Integrated Heart Failure (HF) CoP Webinar:

Integrating Palliative Care into Heart Failure Care

https://www.youtube.com/watch?v=ITaaWZa4pE0

September 17th , 2025

Ontario Health

Land Acknowledgement

Agenda

TIME	TOPIC	NAME
08:00 am	Land Acknowledgement	Colleen Lackey (OH HF Lead Clinical)
08:05 am	Welcome & Introductions Housekeeping	Dr. Darren Cargill (OH Provincial Clinical Co-Lead, Palliative Care Program)
08:10 am	Integrating palliative care into heart failure care	Dr. Leah Steinberg
08 50 am	Q&A	All
08:55 am	Wrap Up	Colleen Lackey

Objectives

1) Participants will gain an understanding of the unique challenges of applying a palliative care approach in heart failure
2) Participants will learn how to apply the four components of a palliative care approach- Identify, Assess, Manage and Prepare for the future- to HF patients
3) Participants will engage in interdisciplinary knowledge exchange and discussion across Ontario Health Teams, to support integrated, patient-centered care for individuals living with advanced heart failure.

Heart Failure: Care in the Community for Adults

Ontario Health

A collaborative and community-based pathway outlining high-quality care based on the Ontario Health *Heart Failure* quality standard

Primary and Community Care

Person suspected of having heart failure (HF)

QS 1 & 10: Assessment and Diagnosis

Perform a medical history, a physical examination, initial laboratory investigation, 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 performed.

Assess the palliative care needs of the person and their family and offer support.

QS 2: Care Plan

Develop an individualized, person-centred, comprehensive care plan.

(See Box 1)

QS 4 & 5: Treatment

Offer a personalized, exercise-based cardiac rehabilitation program.

People with HFrEF and NYHA class II - IV symptoms are offered quadruple therapy.

(See Box 2)

QS 7: Non-Cardiac Comorbidities

Treat non-cardiac comorbidities that are likely to affect heart failure management.

QS 3: Self-Management Program

Create a tailored self-management program with the goal of enhancing skills and confidence.

QS 2, 6 & 10: Ongoing Monitoring

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.

The care plan is reviewed at least every 6 months, and sooner if there is a significant change.

Ongoing , continuous assessment of palliative care needs.

QS 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.

QS 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 for heart failure.

(See Box 3)

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.

Housekeeping

- Please keep yourself on mute unless you are speaking.

- We encourage you to type your questions or comments in the chat box. The chat box is monitored throughout the webinar. Questions will be addressed directly in the chat box or in the discussion following the presentations.

- We also encourage you to share any suggestions/topics for future webinars.

- This meeting **will be recorded**. A copy of the webinar recording, and slides will be available on the virtual CoP shared space.

Speaker

Dr. Leah Steinberg

Palliative Care Consult Service
Sinai Health System

Leah.Steinberg@sinaihealthsystem.ca

Integrating palliative care into heart failure care

Dr. Leah Steinberg
Palliative Care Consult Service
Sinai Health System

September 17, 2025

Introductions

Leah Steinberg

Mount Sinai Hospital, Toronto, Canada:

- Consult service
- Home-based team
- Clinics

Sinai Health System

Disclosures

- Pallium Canada Education Advisor
- Health Canada grant, Communication Skills (ABCs)

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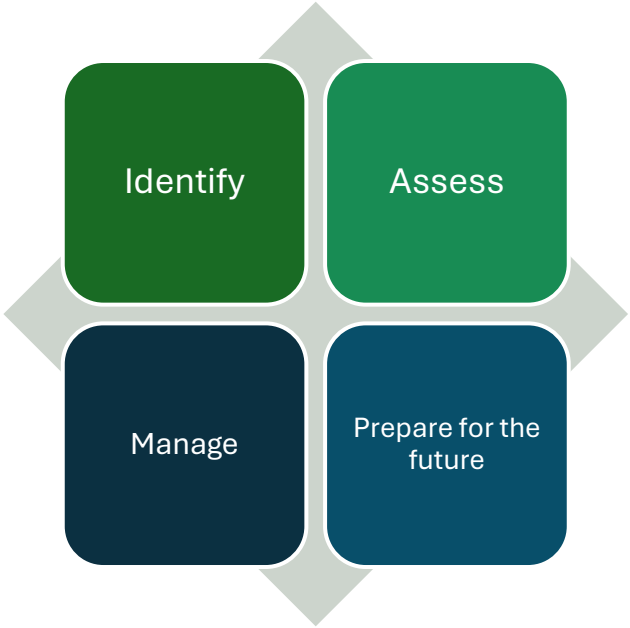
Today's plan:

1. Introductions
2. Challenges of integrating a palliative approach
3. Introduce four components of a palliative care approach to care.



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Challenges

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Heart failure

A palliative care approach in heart failure

Square peg, round hole…

not quite the same as oncology….

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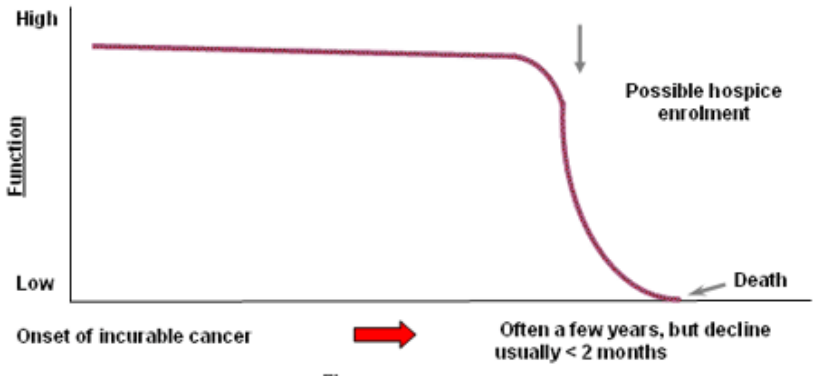
A Tale of Two Illnesses

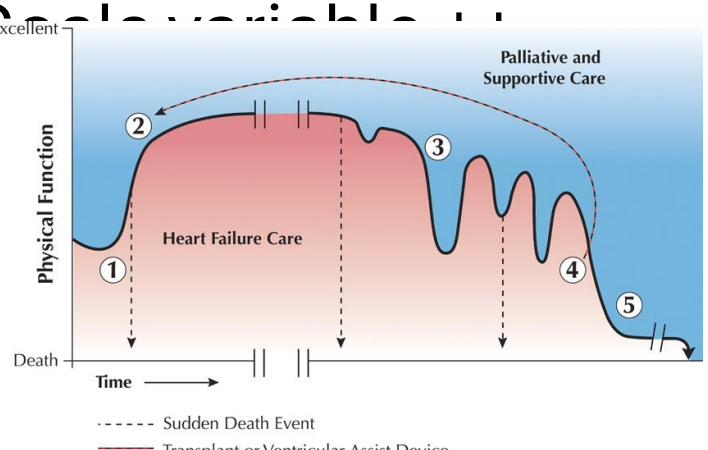
Cancer

- Anti-cancer treatments decrease
- Often a transition point
- Trajectory
- Public awareness that cancer can cause death
- “see” progression
-



Heart Failure

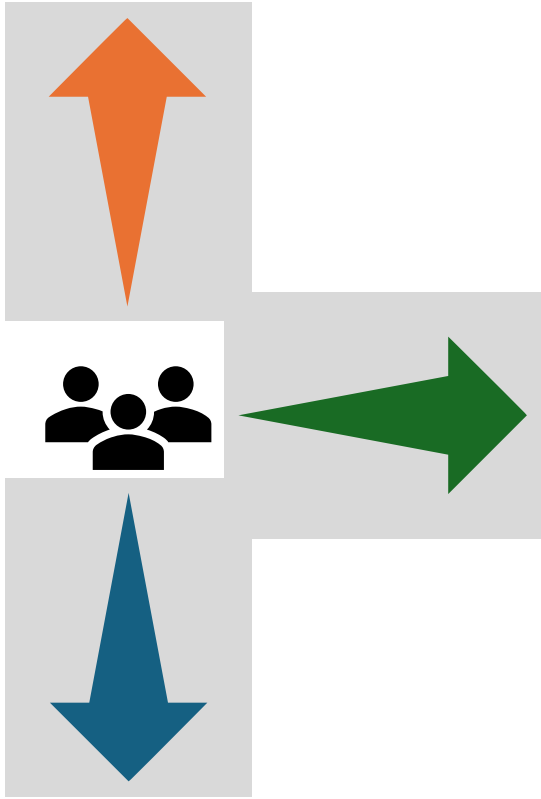
- HF medications continue
- No transition points
- Trajectory
- Little awareness of prognosis in HF
- Imaging “hidden”
- C[illegible]



