



**The Heart  
Failure Policy  
Network**

From guidelines to action

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# Opportunities for change following the 2021 ESC guidelines



**June 2022**

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# About this report

In 2021, the European Society of Cardiology (ESC) updated its [guidelines for the diagnosis and treatment of acute and chronic heart failure](#). This report provides an overview of the most significant changes in the guidelines and their implications for the diagnosis and care of people living with heart failure. It explores the challenges to implementing the new recommendations in Europe, as well as opportunities for advocacy. It is intended as a tool for advocates as they push for better care for people with heart failure. For a lay summary of the key recommendations of the 2016 ESC guidelines, please see the [Understanding heart failure guidelines](#) collection of reports, available on our website.

This report was produced by the Heart Failure Policy Network. Research, coordination, drafting, expert interviews and member consultations were led by Catherine Hodge, Kirsten Budig, Joe Farrington-Douglas and Faith Everett. The report was edited by Madeleine Murphy, Kasia Trojanowska and Alexandra Pollard at The Health Policy Partnership, and designed by Colin Slade at Jumpingstone.

## About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary network of healthcare professionals, advocacy groups, policymakers and other stakeholders from across Europe. It was established in 2015 with the goal of raising awareness of unmet needs and seeking meaningful improvements in heart failure policy and care. To view our work so far, please visit: [www.hfpolicynetwork.org](http://www.hfpolicynetwork.org). All members of the HFPN provide their time for free. All Network content is non-promotional and non-commercial. The Secretariat is provided by The Health Policy Partnership, an independent health policy consultancy based in London, UK.

## Acknowledgements

**HFPN would like to thank the members of the Project Advisory Group for their continued input throughout the development of the report:**

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We would also like to thank the following expert for sharing her knowledge and insights in an interview:

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# Executive summary

**The 2021 European Society of Cardiology (ESC) guidelines for the diagnosis and management of acute and chronic heart failure (HF) provide evidence-based recommendations to improve care for people with HF across Europe.** They include guidance on person-centred care, pharmacological treatments, and management of comorbidities, along with key quality indicators.<sup>1</sup>

**Translating the international guidelines into action at a national and local level could reduce the risk of premature death and improve quality of life for millions of people with HF, while alleviating pressure on health systems.** This could be achieved through increased delivery of person-centred, multidisciplinary care, greater effectiveness of pharmacological treatment and better quality care in the community to prevent unplanned hospitalisations.<sup>1</sup>

**But people living with HF cannot always access guideline-directed care.**<sup>2-4</sup> HF services face regulatory barriers, challenges in knowledge sharing across the health system, and a lack of capacity for delivering care in a way that takes account of the whole person, including any other conditions they may have.<sup>5,6</sup> Specialties and care sectors tend to be siloed, with a lack of collaboration and support for primary care in particular. Pressures on health systems and workforces, along with insufficient resources, have created an environment in which it can be difficult to deliver guideline-directed care to everyone with HF.<sup>7,8</sup>

**People with HF may also face challenges to guideline-recommended self-management.** The guidelines contain new recommendations around the self-management of HF, including the use of telemonitoring at home.<sup>1</sup> Telemonitoring and other self-management solutions are more suitable for some people than others, so it is important that such programmes and tools are tailored to individual needs.<sup>9,10</sup> The guidelines also recommend that some people with HF be prescribed multiple medications, which may lead to difficulties in adherence and issues associated with side effects.<sup>9,11,12</sup>



**Putting guidelines into practice requires action at all levels.** For guideline recommendations to be followed in clinical practice, there must be commitment to implementation both at the system level and at the point of delivery in each country. Policymakers and decision-makers should urgently address regulatory and resource barriers. Health leaders and professionals should be encouraged to devise and implement care pathways across hospital-based and primary care, and to monitor quality standards.

**The new guidelines offer an opportunity for HF advocates** – patients, carers, healthcare professionals and decision-makers – to ensure the latest and best evidence is translated into practice for the benefit of people with HF across Europe.

