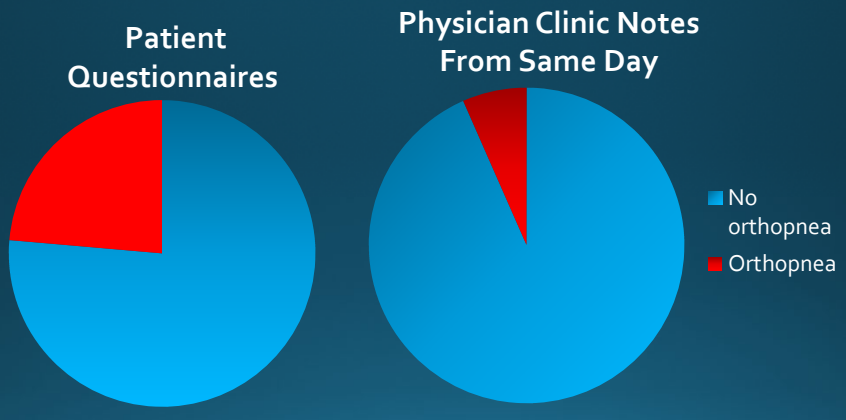
Going PRO With The Guidelines

Complete the Circle Connecting
Patient and Provider and Therapy

- **Recommendation for eliciting patient-reported outcomes**
  as part of serial clinical assessment
- **Information to providers (and patients)**
  about expected benefits of recommended therapies
- **Shared decision-making guided by patient values**

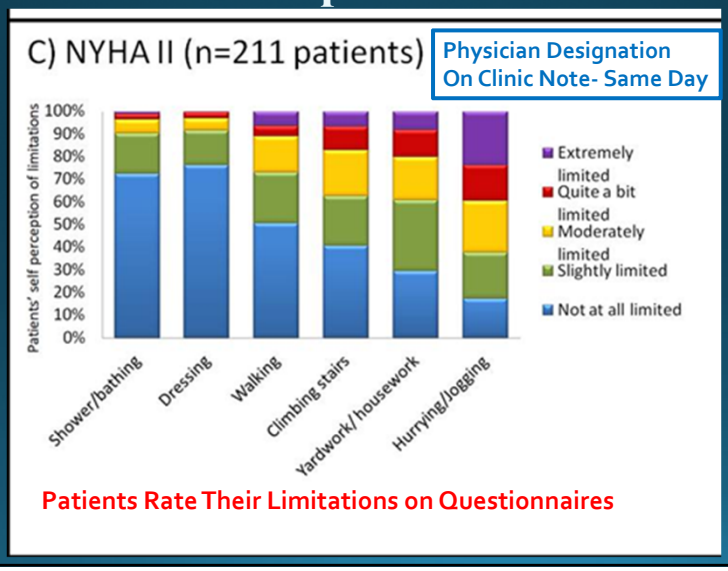
Patients vs. Physicians
Perception of Orthopnea in HF Clinic



N=932

Motiwala, Castro, Lewis et al, HFSA 2017

Mismatch Between Physician NYHA Assessment and Patient Report of Limitations



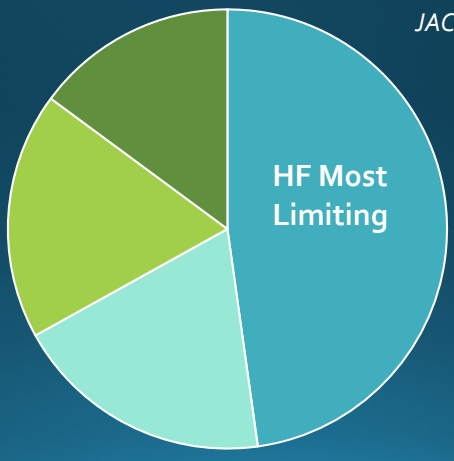
Patients Rate Their Limitations on Questionnaires

Castro, Lewis, et al

Patient-Reported Limitations to Quality of Life With HF Are Often Not Due to HF

726 Ambulatory HF patients
Attribute major limitation of QOL
To:

E. Joyce.....EF Lewis
JACC HF 2016;4: 184-93



HF | HF=Other Med | Other Med > HF | Non-Med

Heart Failure Less Likely to Limit
OR: **HFpEF 0.48**
Female: 0.68
Depression history: 0.86
Arthritis: 0.67

