



2

Challenges and Shifting Paradigms

HEART FAILURE:
UPDATE FOR PRIMARY CARE

‘Corcare Quality and Education Platform’

The Corcare Quality and Education Platform(CQEP),
is a Canadian not-for-profit corporation
Providing quality of care research and medical education
for community care providers
to advance the secondary prevention of cardiovascular disease.

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Learning Objectives

During this session, participants will analyze and interpret the:

- foundational therapies for Patients with Reduced Ejection Fraction
- importance of Collaborative Care between Primary Care and Specialists
- practical approaches to achieving targets for care

ASCVD Secondary Prevention

The Standard of Care

Global Cardiovascular Risk

In one Generation

- Global CVD mortality has fallen >50%
- Myocardial Infarction Mortality declined from 30% to 4%
- > 80% decline in cardiovascular risk factors

55% of the outcome improvement
Due to medical secondary prevention therapies

Why Does Secondary Prevention Matter?

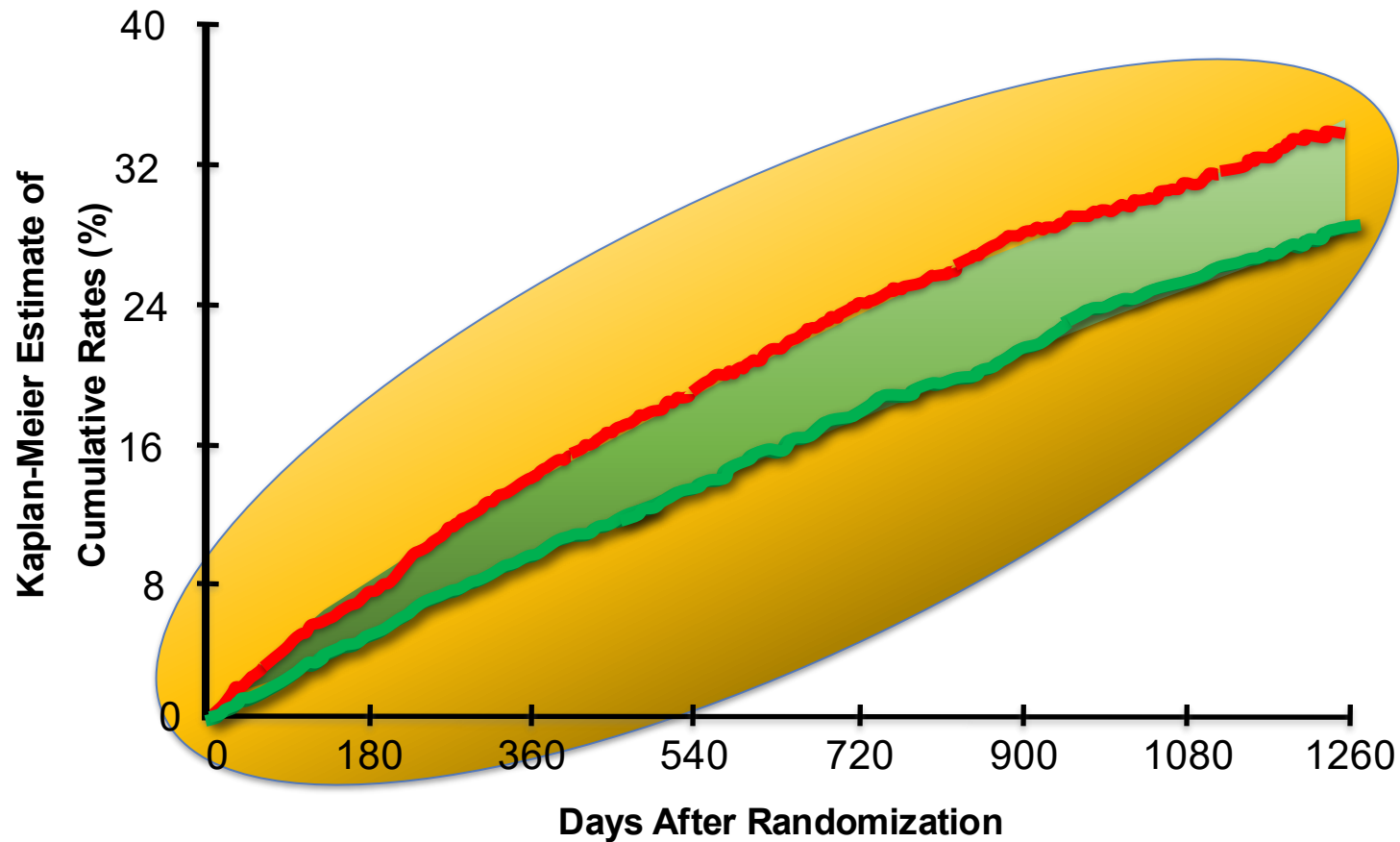
- Vascular Event
- Symptoms
- Imaging evidence
- Risk Score