## **Making the case for change**

To overcome common challenges and ensure guidelines are translated into action, advocates can draw on a number of ‘policy hooks’ to engage policymakers and decision-makers and encourage them to act.

- 1. Focus on preventing hospitalisations**
- 2. Highlight how HF relates to other conditions**
- 3. Encourage monitoring of quality indicators**
- 4. Put quality of life at the heart of the discussion**



# Background to the 2021 ESC heart failure guidelines

**In August 2021, the European Society of Cardiology (ESC) published its new guidelines for the diagnosis and treatment of acute and chronic heart failure.<sup>1</sup>**

The ESC guidelines are consensus documents intended to aid everyday clinical decision-making. They summarise the state of the evidence at the time of creation.<sup>13</sup>

The ESC guidelines for heart failure (HF) are revised every two to five years by an expert task force;<sup>13</sup> the previous version was published in 2016.<sup>14</sup> The task force examines the evidence base for the treatment and management of HF according to strict standards of evidence set by the ESC. For the first time in the history of the ESC HF guidelines, patients were included on the 2021 task force.<sup>15</sup>

National cardiology societies in many European countries, including Belgium, Denmark, France, Greece, Ireland and Poland, endorse the ESC HF guidelines as their national standard; others, such as England and Germany, produce their own guidelines.<sup>15</sup> When new ESC guidelines are published, they are disseminated to national cardiac societies in Europe and beyond – for example, the national cardiac societies in Australia, Brazil and Malaysia are all members of the ESC and have endorsed its clinical practice guidelines.<sup>16</sup>

As reviews and publication processes take a number of months, the results of several relevant trials were released between the completion of the writing process and final publication of the guidelines in August 2021. These are therefore not included in the updated guidelines.<sup>17</sup>



## 2

# Which areas saw the most significant updates to the guidelines in 2021?

## Diagnosis

The updated guidelines aim to simplify the diagnosis of HF. Three types of HF are mentioned in the guidelines (Box 1). A diagram depicts the new diagnostic algorithm, which lists the signs and symptoms of HF, as well as the tests that should be performed to confirm a diagnosis.<sup>18</sup> This is intended to support non-HF-specialists in swiftly recognising signs and symptoms of HF and following through with recommended diagnostic processes.<sup>1</sup>

### Box 1. Types of heart failure

The guidelines distinguish three types of heart failure based on the left ventricular ejection fraction (LVEF), which is the proportion of oxygenated blood in the heart that is pumped out by the left ventricle to the rest of the body with each heartbeat.

**Heart failure with reduced ejection fraction (HFrEF):** in HFrEF, the heart muscle is weakened, and the left ventricle of the heart is typically enlarged.<sup>19</sup> People with heart failure who have a LVEF of less than 40% are diagnosed with HFrEF. There are a number of evidence-based pharmacological treatments recommended for people with HFrEF.<sup>1</sup>

**Heart failure with mildly reduced ejection fraction (HFmrEF):** in HFmrEF, the LVEF is between 40% and 49%.<sup>19</sup> This category was previously commonly referred to as heart failure with mid-range ejection fraction, but has been renamed to reflect research suggesting that the mechanisms involved in HFmrEF are similar to those seen in HFrEF, with implications for recommended treatment.<sup>1</sup>

**Heart failure with preserved ejection fraction (HFpEF):** in HFpEF, the LVEF is at least 50%, but the left ventricle has stiffened and thickened, meaning it can fill with only a small amount of blood.<sup>19</sup> In the 2021 guidelines, there are no new recommendations for the pharmacological treatment of HFpEF.<sup>17</sup> However, trial results published after the release of the guidelines suggest a significant change in treatment recommendations will likely be included in future guidelines.<sup>20,21</sup>



