

**Quality
Standards**

Heart Failure

Care in the Community
for Adults

**Health Quality
Ontario**

Let's make our health system healthier



Summary

This quality standard addresses care for adults who have heart failure, including the assessment and diagnosis of people with suspected heart failure. It applies to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care.

This quality standard does not address care provided in hospital emergency departments or inpatient settings. It does not discuss heart failure related to congenital cardiac conditions. It also does not address the primary prevention of heart failure, although it does provide guidance on risks and lifestyle factors that may affect the progression of heart failure. These may be topics addressed in future quality standards.

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, people with lived experience, and caregivers across the province, is developing quality standards for Ontario. Health Quality Ontario has worked in partnership with CorHealth Ontario to develop this quality standard.

Quality standards are concise sets of statements that will:

- Help people and their caregivers to know what to ask for in their care
- Help care providers know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for people

The statements in this quality standard do not override the responsibility of care providers to make decisions with individuals, after considering each person's unique circumstances.

How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

Tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard. One of these resources is an inventory of indicator definitions to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps in care and areas for improvement. These indicator definitions can be used to assess processes, structures, and outcomes. It is not mandatory to use or collect data when using a quality standard to improve care. The indicator definitions are provided to support quality improvement efforts; clinicians and organizations may choose indicators to measure based on local priorities and local data availability.

For more information on how to use quality standards, contact qualitystandards@hqontario.ca.

About This Quality Standard

Scope of This Quality Standard

This quality standard addresses care for people 18 years of age or older who have heart failure, including the assessment and diagnosis of people with suspected heart failure. It does not address heart failure owing to congenital cardiac conditions. It also does not address the primary prevention of heart failure, although it does provide guidance on risks and lifestyle factors that may affect the progression of heart failure.

This quality standard applies to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care. It does not address care provided in hospital emergency departments

or inpatient settings. Health Quality Ontario and the Ministry of Health and Long-Term Care have developed the *Quality-Based Procedures: Clinical Handbook for Heart Failure (Acute and Postacute)* to provide guidance on hospital care for people with heart failure.¹

This quality standard includes 10 quality statements on areas identified by CorHealth Ontario and Health Quality Ontario's Heart Failure Care in the Community Quality Standard Advisory Committee as having high potential to improve the quality of care in Ontario for people with heart failure.

Terminology Used in This Quality Standard

The New York Heart Association (NYHA) classification system describes heart failure symptoms. Below are the definitions for the four classifications²:

- Class I—no symptoms
- Class II—symptoms during ordinary activity
- Class III—symptoms with less than ordinary activity
- Class IV—symptoms at rest or with any minimal activity

The heart failure population can be divided into three major subpopulations based on ejection fraction:

- “Heart failure with reduced ejection fraction” (HFrEF) refers to a left ventricular ejection fraction that is less than or equal to 40%³

- “Heart failure with preserved ejection fraction” (HFpEF) refers to a left ventricular ejection fraction that is equal to or greater than 50%³
- “Heart failure with midrange ejection fraction” (HFmrEF) is a relatively new classification, referring to an intermediate group with a left ventricular ejection fraction of 41% to 49%^{3,4}

Each quality statement applies to all three of these subpopulations, unless specifically mentioned in the text of the statement.

In this quality standard, the term “caregiver” refers to family members, friends, or supportive people not necessarily related to the person with heart failure. The person with heart failure must give appropriate consent to share personal information, including medical information, with their caregiver(s).

The term “care provider” is used to acknowledge the wide variety of providers who may be involved in the care of people with heart failure. The term includes both regulated health care professionals, such as dietitians, nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, and social workers, as well as unregulated health care providers. Our choice to use “care provider” does not diminish or negate other terms that a person may prefer.

Why This Quality Standard Is Needed

Heart failure is a complex clinical syndrome characterized by the heart’s inability to pump enough blood to meet the body’s demands.¹ The most common symptoms of heart failure include shortness of breath, fatigue, and ankle swelling.¹ Heart failure is a progressive, ultimately fatal condition: 50% of people with heart failure die within 5 years of diagnosis, and over 90% die within 10 years.⁸ People with heart failure also often have multiple comorbidities: in Ontario, 37% of people with heart failure have four or more coexisting chronic conditions.*

In 2015 in Ontario, roughly 250,000 people had diagnosed heart failure, or about 1.8% of the province’s entire population.* Prevalence varied across the province, from 1.34% in the Mississauga Halton Local Health Integration Network (LHIN) to 2.53% in the North East LHIN.* Heart failure is one of the five leading causes of hospitalization and 30-day readmissions, and the most common cause of hospitalization for people over age 65.¹ Health care utilization related to heart failure has a substantial economic impact: the Heart and Stroke Foundation estimates that heart failure accounts for \$2.8 billion in Canadian health care spending each year.⁹

The term “substitute decision-maker” refers to a person who makes care and treatment decisions on another person’s behalf if or when that person becomes mentally incapable of making decisions for themselves.⁵ The substitute decision-maker makes decisions based on their understanding of the person’s wishes, or, if these are unknown or not applicable, makes choices that are consistent with the person’s known values and beliefs and in their best interests.^{6,7}

There are opportunities to improve care for people with heart failure in Ontario and to reduce the health system burden of this disease. A number of regional variations in heart failure care and outcomes have been identified across Ontario: for example, in 2015/16 among people hospitalized for heart failure, the percentage who received a recommended follow-up visit with a primary care provider within 7 days of hospital discharge ranged from 37% in the North West LHIN to 55% in the Central West LHIN.¹ The percentage of people who were readmitted to hospital within 30 days of discharge ranged from 18% in the Waterloo Wellington LHIN to 24% in the South East and North East LHINs.¹

These regional differences in processes of care and outcomes may be linked to variations in the care people with heart failure receive in the community. Based on evidence and expert consensus, the 10 quality statements that make up this quality standard provide guidance on high-quality care, with accompanying indicators to help care providers and organizations monitor and improve the quality of care.

*Ontario Health Insurance Plan Claims Database, National Ambulatory Care Reporting System, Discharge Abstract Database, and Registered Persons Database; provided by the Institute for Clinical Evaluative Sciences, 2015.

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect and equity.

People with heart failure should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.

People with heart failure should be provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, disability, and background (including self-identified cultural, linguistic, ethnic, and religious backgrounds). Equitable access to the health system also includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and needs to be considered throughout a person's health care journey. For example, services should be actively offered in French and other languages.

Care providers should be aware of the historical context of the lives of Indigenous peoples throughout Canada and be sensitive

to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guideline sources developed by non-Indigenous groups, which may not include culturally relevant care or acknowledge traditional Indigenous beliefs and practices. Therefore, it is important for care to be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis peoples in Ontario.

A high-quality health system is one that provides appropriate access, experience, and outcomes for everyone in Ontario, no matter where they live, what they have, or who they are.