Symptoms and Events

Cardiac	MI, CHF,
Neurologic	Stroke, TIA
Renal	CKD
Vascular	Claudication, gangrene

↓ Quality of Life
↓ Survival

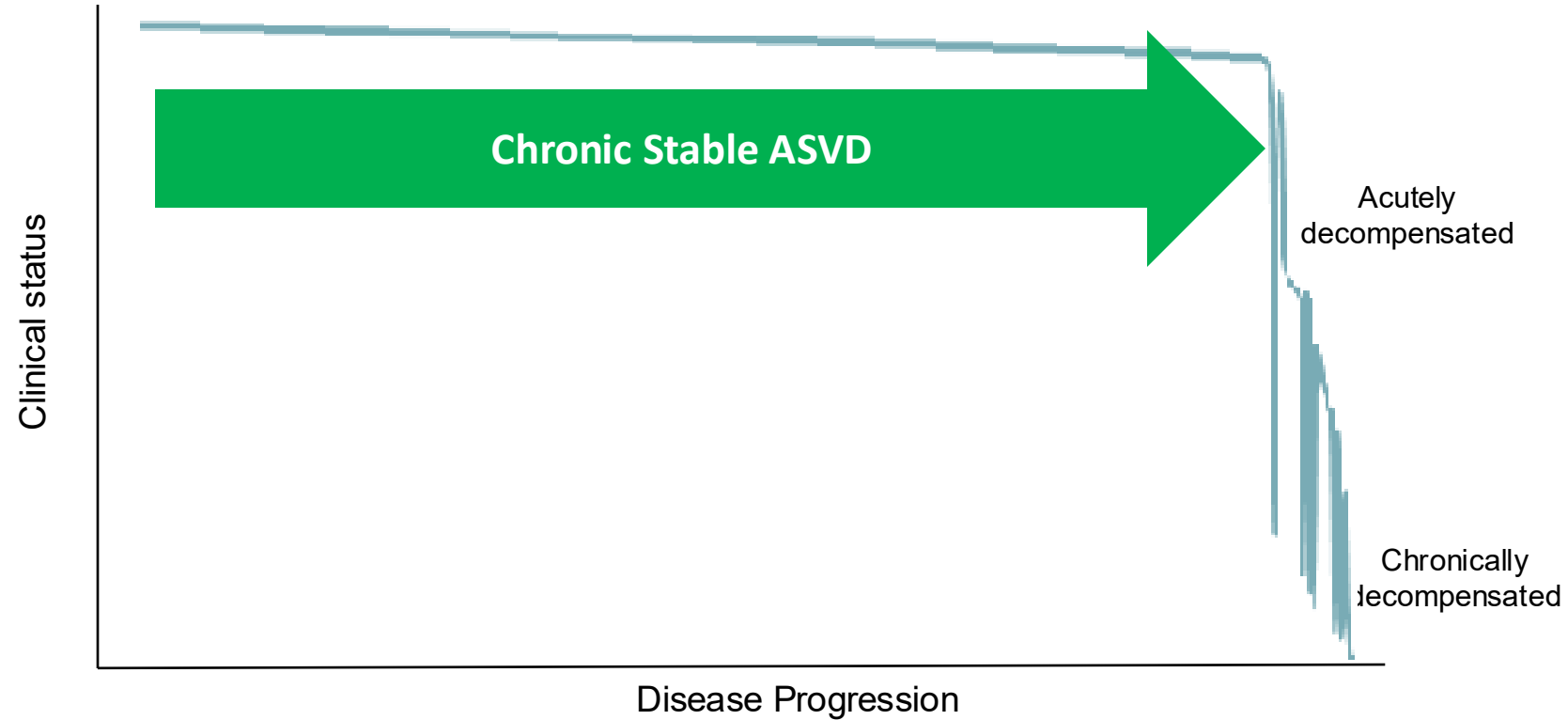