## Person-centred care for people with HF

**The 2021 guidelines underscore the importance of implementing person-centred care at every step of the care pathway.** New recommendations have been included for the multidisciplinary care of chronic HF, including self-care strategies and the use of supervised, exercise-based cardiac rehabilitation for people with more severe disease, frailty or coexisting conditions.<sup>1</sup>

**Multidisciplinary disease management programmes and self-management are strongly recommended for all people with HF.** The previous guidelines recognised the value of multidisciplinary and integrated HF care that covers the whole of a person's life with HF, from diagnosis through to palliative care.<sup>14</sup> The 2021 guidelines see the addition of specific recommendations around self-management strategies as well as home- and clinic-based multidisciplinary disease management programmes, all of which can reduce the risk of avoidable hospitalisations and premature death.<sup>1</sup>

**Self-management strategies should enable people to 'live a good life with HF' as opposed to focusing on symptom control alone.** The 2021 guidelines advocate for comprehensive and tailored patient education that discusses areas of life affected by HF and provides tools for mitigating its impact. They also stress the importance of implementing shared decision-making in the patient–clinician interaction to ensure people with HF can participate in decisions about their care.<sup>1</sup>

**While more research into best-practice models is needed, the potential benefit of telemonitoring in HF care is now clearly recognised.** Following a boost in the use of telemonitoring during the COVID-19 pandemic,<sup>22</sup> the 2021 guidelines acknowledge its potential benefits for the management of HF. The recommendation states that non-invasive, at-home telemonitoring may be considered for people with HF to reduce the risk of hospitalisation and death. However, there is no in-depth discussion of the impact of telemonitoring on people's quality of life, or of the role of other forms of eHealth in HF care.<sup>1</sup>

**The inclusion of people living with HF on the task force for the 2021 guidelines is a positive step.** The presence of patient advocates, recruited from the ESC's patient forum, is a sign of the ESC's commitment to ensuring that the concerns of people living with HF are adequately reflected in the guidelines.<sup>5</sup>

## Day-to-day management of HF

There are now four key medications that can help improve outcomes for people living with HF with reduced ejection fraction (HFrEF). These four medications all reduce the risk of hospitalisation and death, and are sometimes referred to as the 'four pillars', or 'cornerstones', of HFrEF care (Box 2).<sup>2,23</sup> The addition of SGLT2 inhibitors to the three previously recommended medications can reduce the risk of hospitalisation or death by up to 26% in people with HFrEF.<sup>24,25</sup>

It is now recommended that all people diagnosed with HFrEF receive the four cornerstone medications, in parallel, as soon as possible following diagnosis. These medications start to reduce the risk of hospitalisation and death within a month of their initiation, so it is recommended that they are started as soon as safely possible.<sup>1</sup> This is an important change: the previous guidelines recommended that medications be started sequentially, with time to observe their effects between each prescription.<sup>14</sup>

The updated guidelines promote a more personalised approach to the management of HF. Once a person has begun taking the cornerstone medications, further treatment options are recommended depending on the cause of their HF and any other conditions they may have. Exercise-based rehabilitation and multi-professional disease management continue to be recommended for all people with HFrEF. There is a new recommendation that people with HFrEF and other conditions, who find exercise particularly challenging, be supported via supervised cardiac rehabilitation programmes.<sup>1</sup>

### Box 2. Four cornerstone medications for HFrEF

- 1. Angiotensin-converting enzyme (ACE) inhibitors** relax blood vessels, making it easier for the heart to pump blood around the body.<sup>26</sup>  
**or**  
**Angiotensin receptor-neprilysin (ARN) inhibitors** are a combination of two medications that reduce blood pressure, sacubitril and valsartan.<sup>27</sup>
- 2. Beta blockers** prevent the release of stress hormones (including adrenaline), slowing down the heart rate and reducing the force at which blood is pumped around the body.<sup>28</sup>
- 3. Mineralocorticoid receptor antagonists** are a form of diuretic. They prevent the build-up of water and salt in the body.<sup>26</sup>
- 4. Sodium-glucose co-transporter 2 (SGLT2) inhibitors** increase fluid and sodium removal from the body.<sup>29</sup>



