The Heart Failure Policy Network

From guidelines to action

What's new in international heart failure guidelines?

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1. What is the role of clinical guidelines?

Clinical guidelines are evidence-based consensus documents that support healthcare professionals in making decisions about care. They are produced by panels of subject-matter experts, who make recommendations on best practice for the prevention, diagnosis, treatment and management of a condition based on high-quality evidence.

Guidelines provide recommendations, but do not replace individual clinical decision-making. These recommendations are not legally binding, but represent the state of the evidence at the time the guidelines were written.

This report provides a brief analysis of two foremost international heart failure (HF) guidelines and aims to help HF advocates understand how to use the guidelines to plan advocacy initiatives and prepare for opportunities for change in the future.

The international landscape of heart failure guidelines

In HF care, there are two sets of guidelines that have considerable reach across the world:

1. *Guidelines on the diagnosis and treatment of acute and chronic heart failure* published by the European Society of Cardiology (ESC)[1]
2. *Guideline for the management of heart failure* published by the American Heart Association (AHA), American College of Cardiologists (ACC) and the Heart Failure Society of America (HFSA).[2]

The ESC lists 57 national cardiac societies from across Europe, the Middle East and North Africa as members, in addition to 48 affiliated cardiac societies.[3,4] ESC members are not obliged to endorse or adopt the ESC guidelines, but many do so. Some member countries (e.g. England) also have national bodies which produce their own independent guidelines.[5] ESC clinical guidelines are developed by task forces made up of experts from across the region.

The AHA is the national cardiac society of the US, and members of its guideline writing committee are US-based. Nonetheless, the AHA/ACC/HFSA guidelines are influential beyond the US, with both the AHA and the ACC running international medical education programmes and publishing international journals that also disseminate the guidelines.

The wide reach of both sets of guidelines means that their authors must decide whether to consider the different levels of resourcing and different health systems in the various countries in which the guidelines might be implemented. This can lead to differentiation in recommendations, and authors must decide whether to recommend the best care possible regardless of feasibility and availability.[6,7]

2. How are the heart failure clinical guidelines developed?

ESC guidelines

The ESC guidelines are consensus documents, revised every two to five years by an expert task force.[8] The task force examines the evidence base for the treatment and management of HF according to strict standards of evidence set by the ESC. The guidelines are entirely funded by the ESC. Task force members must declare any potential conflict of interest.[9]

Where evidence suggests that the published guidelines are no longer accurately reflecting best practice, the ESC Board and the Committee for Practice Guidelines can give permission for an update or full revision of the guidelines sooner than planned.[8]

AHA/ACC/HFSA guidelines

The AHA and the ACC have been producing clinical practice guidelines since the 1980s.[2 10] Like the ESC guidelines, the American guidelines are consensus documents entirely funded by the clinical societies.[2] Experts who are employed by the pharmaceutical industry, either full- or part-time, are not allowed to join guideline committees.[11] Any other relationships with industry must be declared and are assessed by joint committees of the AHA and ACC.

Currently, evidence is re-reviewed every year following the guideline's publication, with the writing committee surveyed on whether a guideline update is warranted. Once two updates have taken place, or evidence suggests that a certain number of recommendations should be revised, a full revision of the guideline is commissioned, with half of the writing committee replaced by new members. However, in the future specific sections the ACC/AHA guidelines will be updated on an ad hoc basis in line with developments in evidence and the concepts of 'full revisions' and 'focused updates' will be phased out.[2]

3. What has changed in the most recent guidelines?

ESC guidelines, 2021

The European Society of Cardiology published its latest *Guidelines for the diagnosis and treatment of acute and chronic heart failure* in August 2021.[1] The document aims to 'present all the relevant evidence on [the diagnosis and treatment of acute and chronic heart failure] in order to help physicians weigh the benefits and risks of a particular diagnostic or therapeutic procedure'.[1] The previous version was published in 2016.[12]

Some of the key changes to the ESC guidelines in 2021 include:[1]

- new dedicated recommendations for the management of HF alongside commonly co-occurring conditions
- parallel initiation of four 'cornerstone' pharmacological treatments for people living with HF with reduced ejection fraction (HFrEF), as soon as possible after diagnosis
- updated recommendations for patient education and person-centred disease management programmes
- new recommendations on the management of cardiac amyloidosis, reflecting the development of evidence in this area since 2016[2]
- inclusion of key quality indicators.

For a more detailed discussion of the 2021 ESC HF guidelines, please read the HFPN report *From guidelines to action: opportunities for change following the 2021 ESC guidelines*.