Time Under Treatment Matters



Benefits start early

& increase over time

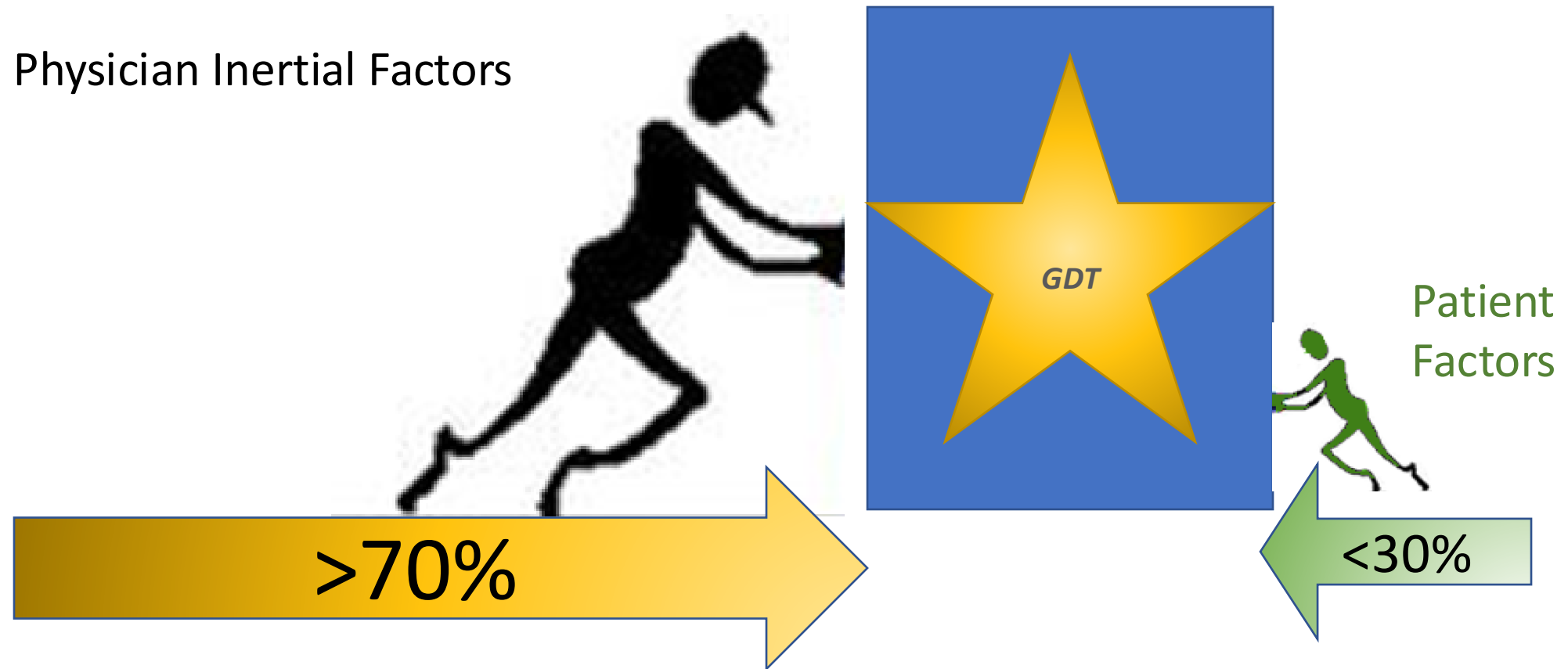
Reframe the Perspective as Lifelong!