**For the first time, the cornerstone HFrEF therapies should also be considered in HF with mildly reduced ejection fraction (HFmrEF).** This is a significant change, as it was previously recommended that people with HFmrEF be treated with diuretics alone.<sup>14</sup>

**There are not yet any pharmacological treatment recommendations for people with HF with preserved ejection fraction (HFpEF), beyond diuretics.** Although there was not sufficient evidence in time for the ESC to make recommendations for the active treatment of HFpEF, it is now recommended that all people with HFpEF be screened and treated for any comorbidities that may exacerbate their HF.<sup>1</sup>

**People with any type of HF should be evaluated for signs of congestion before being discharged from hospital.** In the context of HF, congestion is defined as fluid build-up in and around a person's organs and is the main cause of hospital admission for people with acute HF.<sup>30</sup> The guidelines now recommend that anyone being treated in hospital for HF be evaluated for any signs of congestion before they are discharged.<sup>1</sup> This is because persistent congestion in people with HF is associated with readmission.<sup>30 31</sup>

**Monitoring appointments should be planned within one to two weeks of discharge from hospital.** Once someone has left hospital after an admission for HF, they should be offered a follow-up outpatient appointment. At this appointment, the care team should monitor the effectiveness of medication, adjust doses accordingly and advise the person on how to manage any side effects.<sup>1</sup>

**People eligible for device implantation or heart transplantation should be fully involved in decisions about these procedures.** The updated guidelines recognise that the impact of invasive procedures on people's lives can be significant and complex. They recommend that clinicians ensure people with HF have access to a good level of practical and psychosocial support in making decisions about this type of treatment.<sup>1</sup>

## Treating people with multiple conditions

**The 2021 guidelines devote a whole section to the management of HF alongside other chronic conditions.** The guidelines pay particular attention to the complexity of managing multiple chronic conditions, including those that are common risk factors for and complications of HF. These include: atrial fibrillation, valvular heart disease, diabetes, iron deficiency and cancer. For example, it is recommended that everyone diagnosed with HF should be screened for iron deficiency, and that taking an anticoagulant may reduce the risk of stroke in people with both atrial fibrillation and HF.<sup>1</sup>

**There are recommendations for preventing HF in people living with pre-existing conditions that place them at an increased risk.** The guidelines state, for example, that people receiving cardiotoxic anticancer medications should be assessed by a cardio-oncologist, and that people with type 2 diabetes who are at risk of a cardiovascular event (such as a heart attack or stroke) should be prescribed risk-reducing medication.<sup>1</sup>

## Key quality indicators

**Key quality indicators have been added to the ESC HF guidelines to promote greater accountability for unwarranted variations in care.** The quality indicators aim to capture adequate diagnosis and recording of the different types of HF, the proportion of people with HFrEF who have been prescribed the cornerstone medications, and the presence of multidisciplinary teams in HF services. These indicators have been included as part of the ESC's wider recognition of the value of 'measuring and reporting quality and outcomes across cardiovascular care'.<sup>1</sup> The task force proposes that the indicators may be used by healthcare providers to ensure that guideline recommendations are put into practice.<sup>1 32</sup>



## What could the updated guidelines achieve?

The updated ESC guidelines have the potential to guide healthcare professionals to significantly improve outcomes for people living with HF and reduce the societal harm associated with the syndrome. They also offer HF advocates a powerful and updated evidence base with which to challenge outdated or insufficient practices in HF care.