People with heart failure benefit from care provided by a care provider or care team with the knowledge, skill, and judgment to provide evidence-based treatment for heart failure while also addressing all their primary health care needs. The goal of heart failure management is to improve symptoms, function, quality of life, and prognosis.

How Success Can Be Measured

The Heart Failure Care in the Community Quality Standard Advisory Committee has worked with CorHealth Ontario to identify a small number of overarching goals for this quality standard. These have been mapped to indicators that providers may want to monitor to assess quality of care provincially and locally.

How Success Can Be Measured Provincially

In this section, we list indicators that can be used to monitor success provincially, given

currently available data. If additional data sources are developed, other indicators could be added.

Process Indicators

- Percentage of people with newly diagnosed heart failure who receive an electrocardiogram and a chest x-ray
- Percentage of people with newly diagnosed heart failure who receive an echocardiogram

- Percentage of people with newly diagnosed heart failure aged 65 years and over who are dispensed triple therapy
 - Stratify by:
 - Angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) or angiotensin receptor neprilysin inhibitor (ARNI); beta blocker(s); and mineralocorticoid receptor antagonist (MRA)
 - ACE inhibitor or ARB or ARNI
 - Beta blocker(s)
 - MRA
 - Note: Owing to the limitations of administrative data, it is possible to access provincial drug data only for people with heart failure who are over 65 years of age. Further, it is not possible to separate the diagnosis of heart failure with reduced ejection fraction from other forms of heart failure. About 50% of people with heart failure have heart failure with reduced ejection fraction and should receive triple therapy (see Quality Statement 5)
- Percentage of people who were hospitalized or treated in the emergency department for heart failure who are seen by a primary care physician, cardiologist, or internal medicine physician within 7 days of leaving the hospital
 - Note: Owing to the limitations of administrative data, it is only possible to measure the percentage of people with heart failure seen by a physician. However, current best practice is for people with heart failure to be seen by a member of their community health care team within 7 days of leaving the hospital; this team could include a registered nurse or nurse practitioner in addition to a physician (see Quality Statement 9)

Outcome Indicators

- Percentage of people with newly diagnosed heart failure who die within 30 days of diagnosis of heart failure from any cause of death
- Percentage of people with newly diagnosed heart failure who die within 1 year of diagnosis of heart failure from any cause of death
- Rate of hospital admissions and emergency department visits per 1,000 person days for people with heart failure for:
 - Heart failure–specific reasons
 - Any reason(s)
- Percentage of people who were hospitalized or treated in the emergency department for heart failure who are readmitted within 30 days of discharge for:
 - Heart failure–specific reasons
 - Any reason(s)

How Success Can Be Measured Locally

Providers may want to assess the quality of care they provide to people with heart failure and monitor their own quality improvement efforts. It may be possible to do this using their own clinical records, or they might need to collect additional data.

In addition to the overall measures of success, each quality statement within the standard is accompanied by one or more indicators. These indicators are intended to guide the measurement of quality improvement efforts related to the implementation of the statement.

To assess how equitably care is being provided, the quality standard indicators and the overall indicators can be stratified by patient socioeconomic and demographic characteristics, such as income, education, language, age, sex, and gender.

Quality Statements in Brief

Quality Statement 1: Diagnosing Heart Failure

People suspected to have heart failure undergo an initial evaluation that includes, at minimum, a medical history, a physical examination, initial laboratory investigations, an electrocardiogram, and a chest x-ray. If appropriate, natriuretic peptide levels are tested to help formulate a diagnosis. If heart failure is confirmed or suspected after these tests, an echocardiogram is then performed.

Quality Statement 2: Individualized, Person-Centred, Comprehensive Care Plan

People with heart failure and their caregivers collaborate with their care providers to develop an individualized, person-centred, comprehensive care plan. The care plan is reviewed at least every 6 months, and sooner if there is a significant change. It is made readily available to all members of the person's care team, including the person and their caregiver(s).

Quality Statement 3: Empowering and Supporting People With Heart Failure to Develop Self-Management Skills

People with heart failure and their caregiver(s) collaborate with their care providers to create a tailored self-management program with the goal of enhancing their skills and confidence so that they can be actively involved in their own care.

Quality Statement 4: Physical Activity and Exercise

People with heart failure are informed of the benefits of daily physical activity and offered a personalized, exercise-based cardiac rehabilitation program.

Quality Statement 5: Triple Therapy for People With Heart Failure Who Have a Reduced Ejection Fraction

People with heart failure who have a reduced ejection fraction (HFrEF) and New York Heart Association (NYHA) class II to IV symptoms are offered pharmacological management with "triple therapy." They may require additional medications and are prescribed these as needed.

Quality Statement 6: Worsening Symptoms of Heart Failure

People with heart failure who report gradual, progressive, worsening symptoms are assessed by a care provider and have their medications adjusted (if needed) within 48 hours.

Quality Statement 7: Management of Non-cardiac Comorbidities

People with heart failure are treated for non-cardiac comorbidities that are likely to affect their heart failure management.

Quality Statement 8: Specialized Multidisciplinary Care

People with newly diagnosed heart failure, those who have recently been hospitalized or treated in the emergency department for heart failure, and those with advanced heart failure (NYHA III–IV) are offered a referral to specialized multidisciplinary care for heart failure.

Quality Statement 9: Transition From Hospital to Community

People hospitalized or treated in the emergency department for heart failure receive a follow-up appointment to reassess volume status and medication reconciliation with a member of their community health care team within 7 days of leaving the hospital.

Quality Statement 10: Palliative Care and Heart Failure

People with heart failure and their families have their palliative care needs identified early and are offered support to address their needs.

Diagnosing Heart Failure

People suspected to have heart failure undergo an initial evaluation that includes, at minimum, a medical history, a physical examination, initial laboratory investigations, an electrocardiogram, and a chest x-ray. If appropriate, natriuretic peptide levels are tested to help formulate a diagnosis. If heart failure is confirmed or suspected after these tests, an echocardiogram is then performed.

Background

Heart failure diagnosis is based on a clinical assessment combined with appropriate testing that either supports or rules out its presence. There is no single test that confirms the presence of heart failure. Formulating a diagnosis as soon as possible facilitates rapid symptom management and may help avoid hospitalization.

If an echocardiogram is not needed to help confirm a diagnosis of heart failure, one should be performed shortly after diagnosis to provide the information necessary for an appropriate treatment plan.^{3,4}

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | American College of Cardiology Foundation/American Heart Association/Heart Failure Society of America, 2017¹¹ | Canadian Cardiovascular Society, 2017³ | European Society of Cardiology, 2016⁴ | Institute for Clinical Systems Improvement, 2013¹² | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

If you or your care provider think that you have heart failure, your care provider should ask you how much exercise you can do, how you are sleeping at night, and what medications you are currently taking. Your care provider should also do a physical examination, take blood samples, and order tests that give them images of your heart.