Complexity of health care team

Often multiple providers with:

- different clinical goals and priorities,
- different resources,
- and different health care and organizational systems



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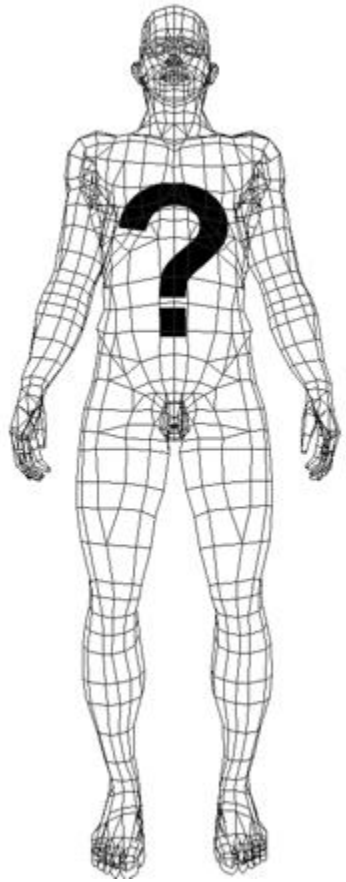
Prognostication:

Prognostication underlies the infrastructure in palliative care

But, in HF ??



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All these challenges

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But despite that,

Palliative Care strongly advocated

- Canadian Cardiovascular Society
- ACC/AHA Practice Guidelines
- European Society of Cardiology

Needs well-documented in many studies

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Canadian Guidelines

Canadian Journal of Cardiology 37 (2021) 531–546

Society Guidelines

CCS/CHFS Heart Failure Guidelines Update: Defining a New Pharmacologic Standard of Care for Heart Failure With Reduced Ejection Fraction

https://www.onlinecjc.ca/action/showPdf?pii=S0828-282X%2821%2900055-6

TREAT COMORBIDITIES PER CCS HF RECOMMENDATIONS

DIURETICS TO RELIEVE CONGESTION (TITRATED TO

Initiate standard therapies as soon as possible and titrate every 2-4 weeks to target or maximally tolerated dose over 3-6 months

↓

Reassess LVEF, Symptoms, Clinical Risk

↙

NYHA III/IV, Advanced HF or High-Risk Markers

CONSIDER

- Referral for advanced HF therapy (mechanical circulatory support/transplant)
- Referral for supportive/palliative care

↓

LVEF ≤ 35% and NYHA I-IV (ambulatory)

Refer to CCS CRT/ICD recommendations

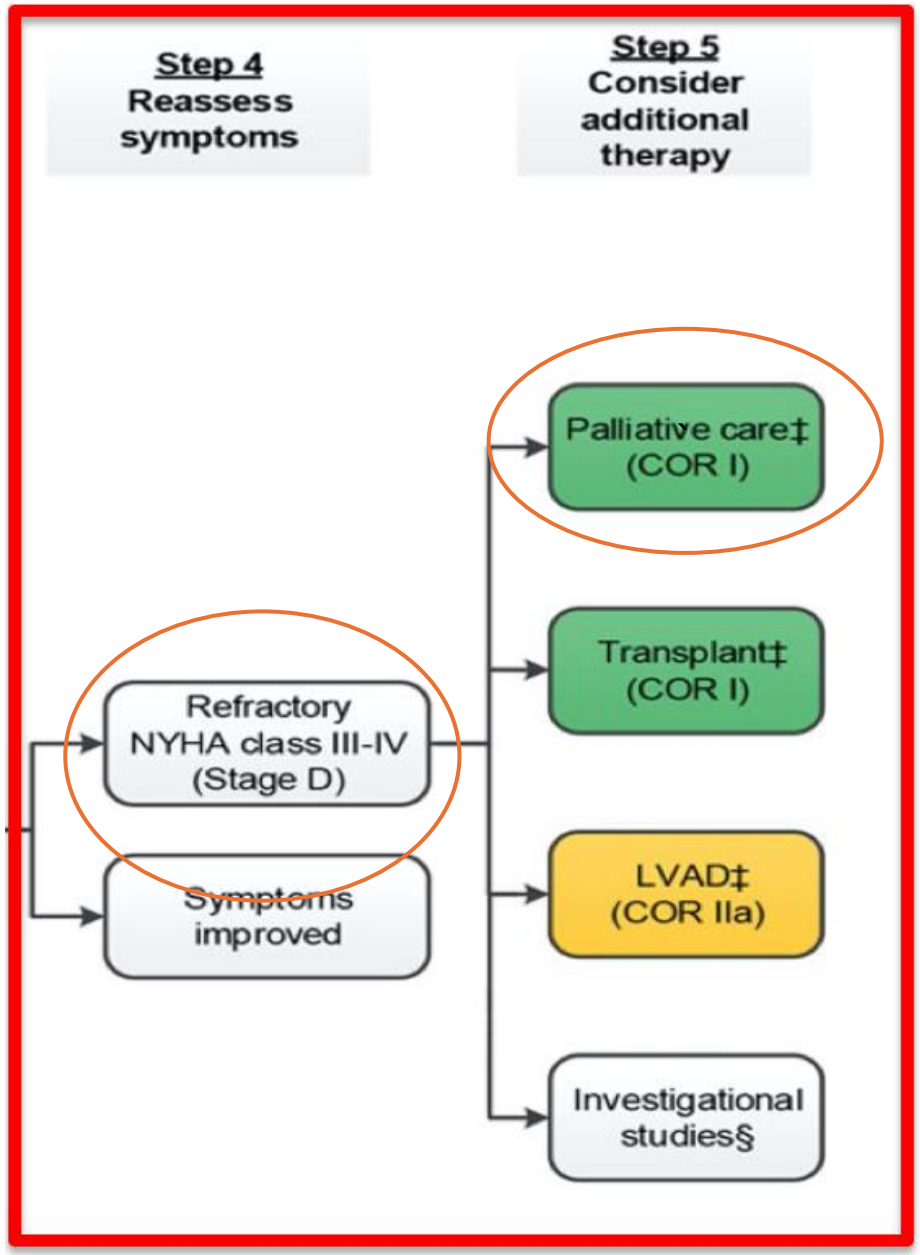
↘

LVEF > 35%, NYHA I, and Low Risk

Continue present management, reassess as needed

EDUCATION, SELF-CARE, EXERCISE)

CUMENTATION OF GOALS OF CARE



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, Volume: 136, Issue: 6, Pages: e137-e161, DOI: (10.1161/CIR.0000000000000509)

Introducing 4 components to integrating palliative care

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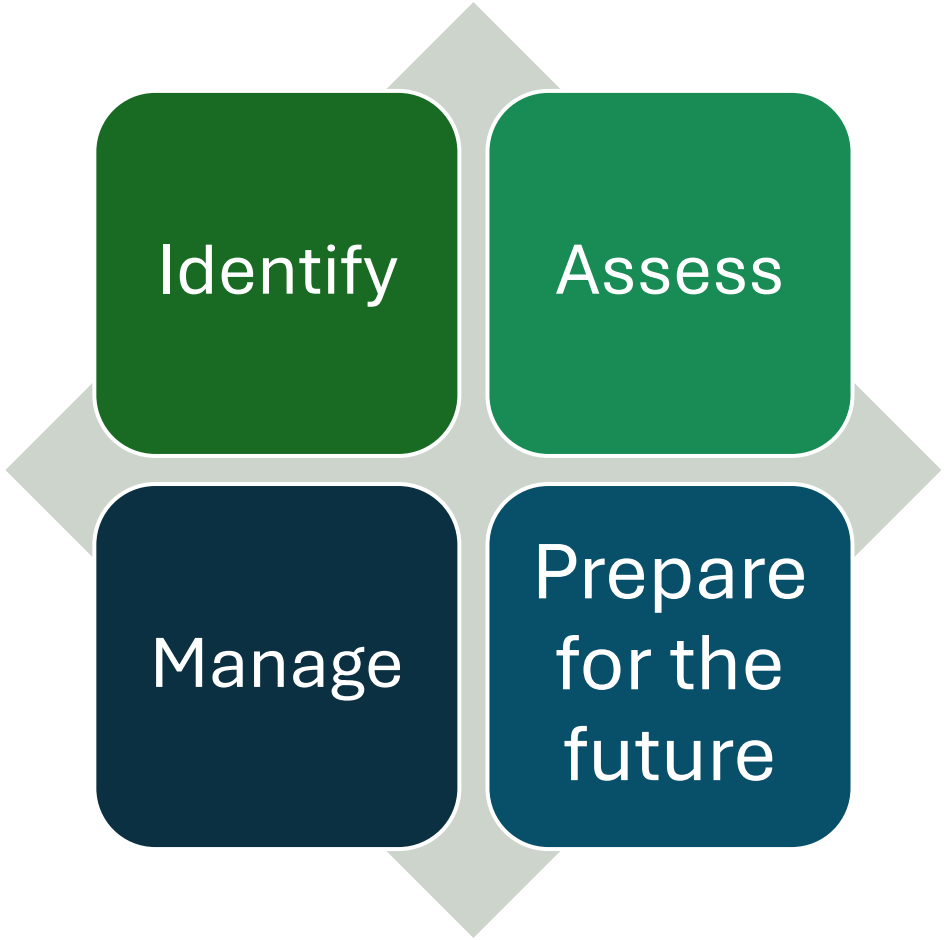
Palliative Care Approach