AHA/ACC/HFSA guidelines, 2022

The most recent version of the US guidelines was released in April 2022.[2] Before this, the last full version was published in 2013, with a 'focused update' released in 2017.[7]

Key changes introduced in the 2022 AHA/ACC/HFSA guidelines include:[2]

- the addition of SGLT2 inhibitors to the list of cornerstone medications recommended for all people with HFrEF[2]
- a recommendation that SGLT2 inhibitors can be beneficial in reducing hospitalisations and cardiovascular mortality in people living with HF with preserved ejection fraction (HFpEF)[2 13]
- a full section on cardiac amyloidosis.[2]

The guidelines also introduced a new staging system for HF, with recommendations for people who are considered to be 'at risk of HF' and people who have 'pre-HF', defined as those who have 'no signs and symptoms, but may have abnormal cardiac function, structure or biomarkers', as well as for people with HF and advanced HF.[2] This staging system is part of a renewed focus on preventing the development and progression of HF, and seems likely to encourage a shift towards prevention in practice.[6]

4. What can we expect from future guidelines?

The timing of guidelines' publication can make an enormous difference to their content. The 2021 ESC guidelines were published shortly before the results were released from two major trials of SGLT2 inhibitors for people with HFpEF. As we can see from the inclusion of a new recommendation in this area in the AHA/ACC/HFSA guidelines, the results of these trials are likely to lead to consideration of such a recommendation in future ESC guidelines.

While recommendations for the use of telemonitoring are included in the ESC guidelines, they are not classed among the highest level of recommendations due to a lack of high-quality evidence. As more randomised controlled trials are carried out using digital tools and remote management programmes following the increased acceptability of eHealth solutions precipitated by the COVID-19 pandemic, it is likely that this evidence will become stronger. This could well lead to more detailed and stronger recommendations for the use of telemonitoring, as well as other forms of eHealth.

The writing committee for the 2022 US guidelines has included a list of 'evidence gaps and future research directions' within the guidelines document:[2]

- The classification of different 'types' of HF according to ejection fraction, and whether this should continue
- Risk stratification in screening for HF
- The potential role of precision medicine in the management of HF
- Developing effective management strategies for people with HFpEF, including pharmacological treatments
- Further studies on telemonitoring and other forms of digital health, including AI, in both diagnostic and management processes.

This list is wide-ranging and includes a number of topics that HF advocates may wish to include in their future plans for policy influencing.

What does this mean for people living with HF?

Recent changes in both the ESC and the AHA/ACC/HFSA guidelines, along with emergent trends in research that are likely to drive future recommendations, indicate that this is a pivotal time for the HF community.

New, more detailed guidance on how to formulate person-centred care – taking into account co-occurring conditions and the increasingly recognised importance of nurse-led programmes and telemedicine – promises to make living with HF a more manageable experience for many people.

In the meantime, it is clear that clinical societies in both Europe and the US are acutely aware of the prospect of increasing HF prevalence. This is reflected in an increased focus on early diagnosis and prevention of both emerging and worsening HF through better disease management. People living with HFpEF, who have historically had limited options available in terms of effective pharmacological treatments, may be able to benefit from new research on the mechanisms of all types of HF and subsequent trials of pharmacological therapies that have proven effective in HFrEF. Ensuring that people with all types of HF are able to access guideline-based care in the future may therefore become an even greater challenge, as the number of people needing intervention is likely to increase.

How can the heart failure community respond to future changes in guidelines?

While advocates should not seek to influence the guidelines, there are some ways in which health system leaders, healthcare professionals, patient organisations and other HF advocates can prepare for likely upcoming changes in the guidelines and ensure that as many people with HF as possible receive guideline-recommended care:

1. Raising awareness among policymakers and decision-makers around the content of the current guidelines and likely future updates
2. Campaigning for the latest guidelines to be quickly reflected in key documents, including national strategies and local care pathways, professional guidance, patient information, regulatory frameworks, quality metrics and commissioning, coverage or reimbursement policies
3. Collecting information from people with HF about whether they are receiving care in line with existing guidelines
4. Promoting and advocating for further research into the realities of service provision and the experiences of people living with different types of HF
5. Staying abreast of any new published evidence that may influence the direction of future guidelines.

By being prepared to deliver on future guidelines, we can ultimately improve care for people living with HF.

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About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary group of healthcare professionals, patient advocacy groups, policymakers and other stakeholders from across Europe whose goal is to raise awareness of unmet needs surrounding heart failure and its care. All members provide their time for free. All Network content is non-promotional and non-commercial. The Secretariat is provided by The Health Policy Partnership Ltd, an independent health policy consultancy based in London.

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