For Care Providers

People suspected to have heart failure should undergo an initial assessment that includes, at minimum, a medical history, a physical examination, initial laboratory investigations, an electrocardiogram, and a chest x-ray. After these tests, if you are still uncertain about the diagnosis or the cause of dyspnea, checking natriuretic peptides is appropriate and recommended. If you still suspect heart failure or if you have confirmed heart failure after these tests, an echocardiogram should be performed.

For Health Services

Ensure that systems and resources are in place to allow care providers to offer appropriate assessment for people suspected to have heart failure, including the availability of natriuretic peptide testing and echocardiograms.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Medical history

A medical history should address, at minimum, the following:

- Symptoms
 - Shortness of breath on rest and exertion
 - Orthopnea
 - Paroxysmal nocturnal dyspnea
 - Reduced activity tolerance
 - Fatigue, tiredness, increased time to recover after exercise
 - Ankle swelling
- Prior cardiac disease and risk factors (e.g., coronary artery disease, valve disease, atrial fibrillation, myocardial infarction, diabetes, smoking, hypertension)
- Exacerbating factors
- Comorbidities (e.g., renal failure; see Quality Statement 7)
- Medications
- Changes in independence and activities of daily living
- Lifestyle (e.g., alcohol used; diet, including sodium intake; physical activity)
- Quality of life

Physical examination

A physical examination should include, at minimum, the following:

- Vital signs
- Volume status
 - Weight change
 - Jugular venous pressure
 - Peripheral edema (e.g., feet, ankles, legs, sacrum)
- Cardiac assessment
 - Cardiac murmur
 - Laterally displaced apical pulse

Quality Indicators

Process Indicators

Percentage of people with suspected heart failure whose initial evaluation includes:

- A medical history
 - A physical examination
 - Initial laboratory investigations
 - An electrocardiogram
 - A chest x-ray
- Denominator: total number of people with suspected heart failure
 - Numerator: number of people in the denominator whose initial evaluation includes the above-listed components
 - Data source: local data collection (to identify each group listed above)

Number of days from when people present with suspected heart failure to when they receive an electrocardiogram and a chest x-ray

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when people present with suspected heart failure to when they receive both an electrocardiogram and a chest x-ray
- Data source: local data collection

Percentage of people with suspected heart failure who receive an echocardiogram

- Denominator: total number of people with suspected heart failure
- Numerator: number of people in the denominator who receive an echocardiogram
- Data source: local data collection
- Note: it is not expected that 100% of these people will receive an echocardiogram, because initial tests may rule out heart failure before an echocardiogram would be needed

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Physical examination (continued)

- Chest examination
 - Reduced air entry and crackles at lung bases (pleural effusion)
 - Wheezing
 - Pulmonary crepitations

Note: Some people with heart failure may have clear lungs on examination but still have fluid overload.

Initial laboratory investigations

When collecting samples, include, at minimum, the following:

- Complete blood count
- Serum electrolytes (including calcium and magnesium)
- Serum creatinine
- Blood urea nitrogen
- Glucose
- Thyroid-stimulating hormone
- Glycated hemoglobin

Appropriate natriuretic peptide testing

Natriuretic peptide testing should be used judiciously, because it is expensive and not always useful in the diagnosis of heart failure. However, it is useful when there is uncertainty about the cause of a person's dyspnea. For example, it should be used if a care provider is unsure about whether the dyspnea is caused by chronic obstructive pulmonary disease or heart failure. In such cases, a natriuretic peptide test would help rule out heart failure.¹⁴

QUALITY INDICATORS CONTINUED

Number of days from when people present with suspected heart failure to when they receive an echocardiogram

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when people present with suspected heart failure to when they receive an echocardiogram
- Data source: local data collection
- Note: it is not expected that 100% of these people will receive an echocardiogram, because it is possible that initial tests may suggest an alternative diagnosis

Note on the indicators for this statement: These indicators rely on the presentation of suspected heart failure and are intended for local data collection. Please see the “How Success Can Be Measured Provincially” section of this quality standard and the accompanying measurement guide for details on two related indicators that can be used to measure heart failure diagnostic imaging using administrative data among people with confirmed heart failure.

2

Individualized, Person-Centred, Comprehensive Care Plan

People with heart failure and their caregivers collaborate with their care providers to develop an individualized, person-centred, comprehensive care plan. The care plan is reviewed at least every 6 months, and sooner if there is a significant change. It is made readily available to all members of the person's care team, including the person and their caregiver(s).

Background

A care plan can help address the medical, social, and mental health concerns of the person with heart failure. Care providers should offer information about heart failure and assess the person's goals to determine which care to provide. The care plan is shared with the person with heart failure and their caregiver(s) or their substitute decision-maker. The person's ability to be involved in making decisions may change as their condition changes, and the care plan should be updated accordingly.

Sources: Advisory committee consensus (timing) | American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017³ | National Institute for Health and Care Excellence, 2018¹³

What This Quality Statement Means

For People With Heart Failure

Your care provider should work with you to make a care plan that fits your values, wishes, and goals. Your care team should use this plan to provide care that meets your needs. They should check in with you regularly to see if your goals for care have changed. If you choose, your caregiver(s) can also help you make your care plan. The [heart failure patient guide](#) can help you have conversations with your health care provider. Inside you will find questions you may want to ask as you work together to make a plan for your care.

For Care Providers

Once a person is diagnosed with heart failure, collaborate with them to create and document a care plan as soon as possible. Review the care plan at least every 6 months, and more frequently if there are any significant changes or a recent hospitalization. Adjust the plan until the person's identified needs and goals are met. Share the [heart failure patient guide](#) to help your patients have conversations with you about their care.

For Health Services

Ensure that systems, processes, and resources are in place to allow care providers to create and implement care plans for people with heart failure and to share care plans electronically among health professionals involved in a person's care.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Individualized, person-centred comprehensive care plan

A care plan is a written document that describes a person's health needs and goals and the care that will be provided to meet them.^{5,15} Care plans describe treatments customized for each person based on their values, wishes, goals, and unique health needs.¹⁶ The person with heart failure drives the care provided; a person-centred approach involves a partnership between the individual and their health care providers.

Having a care plan is not the same as having a discussion about goals of care. Nor is it a decision or consent for treatments. A care plan is broader than and different from a plan of treatment. A plan of treatment is associated with a health care decision and requires informed consent from the patient or substitute decision-maker.