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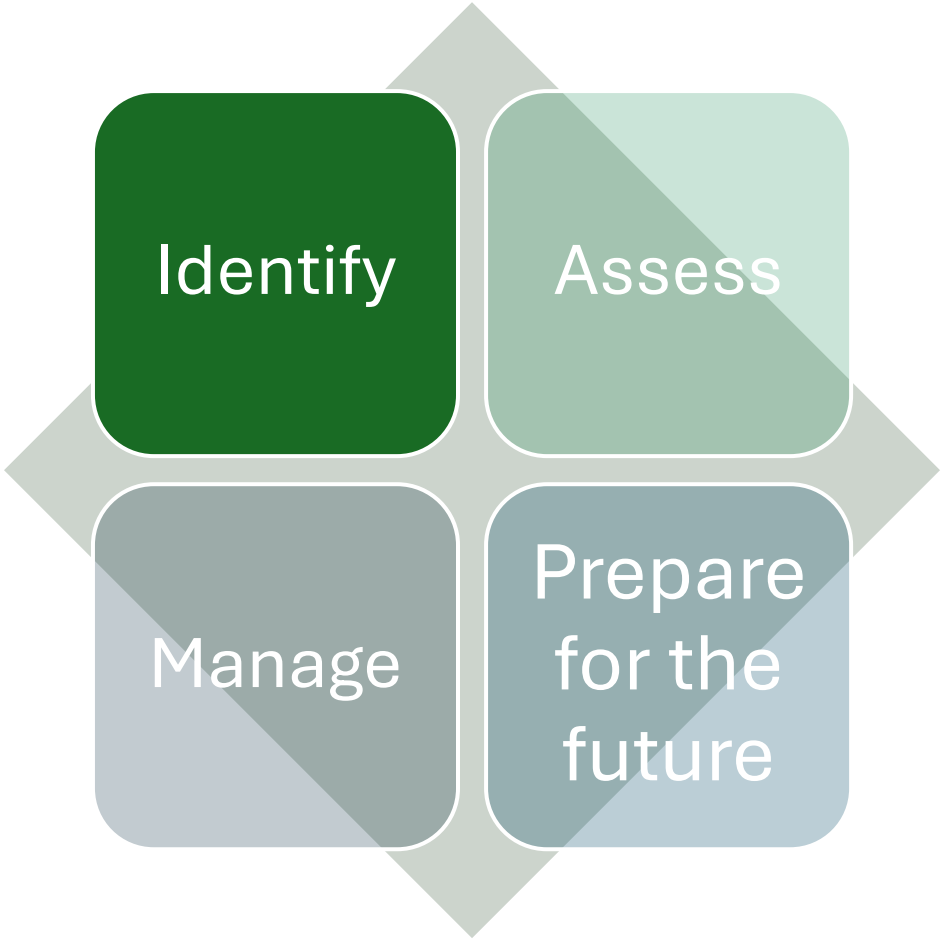
Palliative Care Approach



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Palliative Approach: Identify

Who might benefit from a palliative approach to care?

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How should we identify the right person?

- Prognostic Models and Risk Models?
- Symptoms?
- Hospitalizations?

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Can we identify patients with models?

No, not very well

Underestimates

Speaks about general populations, not your specific patient

Can start with the criteria for Advanced Heart Failure

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Table 2. European Society of Cardiology Criteria for Advanced Chronic Heart Failure

1. Moderate to severe symptoms of dyspnea and/or fatigue at rest or with minimal exertion (NYHA functional class III or IV)
2. Episodes of fluid retention and/or reduced cardiac output
3. Objective evidence of severe cardiac dysfunction demonstrated by at least 1 of the following:

   Left ventricular ejection fraction $<30\%$

   Pseudonormal or restrictive mitral inflow pattern by Doppler

   High left and/or right ventricular filling pressures, or

   Elevated B-type natriuretic peptide
4. Severe impairment of functional capacity as demonstrated by either inability to exercise, 6-min walk distance <300 m, or peak oxygen uptake <12 to 14 $mL \cdot g^{-1} \cdot min^{-1}$
5. History of at least 1 hospitalization in the past 6 mo
6. Characteristics should be present despite optimal medical therapy

NYHA indicates New York Heart Association.

Referral to specialized HF clinicians: I NEED HELP

I: Intravenous inotropes

N: New York Heart Association (NYHA) class IIIB/IV or persistently elevated natriuretic peptides

E: End-organ dysfunction

E: EF ≤35%

D: Defibrillator shocks

H: Hospitalizations >1

E: Edema despite escalating diuretics

L: Low systolic BP ≤90, high heart rate

P: Progressive intolerance or down-titration of guideline-directed medical therapy [GDMT])

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Consistent Predictors for Heart Failure

Increasing age

Lower ejection fraction

Higher NYHA class

Hyponatremia

Elevated and rising BUN

Repeated admissions to hospital

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From Selby, D. 2008

Gold Standards Framework

Predicting needs rather than exact prognostication.

- about **meeting needs** not giving defined timescales
- **more important** than working out the exact time remaining
- leads to better proactive care in alignment with preferences.

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Canadian Cardiovascular Society

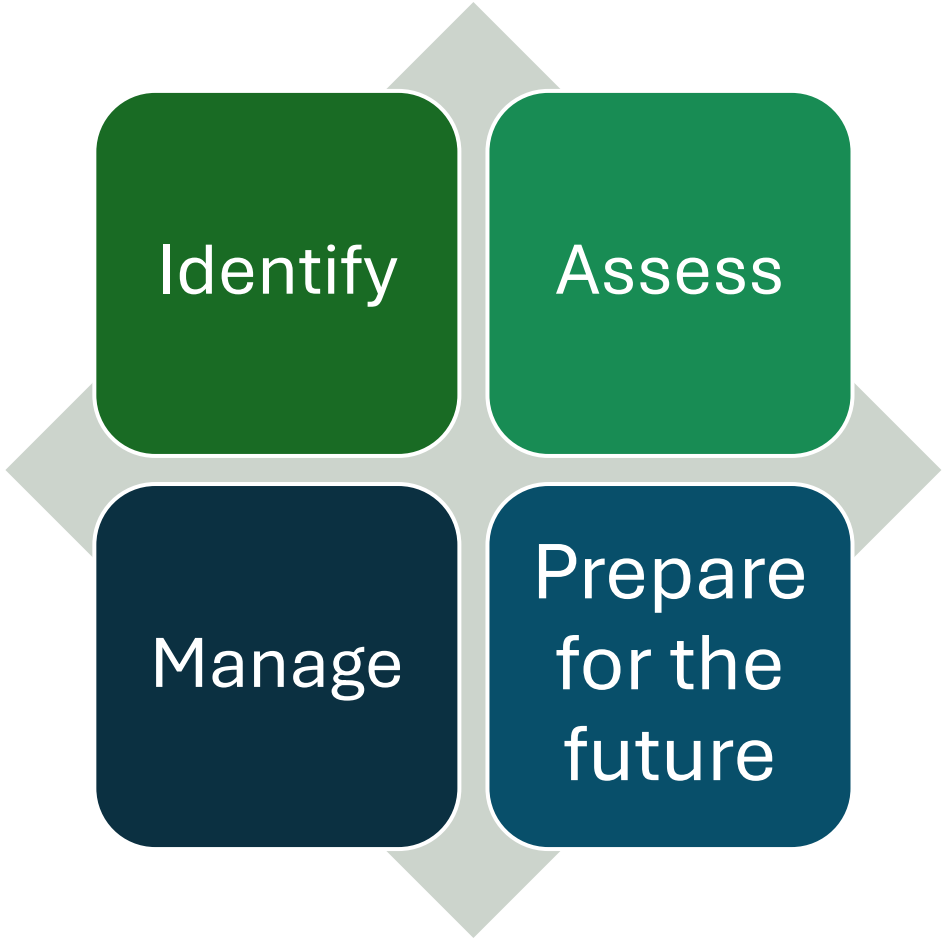
RECOMMENDATION

169. We recommend that clinicians caring for patients with HF should i
ongoing, and repeate
family regarding ac
Recommendation; V
170. We recommend that
to patients with HF
thorough assessment
than on individual
pectancy (Strong
Quality Evidence).
171. We recommend th
advanced HF sympt
confirmed, ideally by
expertise in HF management, to ensure appropriate HF management strategies have been considered and optimized, in the context of patient goals and comorbidities (Strong Recommendation; Very Low-Quality Evidence).