ASCVD as a Chronic Condition

Providers Drive Good Patient Outcomes!

Focus on Positives not the negative (Inertia)

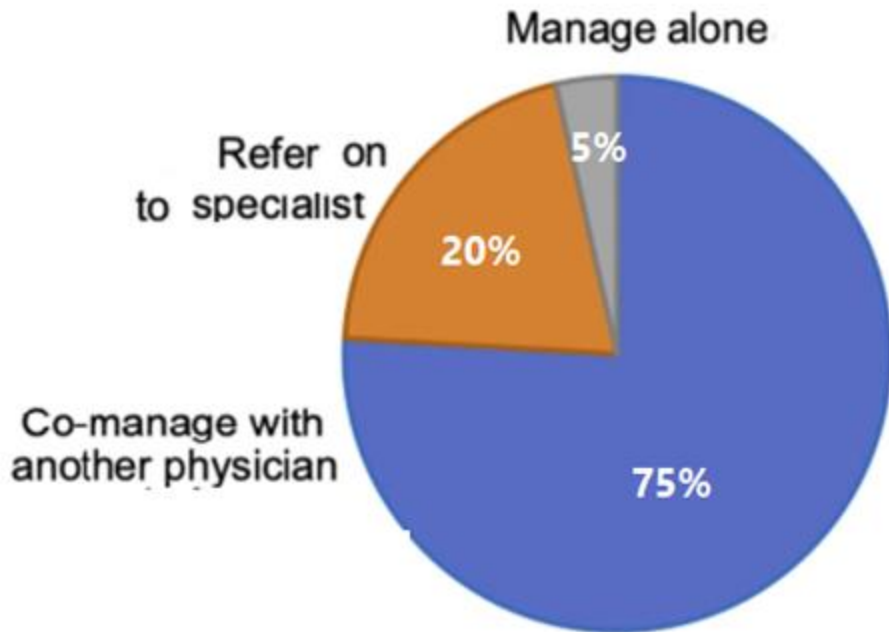


Secondary Prevention

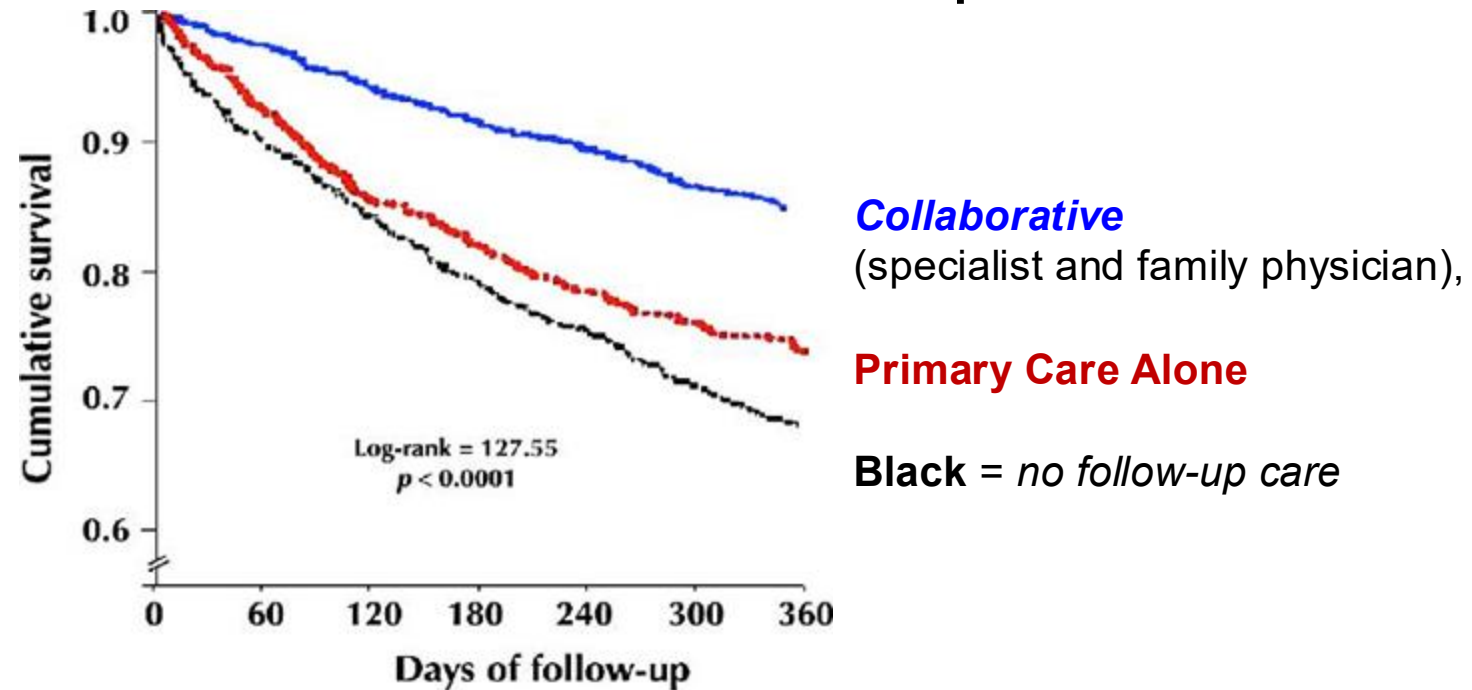


Expect Primary Care & Specialist Alignment

Co-Management



- Provide Collaboration Improves



Heart Failure is a Large Problem



Prevalence CANADA

- 787,000 HF patients in Canada > 40 old
- 111,900 New diagnosis of HF each year



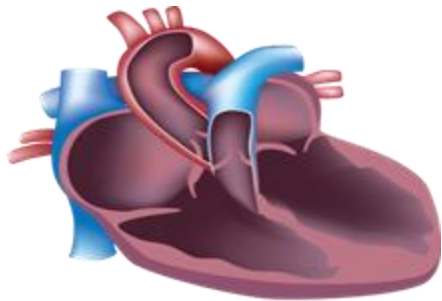
Prevalence Our Community 1M (3% Canada)

- >23,000 HF patients in Scarborough/Durham
- > 3,000 New diagnosis of HF each year

Types of Heart Failure

HF-REF

reduced ejection fraction
EF \leq 35-40%

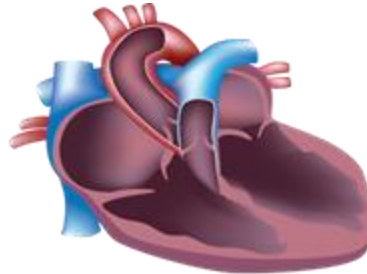


Systolic dysfunction

Enlarged Heart
thinned LV walls,
decreased systolic function

HFMEF

Moderately reduced ejection
fraction
EF \leq 41-50%



Mild Systolic dysfunction

+/- Enlarged Heart
+/- Thinned walls
borderline systolic function

HF-PEF

Heart failure with preserved
ejection fraction EF 50%



Diastolic dysfunction

normal LV size
+/- thickened walls
normal systolic function

6 Facts About HFrEF vs HFpEF

- HFrEF and HFpEF are equally common
- HFpEF and HFrEF cannot be distinguished clinically
- ASCVD is a common cause of HFrEF but not HFpEF
- HF is the commonest cause of death in diabetes, hypertension and obesity
- Amyloidosis is a common & underdiagnosed cause of HFrEF (5%) and HFpEF (30%)
- Foundational therapies for HFrEF are effective and disease altering, but less so for HFpEF

HFrEF and HFpEF are Different Conditions

HF-pEF

Heart failure with preserved
ejection fraction EF 50%

HF-mEF

Heart failure with intermediate
ejection fraction EF 40- 50%

HF-rEF

reduced ejection fraction
EF \leq 35-40%

HFrEF and HFpEF are Different Conditions

HFrEF

reduced ejection fraction
EF \leq 35-40%

Ischemic Heart Disease:	50%
Non Ischemic Heart Disease	50%
Idiopathic/DM/BP/Obesity	40%
Amyloidosis	5%
Other	<5%