For a person with heart failure, a care plan should, at minimum, address the following:

- The name of the person's identified substitute decision-maker and the person's goals and wishes, including consideration for palliative care (see Quality Statement 10)
- Treatment decisions and consents to treatments or plan of treatment
- Immunizations (annual influenza vaccination and one-time pneumonia vaccination)
- Management of heart failure
- Management of cardiac and non-cardiac comorbidities (see Quality Statement 7)
- Comprehensive medication review, including potential financial burden for evidence-based medications
- Psychosocial factors
 - Sex-specific issues that are impacted by heart failure symptoms and medications, such as erectile dysfunction and decreased sexual desire

Quality Indicators

Process Indicators

Percentage of people with heart failure who have a care plan that guides their care

- Denominator: total number of people with heart failure
- Numerator: number of people in the denominator who have a care plan that guides their care
- Data source: local data collection

Percentage of people with heart failure whose care plan has been reviewed in the past 6 months

- Denominator: total number of people with heart failure who have a care plan
- Numerator: number of people in the denominator whose care plan has been reviewed in the past 6 months
- Data source: local data collection

Outcome Indicators

Percentage of people with heart failure (or their caregivers) who report that their care provider always or often involves them in decisions about their care

- Denominator: total number of people with heart failure (or their caregivers)
- Numerator: number of people in the denominator who report that their care provider always or often involves them in decisions about their care
- Data source: local data collection
- An example of a validated survey question that is similar to this indicator is found in the Health Care Experience Survey¹⁷: “When you see your provider or someone else in their office, how often do they involve you as much as you want to be in decisions about your care and treatment?” (Response options: Always; Often; Sometimes; Rarely; Never; It depends on who I see and/or what I am there for; No decisions required on

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Individualized, person-centred comprehensive care plan (continued)

- Socioeconomic concerns, such as income, medical costs (e.g., medications), and healthy food choices
- Social supports
- Mental health concerns, including depression and anxiety
- Self-management skills (see Quality Statement 3)
- Clinician follow-up and care coordination (see Quality Statement 9)
- Physical activity and exercise (see Quality Statement 4)
- Dietary concerns
- Secondary prevention of cardiovascular disease
- Counselling about the possibility of sudden death
- Caregiver needs and goals

Significant change

More frequent review of the care plan will be needed if there is a significant change. This includes anything that has an impact on a person’s physical, emotional, or psychological well-being and may affect their care plan and/or the resources they need, including the following:

- Psychosocial changes, including the death of a caregiver or spouse or significant caregiver burden
- Mental health changes
- Worsening symptoms of heart failure
- Worsening physical health
- Recent hospitalization for heart failure
- Significant changes to medications

QUALITY INDICATORS CONTINUED

care or treatment/not applicable; Don't know; Refused). Exclusions: Those who answer, "It depends on who I see and/or what I am there for," "No decisions required on care or treatment/not applicable," "Don't know," or "Refused"

Percentage of people with heart failure (or their caregivers) who report that their care provider always or often gives them an opportunity to ask questions about recommended treatment

- Denominator: total number of people with heart failure (or their caregivers)
- Numerator: number of people in the denominator who report that their care provider always or often gives them an opportunity to ask questions about recommended treatment
- Data source: local data collection
- An example of a validated survey question that is similar to this indicator is found in the Health Care Experience Survey¹⁷: "When you see your provider or someone else in their office, how often do they give you an opportunity to ask questions about recommended treatment?" (Response options: Always; Often; Sometimes; Rarely; Never; It depends on who I see and/or what I am there for; Not using/on any treatments/not applicable; Don't know; Refused). Exclusions: Those who answer, "It depends on who I see and/or what I am there for," "Not using/on any treatments/not applicable," "Don't know," or "Refused"

Empowering and Supporting People With Heart Failure to Develop Self-Management Skills

People with heart failure and their caregiver(s) collaborate with their care providers to create a tailored self-management program with the goal of enhancing their skills and confidence so that they can be actively involved in their own care.

Background

People with heart failure should acquire the skills to participate in a tailored exercise program, understand their ideal diet, know how to identify symptom changes, and know how to react to symptom changes.³ Promoting self-management empowers people to take control of their condition and actively participate in achieving their best possible outcomes. Ongoing education and coaching through experiential learning, practice, and support should be tailored to the individual, taking into account possible cognitive deficits and language barriers.^{3,14}

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017³ | Institute for Clinical Systems Improvement, 2013¹² | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

At each of your appointments for the first 6 months after diagnosis, you should be offered coaching and support to help you learn about managing your heart failure effectively. If you choose to include your caregiver(s), they can also be offered this information and coaching.

For Care Providers

Offer evidence-based information and coaching about heart failure at each appointment for at least the first 6 months following diagnosis. This coaching should be tailored to meet the person's learning needs and presented in a format and at times that are most appropriate for the person. When caregiver(s) are involved in the person's care, and if the person consents, include them as much as possible in discussions and coaching.

For Health Services

Ensure that appropriate time and resources are available for care providers to support the development of self-management skills in people with heart failure.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Self-management program

People should be offered information, support, coaching, and counselling to enhance their knowledge and skills and to improve their strategies for managing heart failure. The goals of a self-management program are to ensure that people with heart failure are better able to make decisions about their care and to increase their confidence to apply their skills in daily life situations.¹⁸ Self-management education and support should be offered at each visit for at least 6 months after diagnosis. Following this 6-month period, people with heart failure will likely require further support and should be offered it as needed. Self-management programs should include content on the following:

- Diagnosis and disease process
- Available treatment options, including the following:
 - Medications
 - Device therapies
 - Invasive procedures (surgical or interventional options)
- Recognizing early signs and symptoms of worsening heart failure (see Quality Statement 6)
- Daily weights and when to inform care providers of a significant weight change
- Development of an individualized action plan, including when to seek help and who to contact
- Elements of the care plan
- Diet restrictions
- Physical activity and exercise (see Quality Statement 4)
- Motivational interviewing for smoking and alcohol cessation, where applicable
- Stress management

Quality Indicators

Process Indicators

Percentage of people with heart failure who have a tailored self-management program that was developed in collaboration with their health care provider and their caregivers and is documented in their medical record

- Denominator: total number of people with heart failure
- Numerator: number of people in the denominator who have a tailored self-management program that was developed in collaboration with their health care provider and their caregivers and is documented in their medical record
- Data source: local data collection

Percentage of people with heart failure (or their caregivers) who receive information, support, coaching, and counselling about heart failure at each appointment for the first 6 months after diagnosis

- Denominator: total number of people with heart failure (or their caregivers)
- Numerator: number of people in the denominator who receive information, support, coaching, and counselling about heart failure at each appointment for the first 6 months after diagnosis
- Data source: local data collection

Outcome Indicator

Percentage of people with heart failure (or their caregivers) who report that they have the skills and confidence to be actively involved in their own care

- Denominator: total number of people with heart failure (or their caregivers)
- Numerator: number of people in the denominator who report that they have the skills and confidence to be actively involved in their own care
- Data source: local data collection
- Note: This is a summary measure. If you wish to look at further dimensions of confidence, consider using the Self-Care of Heart Failure Index, a publicly available tool that may be used to assess more specific measures of confidence (i.e., the person's ability to keep themselves free of symptoms, follow treatment advice, and recognize changes in their health). Please refer to Section C of the tool.¹⁹

4

Physical Activity and Exercise

People with heart failure are informed of the benefits of daily physical activity and offered a personalized, exercise-based cardiac rehabilitation program.

Background

Physical activity and exercise can improve functional status and quality of life for people with heart failure.^{10,20} Through motivational interviewing, people with heart failure should be encouraged to set realistic and measurable goals and participate in exercise within the limits dictated by their symptoms.^{3,14} If there is uncertainty about how to safely recommend exercises to meet a person's activity goals, providers should consider consulting a physiotherapist or kinesiologist.