Provision of palliative care on the basis of assessment of needs and symptoms rather than estimates of remaining life.

CCS Heart Failure Recommendations Compendium

Palliative Care Approach



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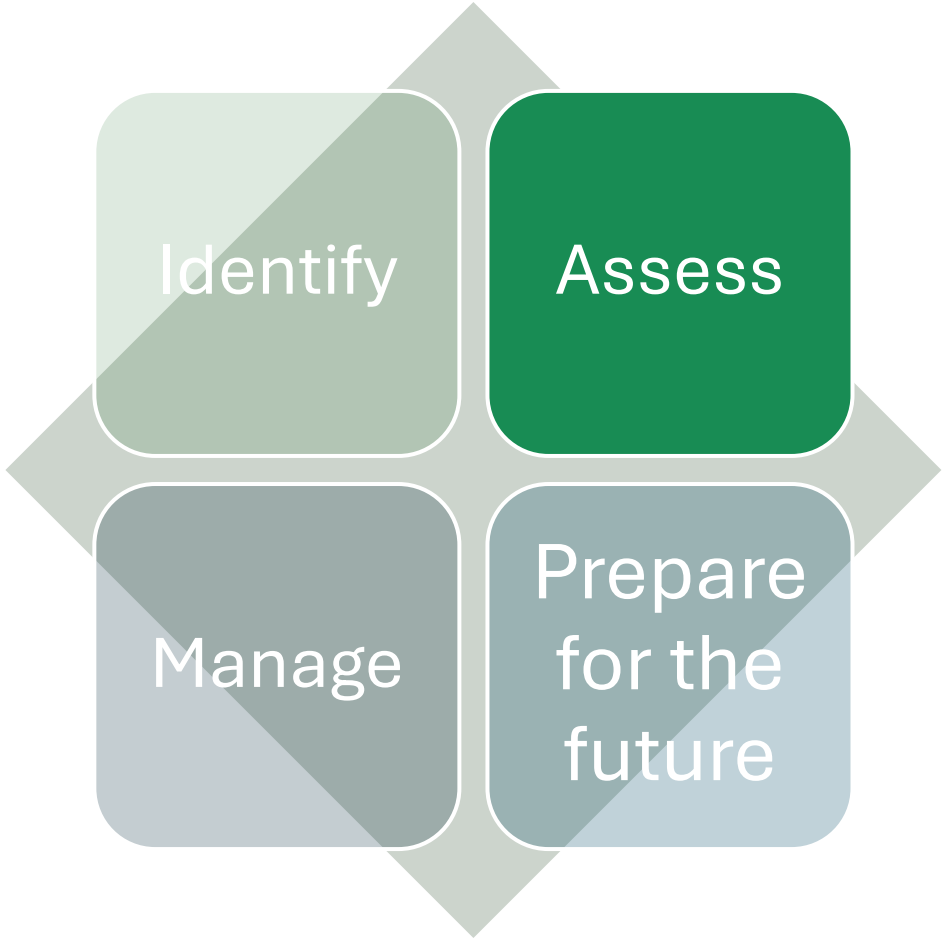
Palliative Care Approach



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What do we assess? Similar but different from oncology

- Illness understanding – e.g.trajectory and what to expect
- Symptoms
- Monitoring plans - weights
- Social Supports
- Values, beliefs, **fears, mood**
- Comorbidities
- Health care team members

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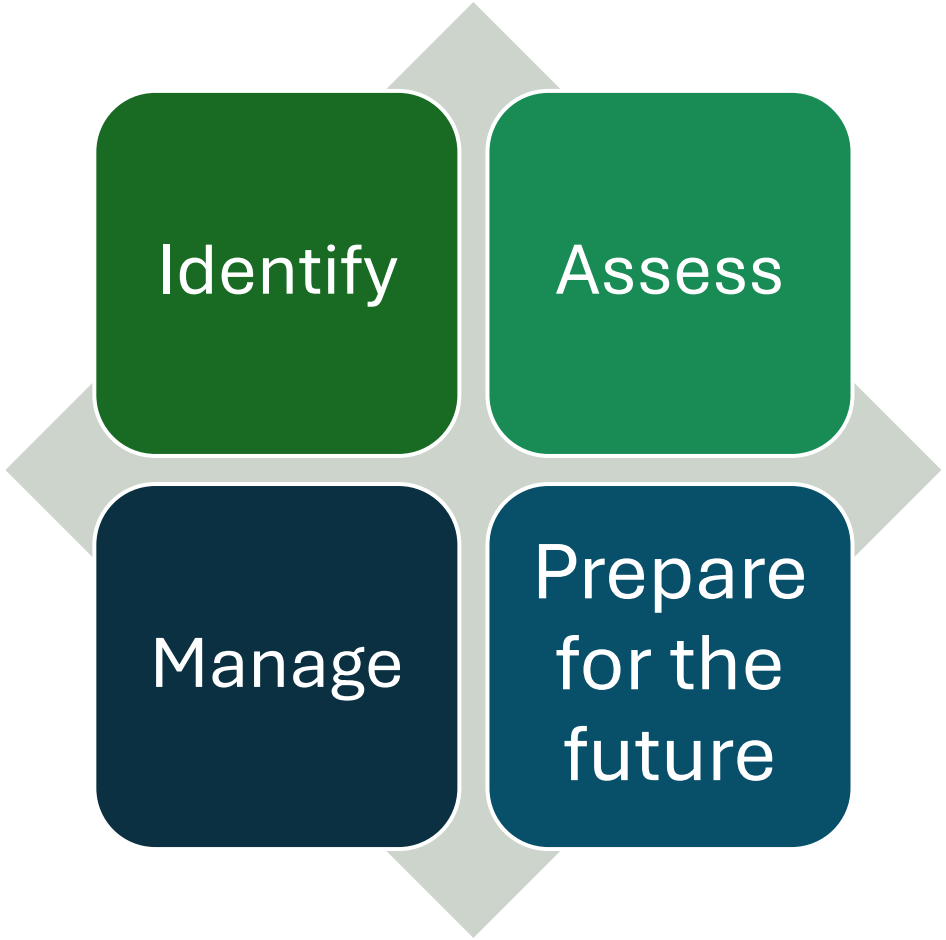
Palliative Care Approach