HFpEF

Heart failure with preserved
ejection fraction EF 50%

Ischemic Heart Disease	0%
Non Ischemic Heart Disease	100%
Idiopathic/DM/BP/Obesity	70%
Amyloidosis	30%

Non-Ischemic HFrEF

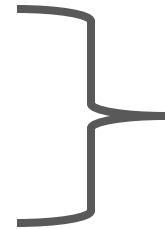
More Common Causes of HFrEF 90%

Myocardial

Idiopathic

Diabetes

Hypertensive



80 %

Less Common Causes of HF < 10%

Amyloid

5%

Valvular

5%

ETOH

Myocarditis

Post partum Cardiomyopathy

Thyroid disease

Hemochromatosis

Diagnosis of Heart Failure

Assess symptoms breathlessness, fatigue, angina, palpitations or syncope

Assess signs HR, BP, murmurs, fluid overload,

ECG ECG

Laboratory nt-pro BNP, Hg

Chest X-ray Pulmonary congestion

Echocardiography HFrEF vs HFpEF, wall motion, valve, LV function; valves

Diagnosis of the Cause of Heart Failure

Echocardiogram	Ejection Fraction Wall motion Hypertrophy Valve Disease
CAD	Myocardial Perfusion Scan
Amyloid	Cardiac aTTR Tc99 amyloid scan
Laboratory	Immunoelectrophoretic, Light Chains Thyroid Function, Ferritin
Genetics *	Hattr, Cardiomyopathy, Hypertrophic Cardiomyopathy
Cardiac Consultation	CCS guideline recommended

* Now covered in the Province of Ontario

My Patient has Reduced Ejection Fraction . What do I do first?

- I. Review goals with patient, start foundational medications and provide follow-up
- II. Review goals with patient, Initiate foundational therapies and refer to a cardiologist for concurrent care
- III. Refer to a cardiologist to initiate care and jointly follow patient
- IV. Refer to cardiologist to assume care
- V. Refer to a heart failure clinic

Large Demands Need Scalable Solutions

- >23,000** Chronic HF patients in Scarborough/Durham
- > 3,000** New diagnosis of HF each year

7 Facts About Heart Failure Therapy

- Heart Failure is a chronic condition
- Foundation therapy improves quality of care and survival
- Ejection fraction improves and can normalize with optimal therapy
- Effective therapy requires doses tested in trials
- Time under treatment matters: Early Better
- Best outcomes occur when the primary care and physicians collaborate
- Stopping therapy not recommended when stable as 10%+ 'Rebound' (even if Ejection Fraction Normalizes!!)

The “Pillars of Care”

CCS Heart Failure Guidelines # 27

We recommend using specific drugs at target doses proven beneficial in clinical trials as optimal medical therapy.