### **Implementing person-centred care could make life better for people with HF**

**The updated guidelines can help clinicians to better address the topics that matter to people living with HF.** HF affects many elements of everyday life; time spent in the cardiologist's office or undergoing surgical procedures is only a small part of this experience.<sup>5,33</sup> Some cardiologists may feel unequipped or too short on consultation time to address sensitive matters, such as the impact of symptoms and treatment on all areas of a person's life, including sexual function and mental health.<sup>5,33-35</sup> This risks leaving people living with HF feeling isolated, as they struggle to come to terms with the ways their lives have been changed as a result of their illness.<sup>33,35</sup>

**Self-management and multidisciplinary disease management programmes can improve quality of life and reduce hospitalisations.** The strengthening of recommendations around self-management strategies is based on increasing evidence that self-management, home visits by nurses and attendance at HF clinics can all reduce the risk of hospitalisation and death in people with HF.<sup>36-39</sup> Person-centred support and self-management interventions have also been shown to have a positive impact on health-related quality of life in HF.<sup>36,40</sup>

**Better management of HF alongside coexisting conditions has the potential to achieve better outcomes and pave the way towards integrated care.** People with HF often live with multiple conditions that significantly raise the risk of poor outcomes.<sup>41</sup> In fact, 98% of people with HF have at least one other condition and 77% have three or more.<sup>42</sup> Optimising care for people by taking account of their multiple conditions could have a very positive impact on outcomes.<sup>43-45</sup> Implementing the guidelines' new treatment algorithm for HFrEF, which provides guidance on treatment for people according to the cause of their HF and any coexisting conditions, may mean that people are more likely to receive appropriate, tailored care from the point of diagnosis.<sup>17</sup>

**Telemonitoring can empower people with HF to monitor their own symptoms and avoid having to go to hospital.** The COVID-19 pandemic has led to the rapid development and roll-out of digital and remote solutions for delivering HF care.<sup>22 44</sup> These technologies can facilitate regular monitoring of symptoms and key measurements such as blood pressure, weight and heart rate, without the disruption of regular visits to a healthcare facility.<sup>22</sup> This can enhance self-management as people can monitor their own symptoms with the reassurance that their care team will intervene if they are concerned by the data.<sup>46</sup>



**Remote consultations with my cardiologist have made my life easier, reducing the time spent travelling to and from appointments. I really like being able to monitor my symptoms and see how changes in my lifestyle translate into progress.**

**Denis Janssen, patient advocate**

**People with advanced HF could be enabled to participate more meaningfully in decisions about procedures available to them.** Implantation of a left ventricular assist device or a heart transplantation are procedures typically reserved for people with advanced HF that has not responded to treatment.<sup>47 48</sup> Both options are potentially life-saving, but require complex surgery.<sup>49 50</sup> This can be psychologically traumatic and may lead to physical complications.<sup>48 51</sup> The new guidelines therefore recommend that people being considered for these interventions should be deemed capable of managing the care of the device, or adhering to post-transplant immunosuppressant medications, and should be given psychological support. Conversations and consideration of these issues with people living with advanced HF should lead to more meaningful shared decision-making about whether to pursue further intervention or focus on palliative care.<sup>5</sup>

## Maximising the potential of clinical management could lead to improved outcomes for people with HF

### Applying the 2021 ESC guidelines consistently could extend the lives of people with HF.

Parallel initiation of the four cornerstone medications as soon as safely possible after diagnosis can reduce the risk of both hospitalisation and death in people with HF.<sup>1</sup> Under the previous guidelines, people could wait for weeks or months to be prescribed all recommended medications.<sup>2,23</sup> The new guidelines should speed up the initiation of evidence-based medical therapies for HFrEF and HFmrEF.<sup>1,2</sup>

**Clear communication around diagnostic processes could enable earlier diagnosis, making treatment more effective.** Efforts in the new guidelines to simplify the algorithm for diagnosing HF in clinical practice could help non-HF-specialists diagnose the syndrome. The new diagram is intended to be easily shareable and accessible to a non-HF-specialist audience.<sup>1</sup> Given that many people diagnosed with HF initially present with symptoms in primary care, a simpler algorithm aimed at general practitioners could assist with earlier diagnosis.<sup>52</sup>