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017³ | European Society of Cardiology, 2016⁴ | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

Your care provider should explain to you the benefits of physical activity and exercise. They should offer you a personalized cardiac rehabilitation program in a setting and format that is easiest for you to do. This includes creating a program that matches your abilities and goals. If your care provider is not sure which exercises are best for you, they may refer you to another care provider with the appropriate expertise.

For Care Providers

Ensure that all people with heart failure are informed about the benefits of physical activity and are offered an exercise-based cardiac rehabilitation program. Work with them to create a tailored exercise-based rehabilitation program that matches their goals and abilities.

For Health Services

Ensure that systems and resources are in place to enable all care providers to offer people with heart failure a personalized exercise-based cardiac rehabilitation program.

Quality Indicators

Process Indicator

Percentage of people with heart failure who receive a personalized, exercise-based cardiac rehabilitation program

- Denominator: total number of people with heart failure
- Numerator: number of people in the denominator who receive a personalized, exercise-based cardiac rehabilitation program
- Exclusion: people with heart failure whose condition is unstable
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Exercise-based cardiac rehabilitation program¹³

A personalized, exercise-based cardiac rehabilitation program should be offered to people with heart failure unless their condition is unstable. The program should be preceded by an assessment to ensure it is suitable for the person, and it should:

- Provide advice on the types of exercises to consider based on the person's abilities and activity goals
- Be provided in a format and setting that is easily accessible for the person
- Include a psychological and educational component
- Be accompanied by information and supports
- Be as close to home as possible

Triple Therapy for People With Heart Failure Who Have a Reduced Ejection Fraction

People with heart failure who have a reduced ejection fraction (HFrEF) and New York Heart Association (NYHA) class II to IV symptoms are offered pharmacological management with “triple therapy.” They may require additional medications and are prescribed these as needed.

Background

Medications are the cornerstone of treatment for HFrEF.¹² If the person with HFrEF has no contraindications and agrees to treatment, they should be started on appropriate pharmacological management as soon as possible.

Special attention should be paid to symptoms such as dizziness and fatigue, as well as blood pressure, heart rate, and electrolyte and creatinine levels, when adding or adjusting medications. Care providers should take into account the specialized skills and expertise that may be required when prescribing these medications. If providing these treatments is beyond the provider’s expertise, they should consult or collaborate with a care provider who has the appropriate expertise. For example, referral to a specialist or specialized team should be considered if there are challenges titrating triple therapy medications owing to competing comorbidities (e.g., renal impairment) or low blood pressure, or for people who have ongoing symptoms despite triple therapy.

Some people with an initial ejection fraction of less than or equal to 40% (and considered HFrEF) will experience an improvement in their ejection fraction to greater than 40% after medications have been optimized. These people are known to have a “recovered” ejection fraction, but the indications for HFrEF medications still apply. In other words, these people continue to be managed as people with HFrEF.³

BACKGROUND CONTINUED

Very few clinical trials on pharmacological management have been conducted in people who have heart failure with a preserved ejection fraction (HFpEF) or heart failure with a mid-range ejection fraction (HFmrEF). Medications for these people should address the underlying etiology, such as ischemia or hypertension, and should provide symptom relief for congestion and fluid overload.^{3,10-12}

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | American College of Cardiology Foundation/American Heart Association/Heart Failure Society of America, 2017¹¹ | Canadian Cardiovascular Society, 2017³ | European Society of Cardiology, 2016⁴ | Institute for Clinical Systems Improvement, 2013¹² | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

When you and your care provider work on your care plan, your care provider should explain the different types of medication you will need and how they will help you. If you have heart failure with reduced ejection fraction, you should be offered medication that includes at least three different types of medication; this is called “triple therapy.” You may need other medications as well. Your care provider should explain how to use your medications, including how and when to take them.

For Care Providers

If a person has NYHA class II to IV symptoms, an ejection fraction of less than or equal to 40%, no contraindications, and agrees to treatment, start them on an ACE inhibitor or an ARB (if they cannot tolerate an ACE inhibitor), a beta blocker, and an MRA as soon as possible, depending on their tolerance. If their heart failure symptoms and low ejection fraction persist despite optimal triple therapy, replace their ACE inhibitor or ARB with an ARNI. If a person’s caregiver(s) are involved in their care, and if the person consents, the caregiver(s) should also be given information about appropriate medications and instructions on how and when to take them.

For Health Services

Ensure that systems, processes, and policies are in place to allow people with HFrEF and NYHA class II to IV symptoms to receive appropriate pharmacological therapy in a timely manner.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Triple therapy

Triple therapy should be adjusted to target doses as tolerated. It includes:

- An ACE inhibitor or an ARB if the person with heart failure cannot tolerate an ACE inhibitor*
- A beta blocker
- An MRA

*If the person’s heart failure symptoms persist and their ejection fraction remains less than or equal to 40%, the ACE inhibitor or ARB is replaced by an ARNI.

Additional medications

In addition to triple therapy, other medications that may be considered in the treatment of people with HFrEF include the following:

- Loop diuretics
- Hydralazine/isosorbide dinitrate
- Ivabradine
- Digoxin

Quality Indicators

Process Indicator

Percentage of people who have HFrEF and NYHA class II to IV symptoms who are prescribed triple therapy

- Denominator: total number of people who have HFrEF and NYHA class II to IV symptoms
- Numerator: number of people in the denominator who are prescribed triple therapy
 - Stratify by:
 - ACE inhibitor or ARB or ARNI; beta blocker(s); and MRA
 - ACE inhibitor or ARB or ARNI
 - Beta blocker(s)
 - MRA
- Data source: local data collection
- Note: It is not expected that 100% of these patients will be on triple therapy, as some patients will have contraindications to certain medications. Consider measuring separately for patients with contraindications.

6

Worsening Symptoms of Heart Failure

People with heart failure who report gradual, progressive, worsening symptoms are assessed by a care provider and have their medications adjusted (if needed) within 48 hours.

Background

People with heart failure who report gradual, progressive, worsening symptoms, such as orthopnea, shortness of breath on exertion, or edema, should have access to a health care provider to assess their symptoms and adjust their medication for relief of these symptoms within 48 hours.⁴ By the time the person's worsening symptoms are reported, the symptoms will have likely been progressing over many days or even weeks, and management within 48 hours of symptom worsening being reported can help prevent further decline, which might necessitate hospitalization or even result in death. Access to a health care provider can be in person or via telemedicine.^{3,12} Alternatively, people experiencing an acute onset of worsening heart failure symptoms such as new shortness of breath at rest should be seen immediately (i.e., do not wait 48 hours).

Medication adjustments typically fall under the scope of practice of physicians and nurse practitioners. However, pathways, order sets, and medical directives may be used to allow other regulated health care providers (e.g., registered nurses, pharmacists) to adjust heart failure medications and to do so remotely.