Current Recommendation for Serial Evaluation

6. Initial and Serial Evaluation of the HF Patient

6.1. Clinical Evaluation

6.1.1. History and Physical Examination: Recommendations

CLASS I

1. A thorough history and physical examination should be obtained/performed in patients presenting with HF to identify cardiac and noncardiac disorders or behaviors that might cause or accelerate the development or progression of HF. *(Level of Evidence: C)*
2. In patients with idiopathic DCM, a 3-generational family history should be obtained to aid in establishing the diagnosis of familial DCM. *(Level of Evidence: C)*
3. Volume status and vital signs should be assessed at each patient encounter. This includes serial assessment of weight, as well as estimates of jugular venous pressure and the presence of peripheral edema or orthopnea (187–190). *(Level of Evidence: B)*

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ACC/AHA Guidelines: Only One Level I For Symptoms

Therapy	Decrease Mortality	Decrease Morbidity (=Hosps)	Improve Quality of Life or Function
ACEI/ARB	√	√	
Beta blockers	√	√	
MRA	√	√	
Sacubitril/valsartan	√	√	
Hydral/Isordil	√	√	
Diuretics			√ Improve symptoms
ICD	√ by decreasing SD		
CRT "is indicated" No reason given			
Digoxin IIa		√	
Exercise Training IIa			√ Improve fn capacity, exercise, HF-related QOL, mortality

Level of Evidence C

Weight of RCT evidence is inversely related to magnitude and immediacy of symptom improvement.

European HF Guidelines

Therapy	Decrease Mortality	Decrease Morbidity (usually =Hosps)	Improve Quality of Life or Function
ACEI/ARB	√	HF Hosps √	
Beta blockers	√	HF Hosps √	
MRA for pts who remain sx	√	HF Hosps √	
Hydral/Isordil IIa	√	HF Hosps √	
ARNI	√	√	
Diuretics		√ HF hosps	
ICD	√ by decreasing SD		
CRT	√	√	√ Improve symptoms