**Long-term monitoring after discharge can maximise treatment efficacy and quality of life.** A post-discharge follow-up appointment scheduled within one to two weeks of leaving hospital would offer an opportunity to discuss any side effects and adjust the dose of medications if necessary to ensure they are at their most effective.<sup>1</sup>



**The change to the pharmacological treatment of HFrEF will impact a very large number of patients. The new treatment algorithm can preserve life even more than the algorithm in earlier guidelines. If the guidelines are adhered to, we can expect that outcomes for patients will improve and people will survive for longer.**

**Professor Jelena Čelutkienė**, cardiologist

## **Delivering care that aligns with the new guidelines could reduce the societal cost of HF**

**Implementing guideline recommendations could prevent hospitalisations and reduce the burden of HF on health systems.** The Organisation for Economic Co-operation and Development (OECD) has identified HF as a condition in which many hospitalisations could be avoided if evidence-based care were provided in the community.<sup>53</sup> Hospitalisations are responsible for the majority of the economic burden of HF, accounting for up to 87% of all HF-related costs.<sup>54</sup> On top of this already significant pressure, health systems are bracing for a ‘tsunami’ of cardiovascular disease, including HF, following the acute phase of the COVID-19 pandemic.<sup>8 55 56</sup> Services were already struggling to cope with the number of people being diagnosed before the pandemic, and the pressure has intensified considerably.<sup>7 8 56</sup>

**Recurrent hospitalisations could be avoided, and quality of life improved, through careful discharge evaluation and planning.** People who leave hospital after being treated for HF are more likely to be readmitted if they continue to have congestion at the point of discharge.<sup>57</sup> Leading studies of best-practice care models in which people with HF are carefully monitored during the transition from hospital to the community have shown that subsequent rehospitalisations can be reduced by 30%.<sup>58</sup> The recommendation for a follow-up appointment within one to two weeks of hospital discharge would offer an opportunity to adjust the doses of medications initiated in hospital. For many people with HF, this scheduled medication review could reduce the risk of further hospitalisation and even death, as well as alleviating their symptoms and supporting them to have a better quality of life.<sup>1</sup>

**Early intervention for people at high risk of HF could significantly reduce the incidence and severity of new cases.** The guidelines present a number of opportunities to protect people who are at high risk of developing HF. These opportunities include the screening and assessment of anyone receiving anticancer treatments that carry a risk of cardiotoxicity, and prescribing all people with type 2 diabetes risk-reducing medications.<sup>1 59</sup> People being treated for breast cancer or lymphoma are three times more likely to develop HF than people who have never had cancer,<sup>60</sup> while the prevalence of HF among people with diabetes is four times higher than in the general population.<sup>61</sup> Intervening early in these cases could have a considerable impact not only for the individuals affected, but for wider society, by avoiding negative outcomes such as unnecessary repeat hospitalisations.<sup>59 61</sup>



## 4

# What are the potential challenges to implementing the updated guidelines in Europe?

### Challenges to maximising the potential of cornerstone medications

Across Europe, many people with HF cannot access guideline-recommended medications, despite their proven effectiveness in reducing hospitalisations and death. Not all of the four cornerstone pharmacological therapies are reimbursed in some European countries.<sup>2,4</sup> This means that people with HF cannot always reliably access guideline-recommended care.<sup>3</sup> Lack of reimbursement drives inequality both between and within countries, as some evidence-based treatments are only available to people who can afford to pay for them.<sup>2,4</sup>



**The guidelines are based on the best evidence we have so far – but, despite this, in many European countries there is a barrier to accessing guideline-recommended treatment.**

**Professor Giuseppe Rosano, cardiologist**

**The guidelines do not give specific guidance on how to initiate the cornerstone medications.**

The guidelines task force has stated that they chose not to include step-by-step instructions for introducing the four cornerstone therapies to people with HFrEF and HFmrEF because they wanted clinicians to consider the needs of each patient.<sup>62</sup> This decision is likely to be helpful to HF specialists, but could cause concern for clinicians with less experience of managing HF.