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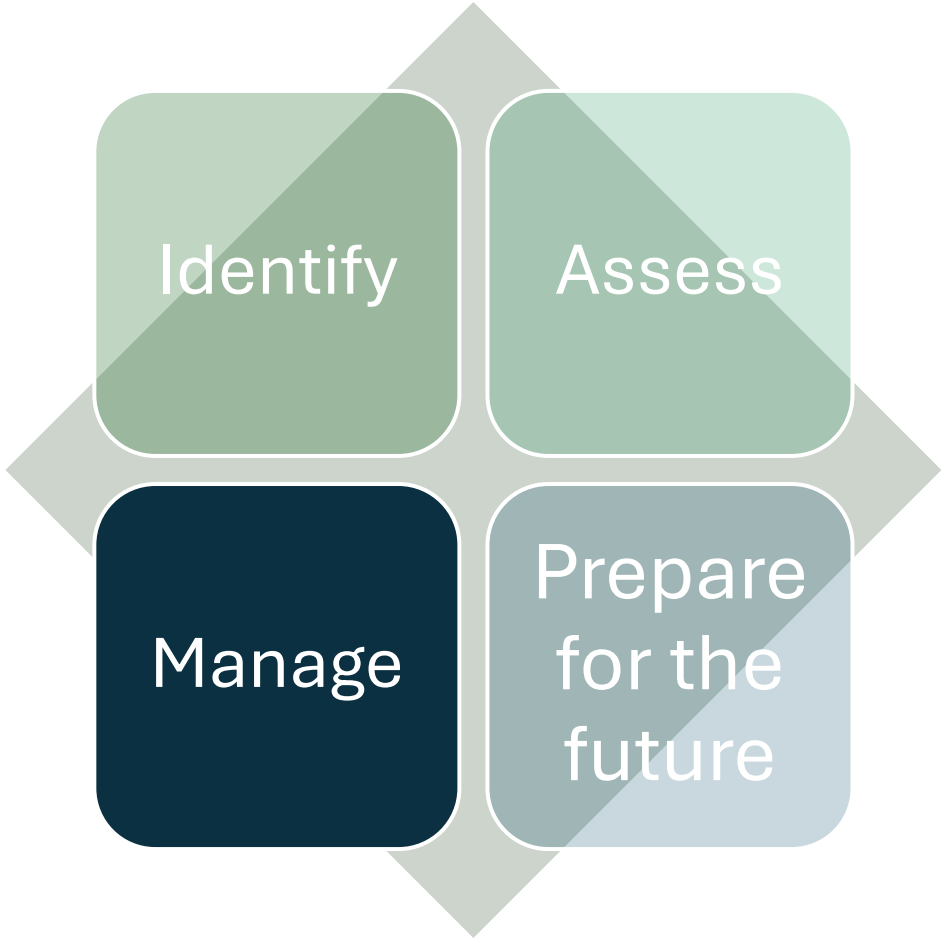

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Management

1. Create a collaborative **team**
2. Treat **symptoms**
3. Use skillful **communication** within team and with patients/loved ones
4. Use a **flexible** approach

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Create a Collaborative Team

1. Helps with the variable trajectory and uncertainty
   - Patients can recover; on-going cardiology support
   - Connect with current team or find support if possible (internist, cardiologist)

2. Use clear and responsive lines of communication
   - Who responds to patient requests?
   - Who manages what? (e.g. anticoagulation)

3. This team will look different in every community

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Collaborative team

At our centre:

- We learned that cardiology viewed themselves as integral to EOL care
- Didn’t want to “hand off patient”
- That was different from oncology
- Cardiology preferred a Collaboration with palliative care

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Collaborative team

- Provide direct support and communication

- Communication and HF pearls

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Communication

- Communication is not from a checklist

- Patient centred and supportive
- Slow
- Individualized
- Allow for emotion

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Symptom management

Applicable to patients whose goal is **comfort**

- **Stay** at home
- **Avoid** hospital
- **Avoid** monitoring

Protocol could

- **Increase** quality of life
- **Decrease** number of hospitalizations

Approach to advanced heart failure at the end of life

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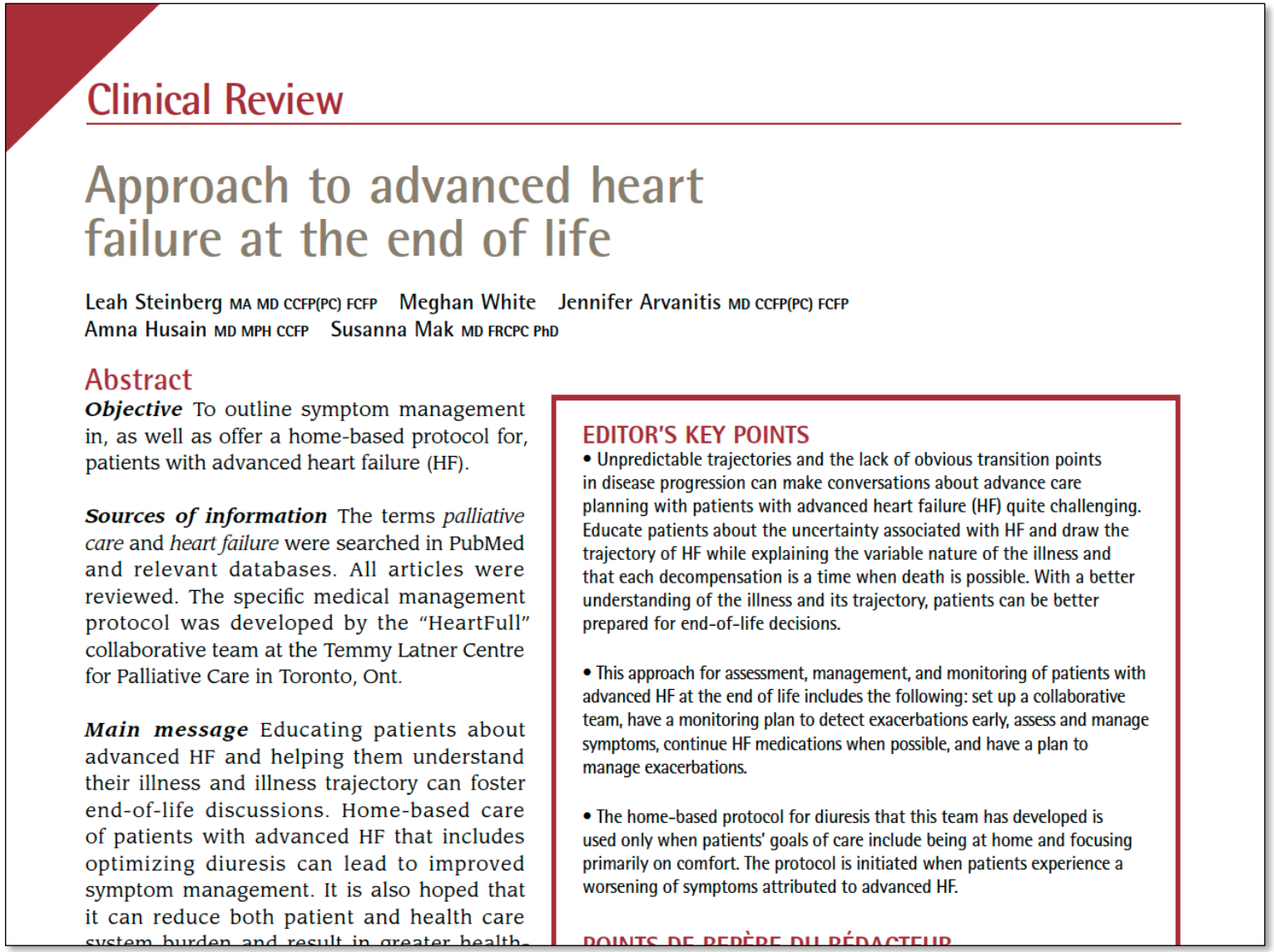
Steinberg et al. Can Fam Physician 2017



Clinical Review

Approach to advanced heart failure at the end of life

Leah Steinberg MA MD CCFP(PC) FCFP Meghan White Jennifer Arvanitis MD CCFP(PC) FCFP
Amna Husain MD MPH CCFP Susanna Mak MD FRCPC PhD

Abstract

Objective To outline symptom management in, as well as offer a home-based protocol for, patients with advanced heart failure (HF).

Sources of information The terms *palliative care* and *heart failure* were searched in PubMed and relevant databases. All articles were reviewed. The specific medical management protocol was developed by the "HeartFull" collaborative team at the Temmy Latner Centre for Palliative Care in Toronto, Ont.