Source: Advisory committee consensus

What This Quality Statement Means

For People With Heart Failure

If you are feeling more tired, more short of breath, are having trouble sleeping, or your weight has gone up in the last few days, you should contact your care provider. A health care provider should assess you. You may need your medications changed to keep you from feeling worse, and if so, this should be done for you within 48 hours. It is better to make these changes when you first start feeling worse rather than waiting too long and needing to go to the hospital. Once you are feeling better, your care provider should talk with you about different ways to manage your heart failure at home to prevent this from happening again.

For Care Providers

If a person presents with gradual, progressive, worsening symptoms of heart failure, ensure that they are assessed rapidly so that medications can be adjusted within 48 hours, if needed. This assessment can be done in person or via telemedicine.

For Health Services

Ensure that systems, processes, and resources are in place to allow care providers to offer access to assessment and treatment in the community within 48 hours for worsening symptoms of heart failure. This includes having policies in place to enable physicians and nurse practitioners to adjust medications quickly to relieve symptoms.

Quality Indicators

Process Indicators

Percentage of people with heart failure who report gradual, progressive, worsening symptoms and who are assessed by a care provider within 48 hours

- Denominator: total number of people with heart failure who report gradual, progressive, worsening symptoms
- Numerator: number of people in the denominator who are assessed by a care provider within 48 hours of their reporting gradual, progressive, worsening symptoms
- Exclusion: people with heart failure who present at the hospital or emergency department
- Data source: local data collection

Percentage of people with heart failure who report gradual, progressive, worsening symptoms and require medication adjustment who have their medications adjusted by a care provider within 48 hours

- Denominator: total number of people with heart failure who report gradual, progressive, worsening symptoms and require medication adjustment
- Numerator: number of people in the denominator who have their medications adjusted by a care provider within 48 hours of their reporting gradual, progressive, worsening symptoms
- Exclusion: people with heart failure who present at the hospital or emergency department
- Data source: local data collection

7

Management of Non-cardiac Comorbidities

People with heart failure are treated for non-cardiac comorbidities that are likely to affect their heart failure management.

Background

People with heart failure should be given care that extends beyond care for their heart failure. Optimal management of people with heart failure is complex, in part because heart failure is never a standalone condition.¹⁰ Comorbidities—including non-cardiac comorbidities—can confound heart failure treatments, interfere with diagnosis, diminish quality of life, complicate management, increase the risk of future deterioration, and lead to poorer prognosis.^{4,21} Appropriate care for someone with heart failure should therefore also include the treatment of their comorbidities.

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | American College of Cardiology Foundation/American Heart Association/Heart Failure Society of America, 2017¹¹ | Canadian Cardiovascular Society, 2017³ | European Society of Cardiology, 2016⁴ | Institute for Clinical Systems Improvement, 2013¹² | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

People with heart failure sometimes have other illnesses that also need to be treated. If you have other illnesses, the care providers helping you manage your heart failure may also be able to treat these, or they may refer you to another care provider or providers.

For Care Providers

Provide support to address a person's non-cardiac comorbidities, if needed, including physical and mental health needs. If you are unable to provide care for these comorbidities, facilitate access to care by offering appropriate referrals.

For Health Services

Ensure that systems, processes, and resources are in place to allow care providers to manage a person's heart failure and any non-cardiac comorbidities. This includes making sure that care providers have the time and resources required to provide comprehensive physical and mental health care or to make appropriate referrals. Pathways should be in place to facilitate referrals to health services when appropriate.

Quality Indicators

There are no recommended indicators for this quality statement.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Non-cardiac comorbidities

People with heart failure often have multiple comorbidities. The following list is not exhaustive but includes common conditions in people with heart failure that can affect their care plan, treatment options, adherence to therapy, follow-up, and prognosis.³ A person with heart failure should be treated if they present with signs or symptoms of any of the following comorbidities:

- Anemia or iron deficiency
- Central or obstructive sleep apnea
- Chronic obstructive pulmonary disease (see the [Chronic Obstructive Pulmonary Disease](#) quality standard)
- Cognitive impairment
- Dementia (see the quality standards [Behavioural Symptoms of Dementia: Care for Patients in Hospitals and Residents in Long-Term Care Homes](#) and [Dementia: Care for People Living in the Community](#))
- Depression or anxiety (see the [Major Depression](#) quality standard)
- Diabetes
- Frailty
- Renal dysfunction

Specialized Multidisciplinary Care

People with newly diagnosed heart failure, those who have recently been hospitalized or treated in the emergency department for heart failure, and those with advanced heart failure (NYHA III–IV) are offered a referral to specialized multidisciplinary care for heart failure.

Background

Specialized multidisciplinary care improves outcomes in people with heart failure, reducing mortality and hospitalizations and improving quality of life.²² This model of care includes a process that enables frequent follow-up and rapid access to specialized care.²² Once people with heart failure have been stabilized with specialized care, they should typically be referred back to their primary care provider with a care plan (see Quality Statement 2).^{13,22}

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017³ | European Society of Cardiology, 2016⁴ | National Institute for Health and Care Excellence, 2018¹³ | Ontario Health Technology Advisory Committee, 2012²³

What This Quality Statement Means

For People With Heart Failure

If your care provider thinks you may need extra attention to manage your heart failure, they should offer you the chance to work with a team of care providers who specialize in heart failure. This team should work closely with you to manage your care, improve your quality of life, and help prevent future hospitalizations related to your heart failure.

For Care Providers

If you are caring for someone with newly diagnosed heart failure, someone who has recently been hospitalized or treated in the emergency department for heart failure, or someone with advanced heart failure (NYHA III–IV), offer them a referral to specialized multidisciplinary care.

For Health Services

Ensure that systems, resources, and pathways are in place so that specialized multidisciplinary care is available to all people with newly diagnosed heart failure, people who have recently been hospitalized or treated in the emergency department for heart failure, and people with advanced heart failure (NYHA III–IV).

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Specialized multidisciplinary care

Specialized multidisciplinary care is care provided by a team including a physician (family physician, internist, or cardiologist) or nurse practitioner, a pharmacist, and a registered nurse. The team should include at least one care provider with specialized training in heart failure. This care should include, at minimum, the following^{10,13,22}:

- Self-management skills (especially for people newly diagnosed with heart failure; see Quality Statement 3)
- Medication management and adjustment
 - Early attention to signs and symptoms of fluid overload and fluid depletion
 - Promotion of self-care, including self-adjusted diuretic therapy when possible
 - Initiation or titration of new medications that need specialist supervision
- Emphasis on behavioural strategies to increase adherence to treatment
- Prompt follow-up after hospital discharge and periods of instability
- Increased access to clinicians, including appropriate referrals
- Assistance with social and financial concerns
- Assessment and monitoring that requires close follow-up
- A collaborative cardiology and palliative approach (see Quality Statement 10)
- Continued management of heart failure after an interventional procedure such as the implantation of a cardioverter defibrillator or a cardiac resynchronization device
- Management of heart failure that is not responding to current treatment

