pharm D, phD<sup>7</sup>, Megan E. Branda, MS<sup>8,9</sup>, and Victor M. Montori, MD MSc<sup>2</sup>

- 112 recorded clinical encounters
  - Testing shared decision-making tools
  - Mayo Clinic
- 40/112 (36%) Patients agenda elicited
  - 30/61 (49%) Primary Care
  - 10/51 (20%) Specialty Care



#### J Gen Intern Med 34(1):36 – 40 (2019)

#### **Patient-Physician Communication**

#### ORIGINAL RESEARCH Eliciting the Patient's Agenda- Secondary Analysis of Recorded Clinical Encounters

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67% patient encounters were interrupted

• Median 11 seconds (IQR 7–22)

Uninterrupted patients took a median of **6 seconds** (IQR 3–19) to state their concern







# *"If you can't explain something simply, you don't understand it well enough*

- Albert Einstein

## Plain Language

- Health literacy
  - Language
  - Education
  - Values

- CanMeds
- Communicator Role

## **Health Literacy**



Why is it important for me to do this?

## Plain language

✓ Focus Your Communication – Know your audience and purpose before you begin. Always open your communication with the most important messages.

- Be Concise
  - 4-6
- Speak/Write at a Grade 8 Level
- Use bullet points
- Use images
- Avoid using jargon
- Avoid using acronyms



## Plain Language – examples

- Ejection Fraction
  - Not EF
  - What is normal
  - Your patient's number relative to normal
- Genetic difference
  - Not genetic variant
  - Not genetic mutant
  - What is the chance of sharing the same genetic difference with a relative (mother, father, sibling, child)

## Plain Language – Rx

- Reason for medication
- What are the options
- What is the dose and timing
- If adjusted what is the change
- Copy of the prescription in hand

**RX: Heart Function Clinic Prescription** 



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Date:

Cardio protective medications	Dose: Frequency:	Supply/Refills: Special Authority:
□ carvedilol □ bisoprolol	mg twice daily mg once daily at evening	
□ sacubitril/valsartan (Entresto) □ ramipril □ candesartan	mg twice daily	
□ spironolactone	mg once daily in the a.m.	
□ empagliflozin	mg once daily in the a.m.	
dapagliflozin	mg once daily in the a.m.	
□ other:		
<u>Diuretic (water pill)</u> □ furosemide	mg	
Other prescription medication	<u>15</u>	<ul> <li>Fair Pharmacare</li> <li>Extended medical</li> <li>Blister packed</li> </ul>
**Words Matter** 



### **Practice...of medicine**

In Practice Practicing physician

**Patient in practice?** 



### FAIL

# First Attempt In Learning

**Growth Mindset** 



# FAIL SAIL TAIL

**Words Matter** 



### **Heart Failure or Heart Function?**



# *"Psoriasis sounded scarier than cardiomyopathy"*HF patient

### The new universal definition of heart failure classifies the different phenotypes according to LVEF



EF, ejection fraction; HF, heart failure; LVEF, left ventricular ejection fraction. Bozkurt B *et al. Eur J Heart Fail.* 2021;23:352.

# **HeartLife Foundation**

### Living with Heart Failure

Heart and Stroke Heart Failure Action Plan and Advisory Committee

• 2021

Heart Failure

Heart Function Clinic





# WHAT REALLY MATTERS NOW NOTES FOR LIVING WITH

### ADVANCED HEART FAILURE



A Comprehensive Resource for People Who have Advanced Heart Failure and the Carers who Support Them

Shared Care Supportive Cardiology Project









### Connection

### Empathy

### "Boundaries are a prerequisite for compassion and empathy

- Brené Brown

# Conclusions

Acknowledge	Acknowledge the longitudinal journey and transitions when caring for HF patients
Use	Use positive and understandable language to communicate and engage with patients and care partners
Apply	Apply methods to improve resiliency in patients and in health care practitioners



### Connection ...now more content



### Implementation Across a Continuum of Ejection Fraction

#### Stephen J. Greene, MD, FACC, FHFSA

Duke University School of Medicine Duke Clinical Research Institute



# Disclosures

 Amgen, AstraZeneca, Bayer AG, Boehringer Ingelheim, Bristol Myers Squibb, Corteria, CSL Vifor, Cytokinetics, Eli Lilly, Lexicon, Merck, Novartis, Novo Nordisk, PharmalN, Pfizer, Roche Diagnostics, Sanofi, scPharma, Tricog Health, and Urovant

# **Learning Objectives**

- 1. Recommend therapies for HF patients across the LVEF continuum
- 2. Review evolving data to support implementation of therapies for patients living with heart failure
- 3. Recognize system and patient-level barriers to implementation



#### Coyle, C....Greene SJ. ESC Congress 2023

### **Strategies to Help Facilitate GDMT Initiation**



# **Nudges in Healthcare**

#### **Defaults and "Opt Out"**



#### Guide Choice Through Defaults

Nudges include: creating automated laboratory orders; reducing standard opioid prescriptions to smaller doses; making the generic medication the default