Main message Educating patients about advanced HF and helping them understand their illness and illness trajectory can foster end-of-life discussions. Home-based care of patients with advanced HF that includes optimizing diuresis can lead to improved symptom management. It is also hoped that it can reduce both patient and health care system burden and result in greater health-

EDITOR'S KEY POINTS

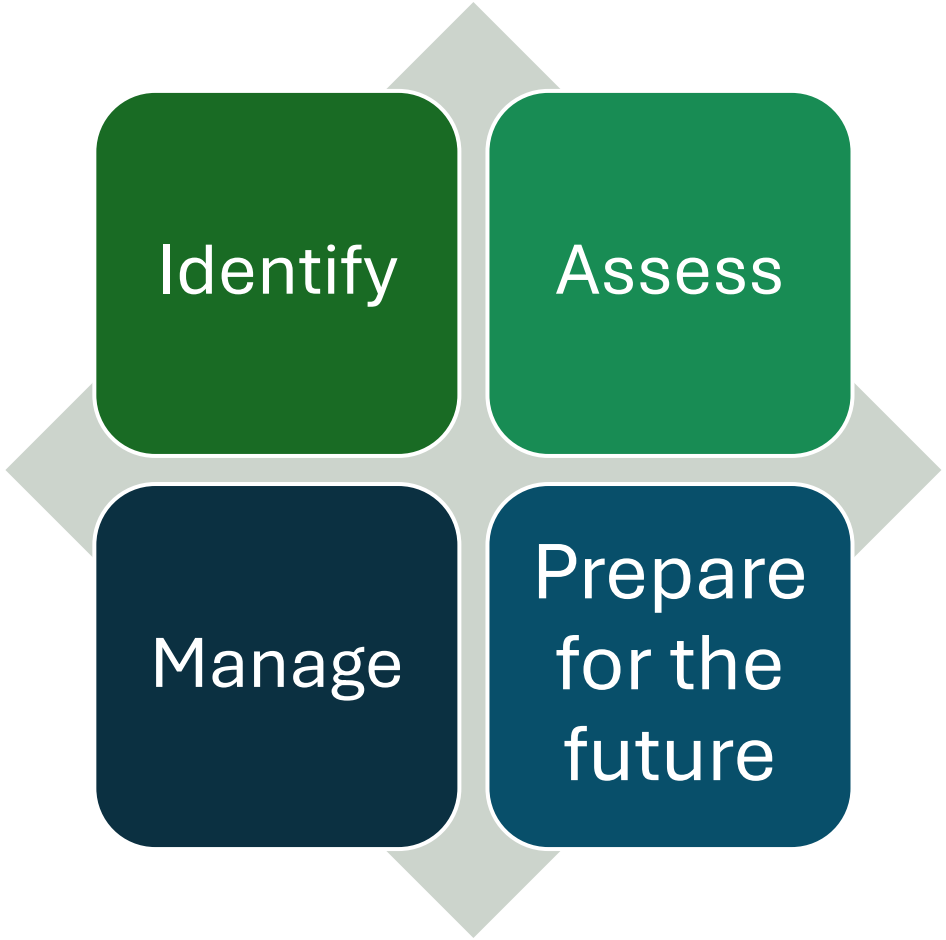
- Unpredictable trajectories and the lack of obvious transition points in disease progression can make conversations about advance care planning with patients with advanced heart failure (HF) quite challenging. Educate patients about the uncertainty associated with HF and draw the trajectory of HF while explaining the variable nature of the illness and that each decompensation is a time when death is possible. With a better understanding of the illness and its trajectory, patients can be better prepared for end-of-life decisions.

- This approach for assessment, management, and monitoring of patients with advanced HF at the end of life includes the following: set up a collaborative team, have a monitoring plan to detect exacerbations early, assess and manage symptoms, continue HF medications when possible, and have a plan to manage exacerbations.

- The home-based protocol for diuresis that this team has developed is used only when patients' goals of care include being at home and focusing primarily on comfort. The protocol is initiated when patients experience a worsening of symptoms attributed to advanced HF.

POINTS DE REPÈRE DU RÉDACTEUR

Palliative Care Approach



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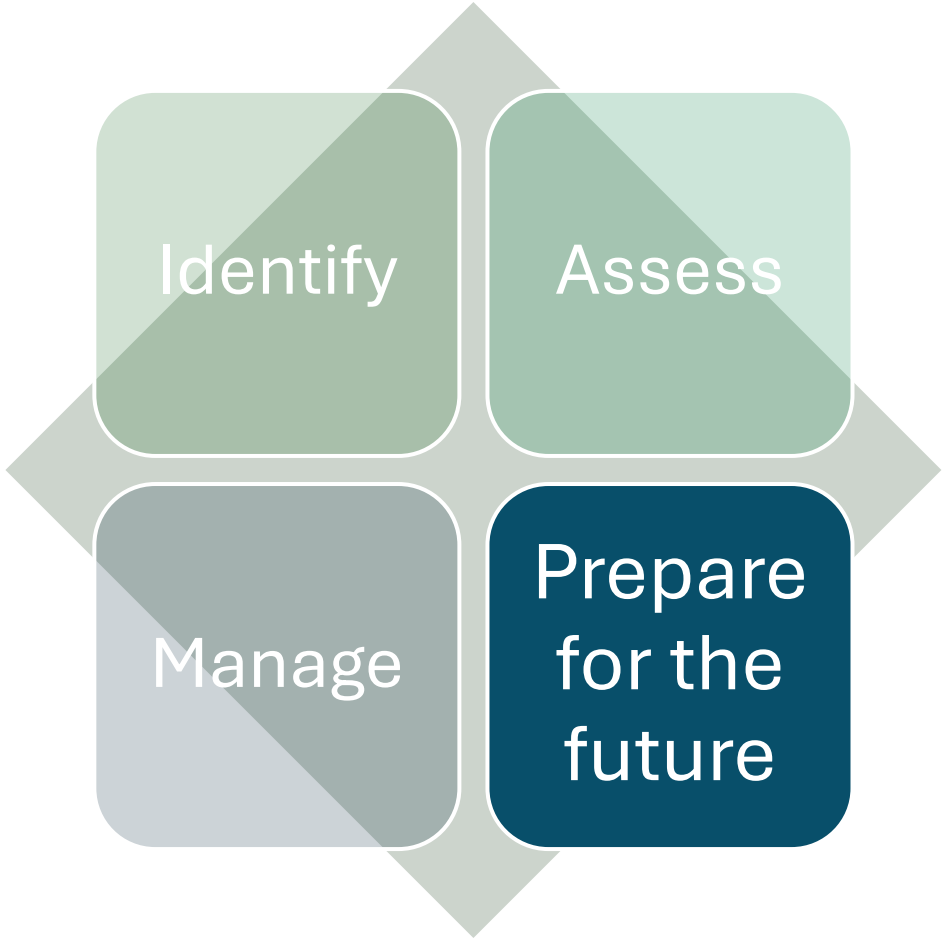
Palliative Care Approach



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What does prepare mean?

- Identify the substitute decision-maker
- Illness education: What to expect over time!
- Explore goals and values over time
- Doesn’t mean making treatment decisions in advance
- There is a lot of focus on decisions around life-sustaining treatments…but without good illness understanding, this can be confusing and traumatic

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Focus on Understanding

- Takes time
- Use plain language
- Ask about function not medical details
- Include family's understanding
- Draw trajectory
- Wait for opportunities

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Resources for you and your patients

- https://ourhearthub.ca/living-with-advanced-heart-failure/

- https://ourhearthub.ca/symptom-management/

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https://ourhearthub.ca/living-with-advanced-heart-failure/

Living with Advanced Heart Failure

Coping with Symptoms and Uncertainty

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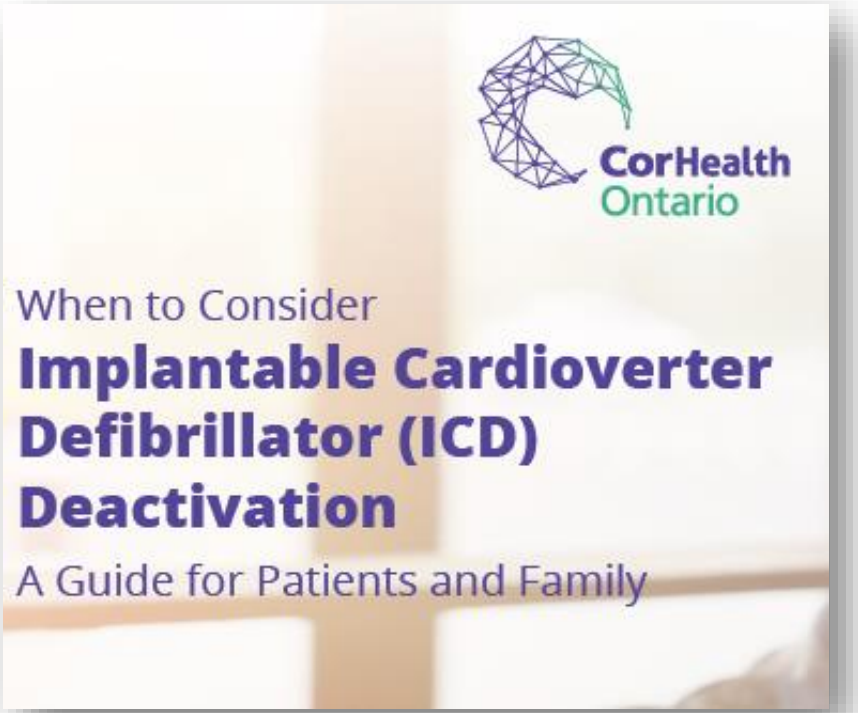