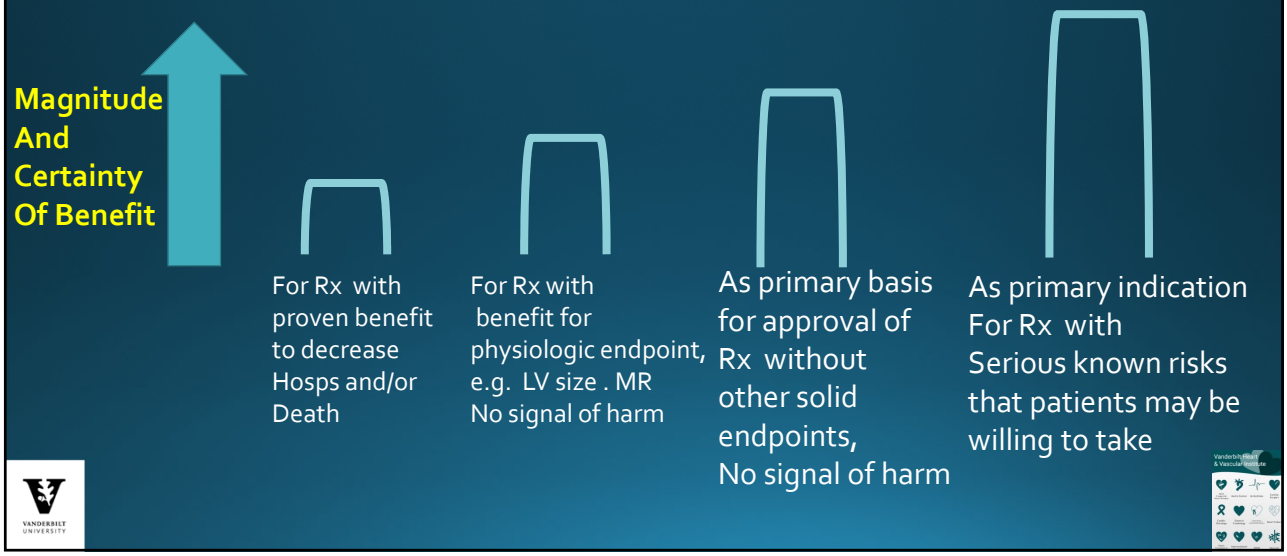
Canadian Guidelines 2017 Update

RECOMMENDATION

33. We recommend that an ARNI be used in place of an ACEi or ARB, in patients with HFrEF, who remain symptomatic despite treatment with appropriate doses of GDMT to decrease cardiovascular death, HF hospitalizations, and symptoms (Strong Recommendation; High-Quality Evidence).

Values and preferences. This recommendation places high value on medications proven in large trials to reduce mortality, HF re-hospitalization, and symptoms. It also considers the health economic implications of new medications.

How High Is The Bar To Include Significant Symptom Improvement?



ACC/AHA Practice Guideline

ACC/AHA Statement on Cost/Value Methodology in Clinical Practice Guidelines and Performance Measures

A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures and Task Force on Practice Guidelines

WRITING COMMITTEE*

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Table 2. Proposed Integration of Level of Value Into Clinical Guideline Recommendations*

Level of Value
High value: better outcomes at lower cost or ICER <$50 000 per QALY gained
Intermediate value: $50 000 to <$150 000 per QALY gained
Low value: ≥$150 000 per QALY gained
Uncertain value: value examined but data are insufficient to draw a conclusion because of no studies, low-quality studies, conflicting studies, or prior studies that are no longer relevant
Not assessed: value not assessed by the writing committee

In exceptional cases…. the designation "high-resource utilization" may be preferred.

AHA Scientific Statement

Cardiovascular Health: The Importance of Measuring Patient-Reported Health Status

A Scientific Statement From the American Heart Association

John S. Rumsfeld, MD, PhD, FAHA, Chair; Karen P. Alexander, MD, FAHA, Vice Chair; David C. Goff, Jr, MD, PhD, FAHA; Michelle M. Graham, MD; P. Michael Ho, MD, PhD, FAHA; Frederick A. Masoudi, MD, MSPH, FAHA; Debra K. Moser, DNSc, RN, FAHA; Véronique L. Roger, MD, MPH, FAHA; Mark S. Slaughter, MD, FAHA; Kim G. Smolderen, PhD; John A. Spertus, MD, MPH, FAHA; Mark D. Sullivan, MD, PhD; Diane Treat-Jacobson, PhD, RN, FAHA; Julie J. Zerwic, PhD, RN, FAHA; on behalf of the American Heart Association Council on Quality of Care and Outcomes Research, Council on Cardiovascular and Stroke Nursing, Council on Epidemiology and Prevention, Council on Peripheral Vascular Disease, and Stroke Council

AHA/ACC Guideline Recommended Rx "Indicated For"

Therapy	Decrease Mortality	Decrease Morbidity (=Hosps)	Improve Quality of Life or Function
ACEI/ARB	√	√	
Beta blockers	√	√	
MRA	√	√	
Sacubitril/valsartan	"further decrease" √	"further decrease" √	Less decrease?
Hydral/Isordil	√	√	could include QOL
Diuretics		could include hosps	√ Improve symptoms
ICD	√ by decreasing SD		
CRT "is indicated" No reason given			Could include QOL and exercise
Exercise Training IIa			√ Improve fn capacity, exercise, HF-related QOL,

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  – When can quality of life and freedom from side effects be allowed to override predicted impact on survival?

What Endpoint Near the End?
Survival Time Adjusted for Patient-Valued Days after HF Hospitalization

- Patient-valued days were 24 + 32% fewer than calendar days of survival (integrated using time trade-off instrument administered 5 times in 6 mos) .
- 6% of patients surviving ≥ 6 months would have traded most of their survival to feel better for whatever time they had left.
- Death was most likely in patients who valued their survival the least.
- 31% of patients surviving < 105 days reported that they would trade most of their survival to feel better for whatever time they had.

Changing preferences for survival after hospitalization with advanced HF (ESCAPE Substudy) J Am Coll Cardiol 2008; 52: 1702-8.