Quality Indicators

Process Indicators

Percentage of people with newly diagnosed heart failure, those who have been hospitalized or treated in the emergency department for heart failure, and those with advanced heart failure (NYHA III–IV) who receive a referral for and are seen by a specialized multidisciplinary care team for heart failure

- Denominator: total number of people with newly diagnosed heart failure, those who have been hospitalized or treated in the emergency department for heart failure, and those with advanced heart failure (NYHA III–IV)
- Numerator: number of people in the denominator who receive a referral for and are seen by a specialized multidisciplinary care team for heart failure
- Data source: local data collection
- Note: consider measuring separately by each group in the denominator or grouping together all patients in the denominator as an overall measure

Number of days from when the referral is made to when the individual with heart failure is seen by a specialized multidisciplinary care team

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when the referral is made to when the individual with heart failure is seen by a specialized multidisciplinary care team
- Data source: local data collection

Structural Indicator

Local availability of specialized multidisciplinary care for heart failure

- Data source: A regional or provincial data collection method would need to be developed

Transition From Hospital to Community

People hospitalized or treated in the emergency department for heart failure receive a follow-up appointment to reassess volume status and medication reconciliation with a member of their community health care team within 7 days of leaving the hospital.

Background

People with heart failure cycle through periods of stability and instability, often resulting in recurrent hospitalizations.²⁴ Prompt follow-up, coordinated services, and appropriate communication between providers and settings can improve outcomes during these transitions. A follow-up appointment with a member of the community health care team within 7 days of returning home can help ensure that a person is recovering well after a heart failure exacerbation and that any other medical conditions, including non-cardiac comorbidities (see Quality Statement 7), are being managed appropriately. Anyone who has been hospitalized for heart failure should also be considered for specialized multidisciplinary care (see Quality Statement 8).

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017⁹ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

You should have an appointment with a member of your community health care team within 7 days of returning home after a hospital visit for heart failure.

For Care Providers

You should be contacted before a person with heart failure leaves the hospital, and a summary of the person's hospital stay should be sent to you. Ensure that the person receives an appointment to see you within 7 days of leaving the hospital.

For Health Services

Ensure that systems, processes, and resources are in place to allow people who have been hospitalized or treated in the emergency department for heart failure to have a follow-up appointment with a member of their community health care team within 7 days of leaving the hospital.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Community health care team

This team includes care providers with the knowledge, skill, and judgment to reassess a person's volume status and provide medication reconciliation. Potential providers include a registered nurse, a nurse practitioner, or a physician.

Quality Indicators

Process Indicator

Percentage of people who were hospitalized or treated in the emergency department for heart failure who receive a reassessment of their volume status and a medication reconciliation during their follow-up appointment by a member of their community health care team within 7 days of leaving the hospital

- Denominator: total number of people who were hospitalized or treated in the emergency department for heart failure
- Numerator: number of people in the denominator who receive a reassessment of their volume status and a medication reconciliation during their follow-up appointment by a member of their community health care team within 7 days of leaving the hospital
- Data sources: local data collection (to identify non-physician health care provider visits, reassessment of volume status, and medication reconciliation), Discharge Abstract Database, National Ambulatory Care Reporting System, Ontario Health Insurance Plan Claims Database, Registered Persons Database (to identify physician and specialist visits)

Palliative Care and Heart Failure

People with heart failure and their families have their palliative care needs identified early and are offered support to address their needs.

Background

People with heart failure and their families should have access to a collaborative-care approach that integrates active heart failure management with palliative care.¹⁴ According to the Ontario Palliative Care Network, “a palliative approach to care focuses on meeting a person and their caregiver(s)’s full range of needs—physical, psychosocial, and spiritual—at all stages of a chronic progressive illness. It reinforces the person’s autonomy and right to be actively involved in their own care—and strives to give individuals and families a greater sense of control. It sees palliative care as less of a discrete service offered to dying persons when treatment is no longer effective, and more of an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging.”¹⁵

Heart failure is incurable and progressive, with a high mortality rate and a trajectory that can be erratic. A comprehensive, holistic assessment allows health care providers to determine the palliative care needs of people with heart failure and their family or caregivers and the services required to meet those needs. Because heart failure is unpredictable, discussions about goals of care should be conducted as soon as possible following diagnosis. These goals should be documented and frequently reassessed.^{3,14}

BACKGROUND CONTINUED

For people with heart failure, palliative care should include the following^{7,14,25}:

- Active heart failure management in conjunction with symptom control
- Reassessment of goals and current heart failure management
- Rationalization of medical therapy that does not support symptom relief or control
- Discussions about deactivating anti-tachy therapy (e.g., shock therapy) if the person has an automatic implantable cardioverter defibrillator
- Integrated care from an interdisciplinary team
- Seamless transitions in care coordinated across settings and health care providers
- Timely psychosocial support
- Access to resources, respite care, and grief and bereavement support for family and caregivers

For more information on palliative care, please see the [Palliative Care](#) quality standard.⁷

Sources: American College of Cardiology Foundation/American Heart Association, 2013¹⁰ | Canadian Cardiovascular Society, 2017³ | National Institute for Health and Care Excellence, 2018¹³ | Scottish Intercollegiate Guidelines Network, 2016¹⁴

What This Quality Statement Means

For People With Heart Failure

If you have heart failure, your care team should assess your palliative care needs. This includes your physical, mental, emotional, cultural, and spiritual well-being. You should be offered supports to address your needs.

For Care Providers

Ensure people with heart failure have access to a collaborative cardiology and palliative care approach from diagnosis onward.

For Health Services

Ensure that systems, processes, and resources are in place in the community for care providers to address the palliative care needs of people with heart failure.

Quality Indicators

The following indicators closely align with indicators found in the [Palliative Care](#) quality standard.

Process Indicators

Percentage of people with heart failure and identified palliative care needs who have discussions with a health care professional documented in their medical record about their goals of care and understanding of their illness

- Denominator: total number of people with heart failure and identified palliative care needs
- Numerator: number of people in the denominator who have discussions with a health care professional documented in their medical record about their goals of care and understanding of their illness
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Palliative care needs

Palliative care needs can stem from any part of a person's full range of needs (for example, physical, psychological, social, linguistic, cultural, legal, ethical, or spiritual) at any stage of illness. The goal of palliative care is to help people achieve their best possible quality of life in the face of a progressive, life-limiting illness.