#### **Enable Choice**

Nudges include: reducing effort by putting a seat in the ED for clinicians to spend more time with patients; increasing effort to prescribe brand name medication; presenting choices in the electronic health record

#### **Prompt Implementation Commitments**

Nudges include: prompting individuals to think through their concrete plan for how they will implement the intervention; ask individuals to precommit to an action

#### **Frame Information**

Nudges include: social comparison feedback using leaders or descriptive norm as the reference point; setting up accountable justification for actions that do not adhere to guidelines; audit and feedback

#### **Provide Information**

Nudges include: regular emails about the clinical guidelines, text message reminders about evidence-based practices; posters around the office; best practice advisory alerts in the electronic health record.

#### Do Nothing



### **PROMPT-HF:** An Example of Clinician Decision Support Tools

**CENTRAL ILLUSTRATION:** Electronic Health Record-Based Alerting Led to Significantly Higher Rates of Guideline-Directed Medical Therapy



### Effect of Multidisciplinary In-Hospital Virtual Consult Team on GDMT Optimization



Rao VN et al. *Circ Heart Fail* 2023 Bhatt AS et al. *JACC* 2023 Patolia H...Greene SJ. *JACC* 2023



An Electronically Delivered Patient-Activation Tool for Intensification of Medications for Chronic Heart Failure With Reduced Ejection Fraction

*Question:* Can "activating" patients prior to a clinic appointment lead to better engagement with their clinician around the HFrEF medication plan, and in turn prompt greater optimization of GDMT?

*Intervention:* 3-minute patient activation video + 1-page medication checklist delivered to patients before clinic

### **Effect of Patient Activation on GDMT Prescription**

**Proportion of Patients with GDMT Initiation or Intensification** 



Patient Activation Strategy Usual Care

### **Remote, Algorithm-Based Titration Using Navigators**

#### **Remote GDMT Optimization (N=197)**

Usual Care (N=831)



Remote GDMT optimization with significant increases in ACEi/ARB/ARNI and beta blocker use

### **Strategies to Help Facilitate GDMT Initiation**



#### VIEWPOINT

Simultaneous or Rapid Sequence Initiation of Quadruple Medical Therapy for Heart Failure– Optimizing Therapy With the Need for Speed

GDMT	Day 1	Days 7–14	Days 14–28	Days 21–42
ARNI	Initiate, low dose	Continue	Titrate, as tolerated	Titrate, as tolerated
Beta-blocker	Initiate, Iow dose	Titrate, as tolerated	Titrate, as tolerated	Titrate, as tolerated
MRA	Initiate, Iow dose	Continue	Titrate, as tolerated	Continue
SGLT2i	Initiate	Continue	Continue	Continue

### Start all 4 mortality reducing drugs without delay, or in rapid sequence

Greene SJ, Butler J, Fonarow GC. JAMA Cardiol 2021

# The "Status Quo" Serial and Selective Approach to Optimizing GDMT

Initial Diagnosis of HFrEF	2–4 weeks	2–4 more weeks	2–4 more weeks	
ACEi starting dose	Titration	Titration	Titration	
2–4 more weeks	2–4 more weeks	2–4 more weeks	2–4 more weeks	
Beta blocker starting dose	Titration	Titration	Titration	
2–4 more weeks	2–4 more weeks	2–4 more weeks	<ul> <li>28–56 weeks before GDMT fully implemented</li> <li>At each step, clinical inertia stands in the way of success</li> <li>Patients exposed to the excess risk of death and clinical worsening during prolonged initiation and titration process</li> </ul>	
MRA starting dose	Titration	Titration		
2–4 more weeks	2–4 more weeks	2–4 more weeks		
ARNi starting dose	Titration	Titration		

### Minimal Initiation and Titration of GDMT During Hospitalization in US and Canada



VICTORIA Registry, Median systolic BP 110–127 mmHg, median eGFR 50–60 mL/min/1.73 m<sup>2</sup>

Percentage of eligible HFrEF patients NOT receiving GDMT at discharge: ACEi/ARB/ARNi – 33% | Beta blocker – 25% | MRA – 55%

ACEi, angiotensin-converting-enzyme inhibitor; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor–neprilysin inhibitor; BP, blood pressure; eGFR, estimated glomerular filtration rate; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; MRA, mineralocorticoid receptor antagonist; SGLT2i, sodium–glucose cotransporter 2 inhibitor; VICTORIA registry, Vericiguat Global Study in Subjects with Heart Failure with Reduced Ejection Fraction. Greene SJ, et al. *J Card Fail*. 2022;28(7):1063-1077.