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Resources for ICD deactivation

- https://www.corhealthontario.ca/Implantable-Cardioverter-Defibrillator-Deactivation-A-Guide-for-Health-Care-Professionals.pdf

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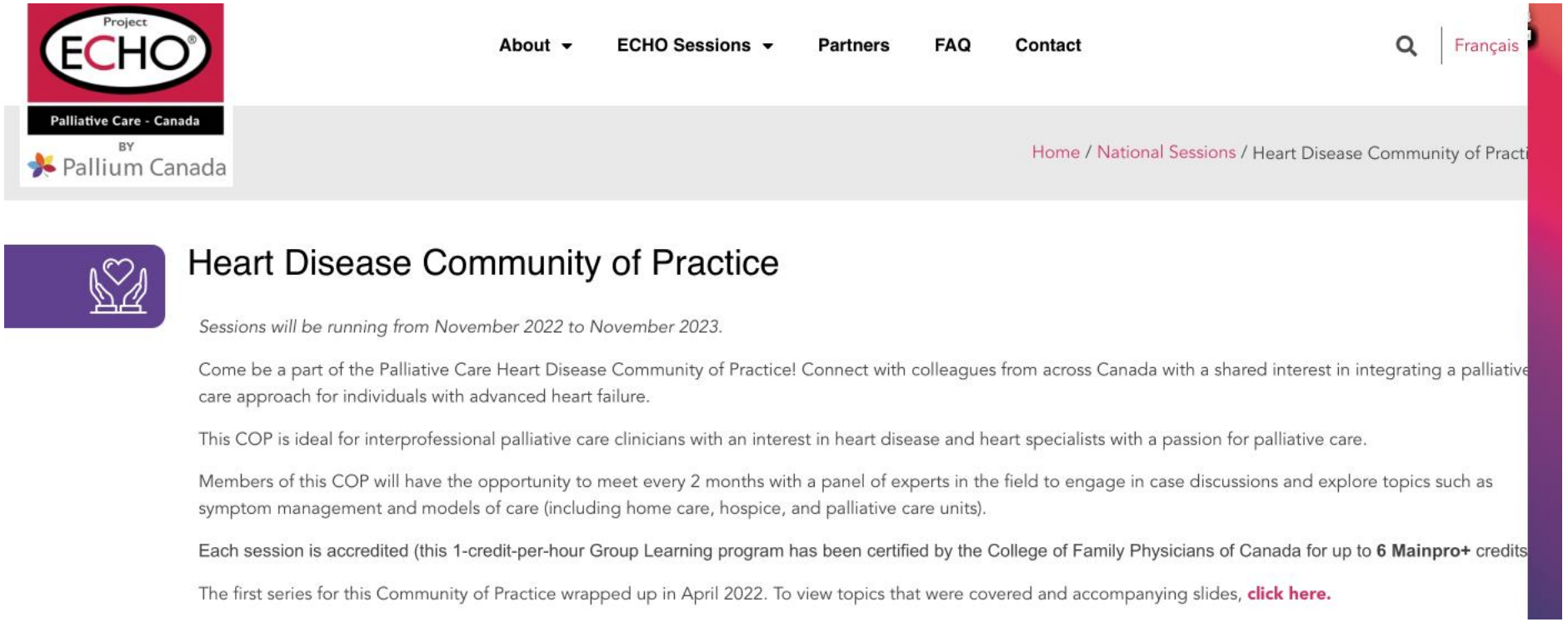
ECHO



[Heart Disease Community of Practice - The Palliative Care ECHO Project]

This COP connected colleagues from across Canada with a shared interest in integrating a palliative care approach for individuals with advanced heart failure. You can find the recordings from 3 webinar series hosted between January 2022 and August 2025 at the link above.

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Collaborative clinics

- Ottawa
- Barrie RVH
- SinaiHealth
- UHN
- London
- Vancouver
- Edmonton

Summary

- Collaboration is key
- Accept the variability
- Goals of care fluctuate with functional status
- Get comfortable with the grey area

Thank you!

Leah.Steinberg@sinaihealthsystem.ca

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Questions & Discussion

Join the…

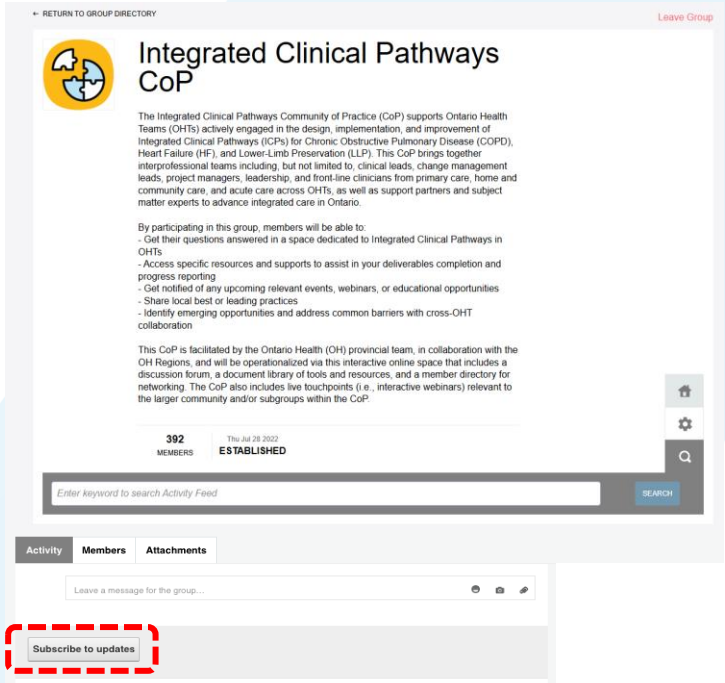
Community of Practice

Teams are encouraged to join the online **Integrated Clinical Pathways Community of Practice** in the OHT Shared Space to access and share resources, connect with peers, and advance integrated care.

1. Visit the OHT Shared Space and click "SIGN UP" to create your account.

2. Visit the Integrated Clinical Pathways CoP and click the "JOIN GROUP" button. You will receive an email notification when you've been accepted into the group.
   Note: You are automatically accepted into the "General Discussion" Group.

3. Don't forget to click on the "Subscribe to Updates" button once you've been accepted into your CoP!



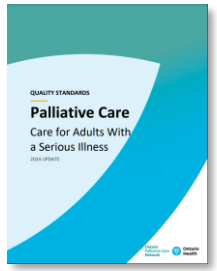
We want to hear from you!
We'd like to get your feedback to help tailor the CoP supports to your needs moving into FY25/
Please fill out this short survey!

Thank You

OH HF Project Team

Additional Resources

Key Tools and Resources

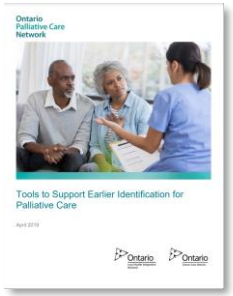


Palliative Care Quality Standard

Describes what high-quality palliative care should look like.

Competency Framework

A comprehensive guide to palliative care competencies required for every type of care provider, from specialists to volunteers.

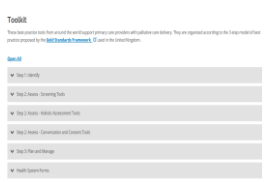


Tools for Earlier Identification

Tools to support earlier identification of patients who would benefit from palliative care.

Health Services Delivery Framework

An innovative Model of Care to enable adults with a life-limiting illness to remain at home as long as possible.



Online Palliative Care Toolkit

Best-practice tools from around the world to support primary care providers with palliative care delivery.

Goals of Care Resources

Four resources to enable better provider-patient conversations about goals of care.