QUALITY INDICATORS CONTINUED

Percentage of people with heart failure and identified palliative care needs who have a documented assessment of their palliative care needs (see definition)

- Denominator: total number of people with heart failure and identified palliative care needs
- Numerator: number of people in the denominator who have a documented assessment of their palliative care needs
- Data source: local data collection

Outcome Indicator**Percentage of people with heart failure and identified palliative care needs (or their caregivers) who state that they are able to receive community palliative care support, including after-hours care, when needed**

- Denominator: total number of people with heart failure and identified palliative care needs (or their caregivers)
- Numerator: number of people in the denominator who state that they are able to receive community palliative care support, including after-hours care, when needed
- Data source: local data collection

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References

1. Health Quality Ontario, Ministry of Health and Long-Term Care. Quality-based procedures: clinical handbook for heart failure (acute and postacute) [Internet]. Toronto (ON): Queen's Printer for Ontario; 2015 [cited 2017 Apr 12]. Available from: <http://www.hqontario.ca/Portals/0/Documents/evidence/clinical-handbooks/heart-failure-02042015-en.pdf>
2. Criteria Committee of the New York Heart Association. Nomenclature and criteria for diagnosis of diseases of the heart and great vessels. 9th ed. Boston (MA): Little, Brown; 1994.
3. Canadian Cardiovascular Society. 2017 comprehensive update of the Canadian Cardiovascular Society guidelines for the management of heart failure. *Can J Cardiol*. 2017;33(11):1342-433.
4. European Society of Cardiology. ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. *Eur Heart J*. 2016;37:2129-200.
5. Ontario Palliative Care Network. Key palliative care concepts and terms [Internet]. Newmarket (ON): The Network; 2017 [cited 2018 Feb 26]. Available from: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/KEY_PALLIATIVE_CARE_CONCEPTS_AND_TERMS.pdf
6. Substitute Decisions Act, S.O. 1992, c. 30 (1992).
7. Health Quality Ontario. Palliative care: care for adults with a progressive, life-limiting illness [Internet]. Toronto (ON): Queen's Printer for Ontario; 2018 [cited 2018 Nov 28]. Available from: <https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-palliative-care-clinical-guide-en.pdf>
8. Roger VL. Epidemiology of heart failure. *Circulation Res*. 2013;113(6):646-59.
9. Heart and Stroke Foundation. Report on the health of Canadians: the burden of heart failure [Internet]. Toronto (ON): The Foundation; 2016 [cited 2018 Mar 26]. Available from: <https://www.heartandstroke.ca/-/media/pdf-files/canada/2017-heart-month/heartandstroke-reportonhealth-2016.ashx?la=en>
10. Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE Jr, Drazner MH, et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2013;62(16):e147-239.
11. Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE Jr, Colvin MM, et al. 2017 ACC/AHA/HFSA focused update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *J Am Coll Cardiol*. 2017;70(6):776-803.
12. Institute for Clinical Systems Improvement. Health care guideline: heart failure in adults [Internet]. Bloomington (MN): The Institute; 2013 [cited 2017 Mar]. Available from: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_cardiovascular_guidelines/heart_failure/
13. National Institute for Health and Care Excellence. Chronic heart failure in adults: diagnosis and management [Internet]. London: The Institute; 2018 [cited 2018 Sep 20]. Available from: <https://www.nice.org.uk/guidance/ng106/evidence/full-guideline-pdf-6538850029>
14. Scottish Intercollegiate Guidelines Network. Management of chronic heart failure [Internet]. Edinburgh: The Network; 2016 [cited 2017 Mar]. Available from: <http://www.sign.ac.uk/pdf/SIGN147.pdf>
15. Canadian Hospice Palliative Care Association. Lexicon [Internet]. Ottawa (ON): The Association; 2014 [cited 2017 Jul 20]. Available from: <http://www.hpcintegration.ca/media/53072/TWF-lexicon-eng-final.pdf>
16. Bidy R, Griffin C, Johnson N, Laroque G, Messersmith H, Moody L, et al. Program in evidence based care (PEBC): person-centred care guideline [Internet]. Toronto (ON): Cancer Care Ontario; 2015 [cited 2017 Jul 20]. Available from: <https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=340815>

REFERENCES CONTINUED

17. Ministry of Health and Long-Term Care. Health care experience survey. Toronto (ON): The Ministry; 2017.
18. Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. *JAMA*. 2002;288(19):2469-75.
19. Riegel B, Lee CS, Dickson VV, Carlson B. An update on the Self-Care of Heart Failure Index. *J Cardiovasc Nurs*. 2009;24(6):485-97.
20. Health Quality Ontario. Aerobic exercise training in patients with heart failure: a rapid review [Internet]. Toronto (ON): Queen's Printer for Ontario; 2015 [cited 2017 Apr 12]. Available from: <http://www.hqontario.ca/evidence/evidence-process/episodes-of-care#community-chf>
21. Canadian Cardiovascular Society. The 2014 Canadian Cardiovascular Society heart failure management guidelines focus update: anemia, biomarkers, and recent therapeutic trial implications. *Can J Cardiol*. 2014;31(1):3-16.
22. Health Quality Ontario. Specialized community-based care: an evidence-based analysis [Internet]. Toronto (ON): Queen's Printer for Ontario; 2012 [cited 2017 Jun]. Available from: <http://www.hqontario.ca/Evidence-to-Improve-Care/Health-Technology-Assessment/Reviews-And-Recommendations/Specialized-Community-Based-Care>
23. Ontario Health Technology Advisory Committee. Specialized community-based care: OHTAC recommendation [Internet]. Toronto (ON): Queen's Printer for Ontario; 2012 [cited 2018 Nov 28]. Available from: <http://www.hqontario.ca/Portals/0/Documents/evidence/reports/ohtac-recommendation-specialized-care.pdf>
24. Cardiac Care Network. Strategy for community management of heart failure in Ontario. Toronto (ON): The Network; 2014.
25. Teuteberg JJ, Teuteberg WG. Palliative care for patients with heart failure [Internet]. Washington (DC): American College of Cardiology; 2016 [cited 2018 Nov 28]. Available from: <https://www.acc.org/latest-in-cardiology/articles/2016/02/11/08/02/palliative-care-for-patients-with-heart-failure>

About Health Quality Ontario

Health Quality Ontario is the provincial lead on the quality of health care. We help nurses, doctors and other health care professionals working hard on the frontlines be more effective in what they do—by providing objective advice and data, and by supporting them and government in improving health care for the people of Ontario.

We focus on making health care more effective, efficient and affordable through a legislative mandate of:

- Reporting to the public, organizations, government and health care providers on how the health system is performing,
- Finding the best evidence of what works, and
- Translating this evidence into clinical standards; recommendations to health care professionals and funders; and tools that health care providers can easily put into practice to make improvements.

For more information about Health Quality Ontario, visit hqontario.ca.

About CorHealth Ontario

CorHealth Ontario is an organization formed by the merger of the Cardiac Care Network of Ontario and the Ontario Stroke Network, with an expanded mandate spanning cardiac, stroke, and vascular care. CorHealth Ontario proudly advises the Ministry of Health and Long-Term Care, Local Health Integration Networks, hospitals, and care providers to improve the quality, efficiency, accessibility, and equity of cardiac, stroke, and vascular services for patients across Ontario.

For more information about CorHealth Ontario, visit corhealthontario.ca.

Looking for more information?

Visit our website at hqontario.ca and contact us at qualitystandards@hqontario.ca if you have any questions or feedback about this guide.

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