### **Deferring Initiation = Never Initiating (or Substantial Delay)**

Postdischarge Use of GDMT by Prescription Status at Hospital Discharge



ARNi, angiotensin receptor–neprilysin inhibitor; GDMT, guideline-directed medical therapy; MRA, mineralocorticoid receptor antagonist. Rao VN...Greene SJ. J Am Coll Cardiol. 2021;78(20):2004-2012.a

# Rationale for Simultaneous, Rapid Sequence, and/or In-Hospital Initiation and Titration of GDMT for HFrEF

#### **RCT** and Real World Evidence



Benefits of quadruple medical therapies on clinical events appear early after initiation (ie, days to weeks)



Benefits of each GDMT are fully additive



Therapies may maximize tolerance of each other when used in combination



Simultaneous/rapid sequence initiation of multiple medications routinely done in other areas of medicine (eg, post-AMI, combination DM and HTN pills, polypills)



Deferred initiation of any GDMT in an eligible patient consistently associated with never initiation or substantial delay







Primary Endpoint: 180-day Death or HF Hospitalization 34% RRR, 8.1% ARR, Number-Needed-to-Treat = 12

#### High-Intensity Simultaneous/Rapid Sequence GDMT Optimization Led to:

- Significantly lower risk of death or HF hospitalization
- ✓ Improved patient-reported health status and NYHA functional class
- Improved clinical congestion and incremental lowering of NT-proBNP
- ✓ Substantially higher use and dosing of GDMT throughout follow-up
- ✓ No excess risk of serious adverse events

### 2022 AHA/ACC/HFSA HF Guidelines: 4 Pillars of Medical Therapy for HFrEF



# Step 1 therapies may be started simultaneously or without specific medication sequence and should not be delayed

<sup>a</sup>Diuretics are also recommended as needed in patients with fluid retention; <sup>b</sup>ARNI is recommended as de novo treatment or to replace ACEi or ARB in patients with NYHA class II–III. In patients with NYHA class II–IV, ACEi (or ARB when intolerant to ACEi due to cough or angioedema) is recommended when ARNI use is not feasible; <sup>c</sup>One of the three β blockers proven to reduce mortality; <sup>d</sup>estimated glomerular filtration rate >30 mL/min/1.73 m<sup>2</sup> and potassium <5.0 mEq/L

ACC, American College of Cardiology; ACEi, angiotensin-converting-enzyme inhibitor; AHA, American Heart Association; ARB, angiotensin receptor blocker; ARNI, angiotensin receptor–neprilysin inhibitor; COR, class of recommendation; GDMT, guideline-directed medical therapy; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; HFSA, Heart Failure Society of America; LOE, level of evidence; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; NYHA, New York Heart Association; SGLT2, sodium–glucose co-transporter 2

Heidenreich PA, et al. J Am Coll Cardiol 2022. doi: 10.1016/j.jacc.2021.12.012 [Epub ahead of print]



Barring contraindication, all patients with HFpEF should be treated with an SGLT inhibitor to reduce CV death/HF hospitalization and improve health status

### **Strategies for Optimal Implementation of GDMT**

- Multiple strategies have supporting evidence for improving implementation of GDMT.
- For many strategies, evidence limited to single health system and with modest absolute improvements. Multi-modal combination strategies may be needed to make large improvements in GDMT utilization.
- Of the strategies for GDMT implementation, which can we do <u>today</u> to improve GDMT for our patients?
  - Answer = simultaneous or rapid sequence initiation of quadruple medical therapy for HFrEF, and prompt initiation of SGLT2i for HF with EF >40%.
  - Serial or selective approach = needless and prolonged delays in GDMT optimization...and excess HF hospitalizations and deaths that could have been prevented.
- Break clinical inertia and treat HF with the sense of urgency it deserves.



# **Lived Experience Commentary**

Wayne Sandvik

# Disclosures

• No disclosures



# **Q&A Period**

All panelists



# **CHFN Awards**

**Dr. Jonathan Howlett**
## THE CANADIAN HEART FAILURE NETWORK: EST. 1996







RECIPIENT: John Arnold

## MALCOLM ARNOLD AWARD FOR MENTORSHIP AND SERVICE IN HEART FAILURE

#### **Purpose of the Award:**

 To support a practicing health care provider in a Canadian health care system

#### **Award Value:**

Inaugural year \$5000.00 CDN



RECIPIENT: **Rodolfo Pike,** St John's, NL

## THE CHFN ANNUAL RESEARCH AWARD

#### **Purpose of the Award:**

• To support an outstanding researcher working in the area of heart failure

### **Award Value:**

Inaugural Award: \$5000.00 CAD



RECIPIENT: Jordan Gibson, AB



## **THANK YOU!**

# Please remember to complete the session evaluation



Next Up! Please proceed to the Foyer for the *Trainee Competition Poster Presentations, Health break in the Exhibit Hall* and then up to the 36<sup>th</sup> floor for the *Community of Practice Sessions (11:30 am)*