- Person-Centred Decision Making
- Making Decisions about Your Care
- Approaches to Goals of Care Discussions
- Advance Care Planning FAQ

The Quality of Standard for Palliative Care

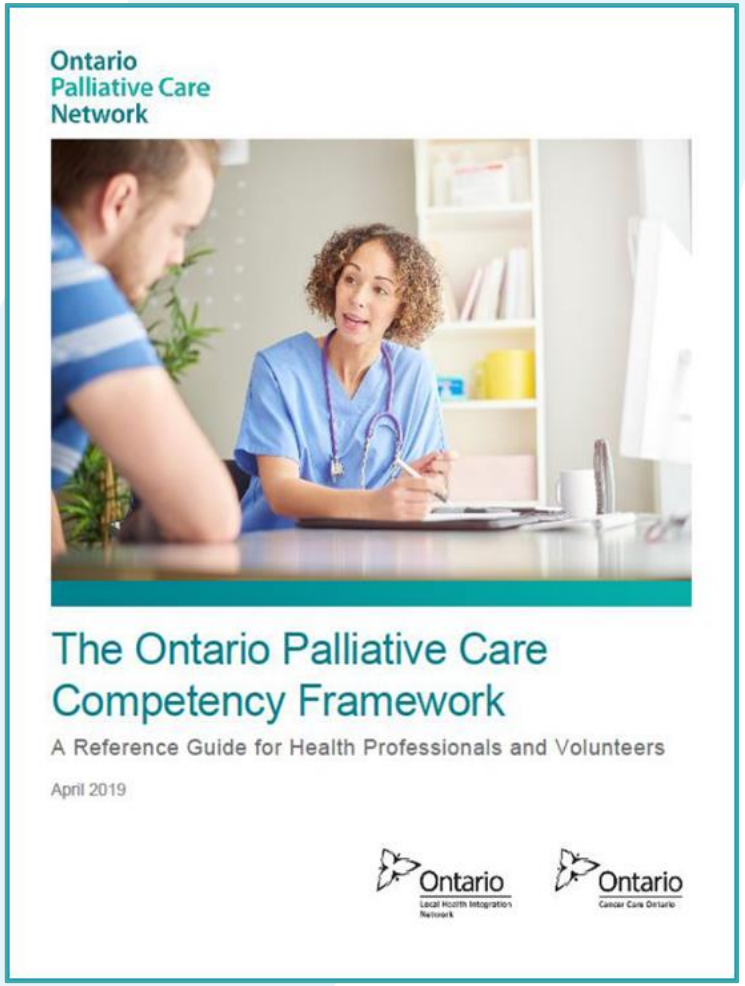
- Originally released in April 2018.
- Outlines **13 Quality Statements** that describe what high-quality
- palliative care should look like.
  - Applicable to care for adults in all settings, including home and community, hospice, hospital, and long-term care.
  - Provides quality indicators to evaluate how well performance is aligned with the standard.

- Includes a Patient Reference Guide, Placemat, Recommendations for Adoption and indicators to help assess quality of care.
- Recently underwent a 5-year review process. The updated materials are now available online.

Quality Standard for Palliative Care

Palliative Care Competency Framework

- Describes the knowledge, personal attributes and skills that providers need to deliver high-quality palliative care in Ontario.
- Applying these competencies in practice will lead to better care for people with a serious condition and encourage collaboration among professionals & organizations providing palliative care.
- Includes key professions commonly involved in palliative care delivery in Ontario.
- Competencies apply to all settings of care.
- Providers can use the guide to complete a self-assessment

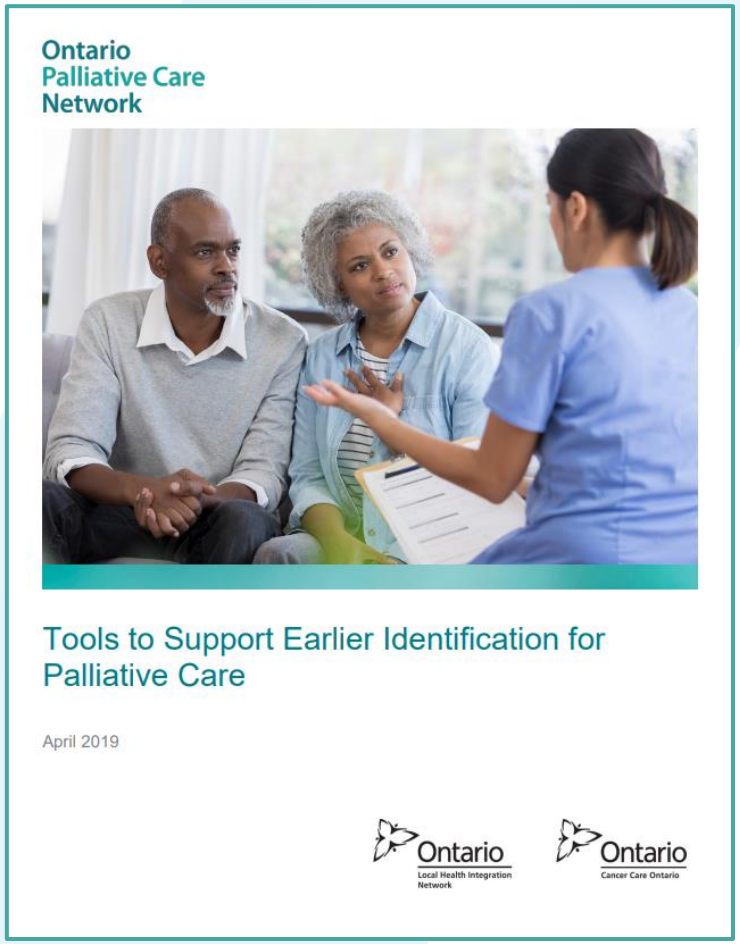


Palliative Care Competency Framework

Tools to Support Early ID for Palliative Care

The OPCN resource outlines tools and processes that lead to earlier identification and assessment of needs.

- Tools can be integrated across settings of care.
- The use of tools is not limited to a single point in time.
- Tools should be leveraged as the needs and health status of the patient change.
- Tools can be integrated into digital platforms that support patient care.



Tools to support Earlier Identification

Tools to Support Earlier ID: Preferred Tools

Tools/ Guides/ Indicator/ Trigger/ Score Name	Disease Status	Care Setting
Supportive & Palliative Care Indicator Tool (SPICT) https://www.spict.org.uk/	Not disease specific	All Settings
UK Gold Standards Framework – Proactive Identification Guidance (7th edition, 2022): Link to Organization	Not disease specific	All Settings
NECesidades PALiativas Centro de la Organizacion Mudial de la Salud (NECPAL CCOMS-ICO tool) Link to checklist version	Not disease specific	All Settings
RADboud Indicators for Palliative Care Needs (RADPAC) Link to review	Used only in CHF, COPD or Cancer Populations	All Settings (Not Current in ON)
Risk Evaluation for Support: Prediction for Elder-life in the Community Tool (RESPECT)	Not disease specific	Promoted in LTC and Other Community Settings
Hospital One-year Mortality Risk (HOMR)	Not disease specific	Acute Care Settings

Tools to Support Goals of Care Discussions

The Provincial Palliative Care Program has developed four tools to help care providers and patients engage in conversations that make sure treatment decisions align with a patient's wishes, values, and beliefs for their care.

Includes 2 provider resources, a patient resource, and an FAQ

- Person-Centred Decision Making
- Making Decisions about Your Care
- Approaches to Goals of Care Discussions
- Advance Care Planning FAQ

Resources are not disease-specific so can be used with all patients and in all care settings, and regardless of the type of serious illness.

Key Messages re: Tools and Resources

The Provincial Palliative Care Program was formed to develop a coordinated and standardized approach for delivering palliative care services in the province

- The Provincial Palliative Care Program has created various tools and resources to help advance provincial priorities for palliative care.
- To avoid duplication, and to ensure ongoing alignment with provincial direction OH Regions are encouraged to leverage existing tools and resources.

If you are looking for content or materials, reach out to the team for support.

Key Context Reading List

1. Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action (The Declaration), 2011
2. Framework on Palliative Care in Canada, 2018
3. Compassionate Care Act, 2020
4. Ontario Provincial Framework for Palliative Care, 2021
5. Progress on Ontario's Provincial Framework for Palliative Care, 2025
6. Fixing Long-Term Care Act, 2021
7. Plan to Stay Open: Health System Stability and Recovery
8. CIHI: Access to Palliative Care in Canada, 2023
9. The Framework on Palliative Care in Canada—Five Years Later: A Report on the State of Palliative Care in Canada, 2023
10. Palliative Care Quality Standard
11. Ontario Palliative Care Competency Framework
12. Palliative Health Services Delivery Framework
13. Tools to Support Earlier Identification for Palliative Care
14. Palliative Care Toolkit