**People living with HF may struggle to manage multiple medications.** The side effects of key HF medications can be significant and, given the high rates of comorbidity, many people with HF may be on a number of medications, further increasing the likelihood of side effects. Managing prescriptions for multiple medications can be confusing and time-consuming.<sup>9,11,12</sup> This underlines the importance of close support and therapeutic education for people living with HF, to help them manage all of the ways in which the syndrome impacts their lives.<sup>5,6,33</sup>

## Challenges to implementing person-centred care for people with multiple conditions

**Optimal management of HF in conjunction with other chronic conditions may be hindered by gaps in collaboration between cardiology and other specialties.** For care to be optimised in line with the new recommendations, communication between specialties will be necessary.<sup>2</sup> As a number of the new guideline recommendations concern the prevention of HF in people with other conditions, such as cancer and diabetes, they are more likely to be implemented if oncologists and diabetes specialists, as well as general physicians, are made aware of the HF guidelines.<sup>2 5 63</sup>



**Although there has been so much progress in cardiology, healthcare professionals aren't always prescribing the right medications in the correct doses. If we can develop the other aspects of heart failure care as well – the person-centred support and disease management – I think the therapies that we have will be used more correctly and effectively.**

**Ekaterini Lambrinou**, heart failure specialist nurse

**Existing pressures on healthcare professionals likely present a barrier to implementing more comprehensive, person-centred care strategies.** Healthcare professionals were under enormous pressure even before the COVID-19 pandemic, and this is likely to continue as systems work to clear waiting lists and support people living with the long-term effects of COVID-19.<sup>87</sup> While multidisciplinary disease management programmes and telemonitoring systems have the potential to make workloads more sustainable in the long term, they also require investment. Nurses are likely to be responsible for supporting people with HF in the use of telemonitoring equipment, helping them manage their symptoms at home and monitoring the data.<sup>10 63</sup> As the guidelines add more recommendations in these areas, it will be important for health systems to factor these additional responsibilities into workforce planning.<sup>10 33</sup>



**Telemonitoring and remote consultations will only work if they come from trusted healthcare providers. It should be a part of their offering.**

**Denis Janssen**, patient advocate

**People with HF have a range of needs and preferences for telemonitoring, so a menu of options will need to be offered.** Much has been made of the role of telemedicine, including the remote monitoring of people's signs and symptoms, throughout the COVID-19 pandemic.<sup>64</sup> Some people with HF feel empowered by using telemonitoring systems to feed data to their care teams and manage their own symptoms.<sup>10 33 46</sup> However, there are others who find telemonitoring inaccessible and alienating, or who have concerns about data privacy.<sup>10 22</sup> Just as in-person care and pharmacological treatment need to be tailored, telemonitoring systems must also be responsive to people's individual needs and preferences.<sup>5 9 10</sup>

## **Challenges to adopting guidelines in national policy and practice**

**To ensure guidelines are implemented, their recommendations should inform national policy goals and care quality standards.** The use of quality and process indicators can improve the quality of HF care by identifying gaps and shortfalls and providing motivation to deliver better care.<sup>65 66</sup> In some countries, the ESC guidelines are automatically adopted by the national cardiology society.<sup>15</sup> To ensure implementation in such cases, new care pathways may need to be developed at national and regional level.<sup>9 67 68</sup>

**Many European health systems are struggling to adapt to multidisciplinary and integrated care for people with HF.** While some countries have relative strengths in building multidisciplinary care teams for HF (e.g. care pathways and referral processes, shared health records, use of clinical delegation to specialist nurses and allied health professionals, telemedicine), others have not yet adopted key elements of such models, despite strong evidence for their efficacy.<sup>5 15 68</sup>

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**I think that the guidelines are implementable, but health systems need to adapt. A heart failure clinic might need to look a bit different from how it did five years ago. In some cases, we need to be critical about how the whole system looks. There are still a lot of places where there are no disease management programmes and no multidisciplinary heart failure teams.**

**Tiny Jaarsma**, professor of nursing

**It is essential that guidelines are communicated effectively to people working in primary care.** HF is often managed in community settings.<sup>69</sup> As primary care professionals need to know how to care for people with a broad range of conditions, national cardiology societies and specialists should invest in reaching out to disseminate the major changes in the updated guidelines.<sup>9</sup> Primary care staff should also be supported to meet the needs of people with complex conditions like HF through training and development. Policy should allow for ensuring that there is adequate time to enable patients to discuss their concerns with their primary care providers.<sup>9</sup>

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**For these guidelines to be implemented in primary care, we need changes at the policy level. Primary care physicians and nurses need to be afforded the time and resources to meet the needs of people living with heart failure.**

**Mar Domingo**, primary care physician



## 5. How can advocates engage policymakers to ensure the updated guidelines are implemented in practice?

**The updated ESC guidelines offer an opportunity to improve HF diagnosis and management, leading to better outcomes for people living with the syndrome.**

To maximise this opportunity, coordinated advocacy is required from clinical leaders, experts and people with HF. They need to raise awareness of advances in care and make the case for policy changes to enable these advances. There are four key elements of the case for change that advocates can use to engage and persuade policymakers.

### **Focus on preventing hospitalisations**

**Most of the significant cost associated with HF in Europe can be attributed to hospitalisation.**<sup>54</sup>

The number and cost of hospitalisations can be reduced through the effective early diagnosis and appropriate management of HF, using guideline-recommended medications, telemonitoring, structured post-discharge follow-up and multidisciplinary disease management programmes.<sup>1</sup> For those people who are admitted to hospital, careful pre-discharge evaluation and post-discharge monitoring in the community can help to prevent readmission.

**Implementing the ESC guidelines across Europe should reduce the economic burden on health systems and improve quality of life for people living with HF.** This must be a key argument for advocates striving to persuade decision-makers with control of healthcare budgets that HF guideline implementation is a valuable investment.

### **Highlight how HF relates to other conditions**

**Adopting person-centred approaches to care that consider all of a person's needs will become increasingly important as the European population ages.** As people grow older, they are more likely to live with multiple conditions.<sup>70</sup> Most people with HF have at least one other chronic condition;<sup>42</sup> in addition, many of the increasing number of people who live beyond cancer or cardiovascular events such as heart attacks are at significant risk of developing HF.<sup>71</sup>

**The updated ESC guidelines include specific recommendations for the management of HF alongside the most common coexisting conditions.**<sup>1</sup> By emphasising the evidence and guideline recommendations, HF advocates can galvanise action around the effect that comorbidities have on the management of non-communicable diseases.<sup>72-74</sup>

## **Encourage monitoring of quality indicators**

**The inclusion of quality indicators for the evaluation of care and outcomes in the 2021 ESC guidelines represents a significant opportunity for advocates.** By pointing to these indicators – and the ESC’s recommendation that they be used to help operationalise the guidelines – advocates can encourage decision-makers to embed indicators within national and local-level audits. On an individual level, people with HF can be made aware of the indicators, helping them to advocate for their own care.

## **Put quality of life at the heart of the discussion**

**As well as its impact on the economy and health system, HF can have a devastating effect on people’s quality of life.**<sup>75</sup> Individual people’s stories can play an important role in the decision-making processes of policymakers, key opinion leaders and the media,<sup>76,77</sup> so advocates should be bold in telling the truth about the burden of HF, as well as communicating the hope that new treatments and personalised management of HF can bring.

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**Please cite this report as:**

Heart Failure Policy Network. 2022. *From guidelines to action: opportunities for change following the 2021 ESC guidelines*. London: HFPN

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