If these doses cannot be achieved, the maximally tolerated dose is acceptable

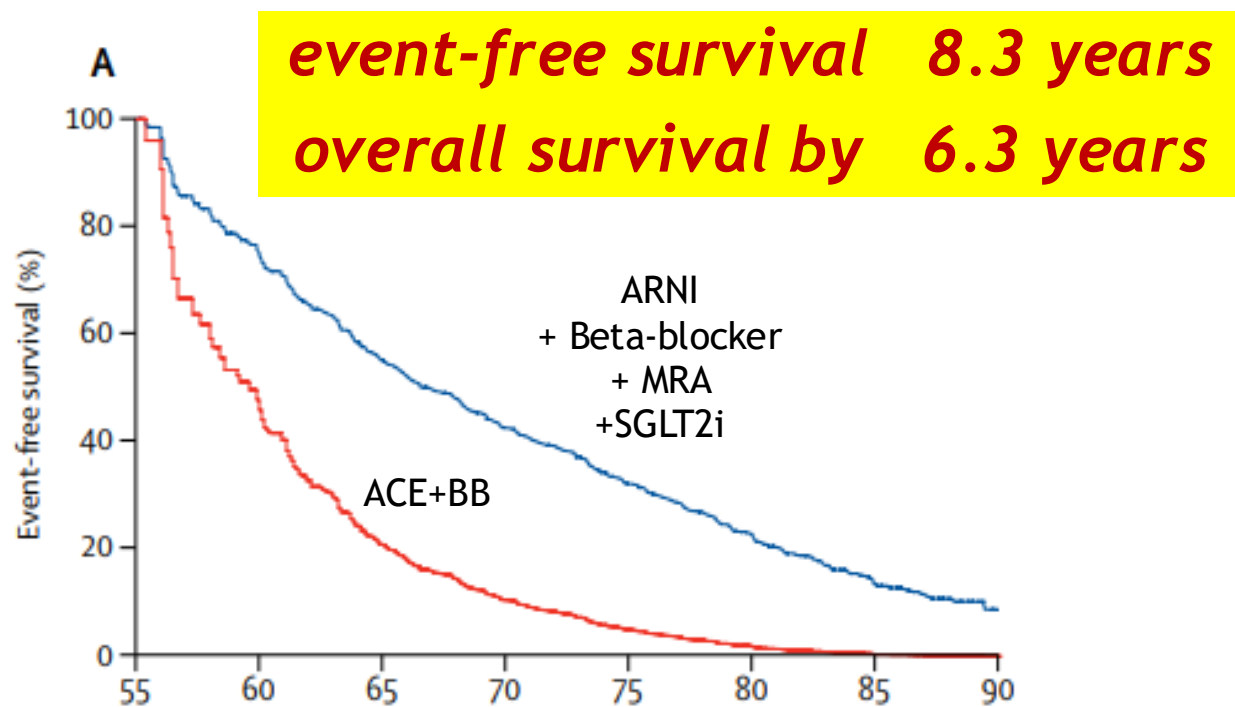
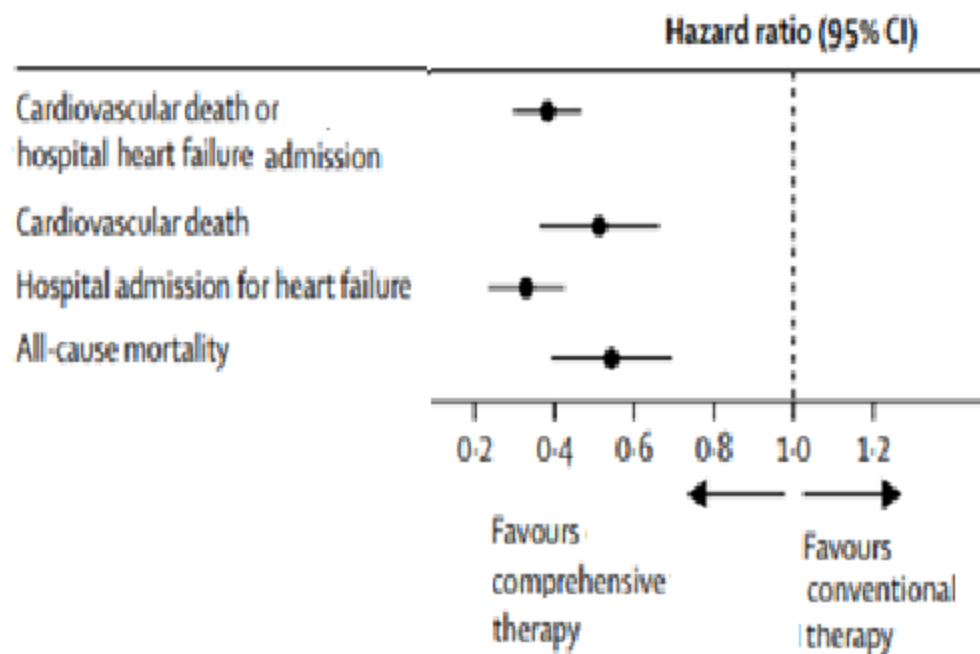
Strong recommendation: High Quality Evidence

THESE ARE STANDARDS
OF CARE

NOT

GUIDELINES

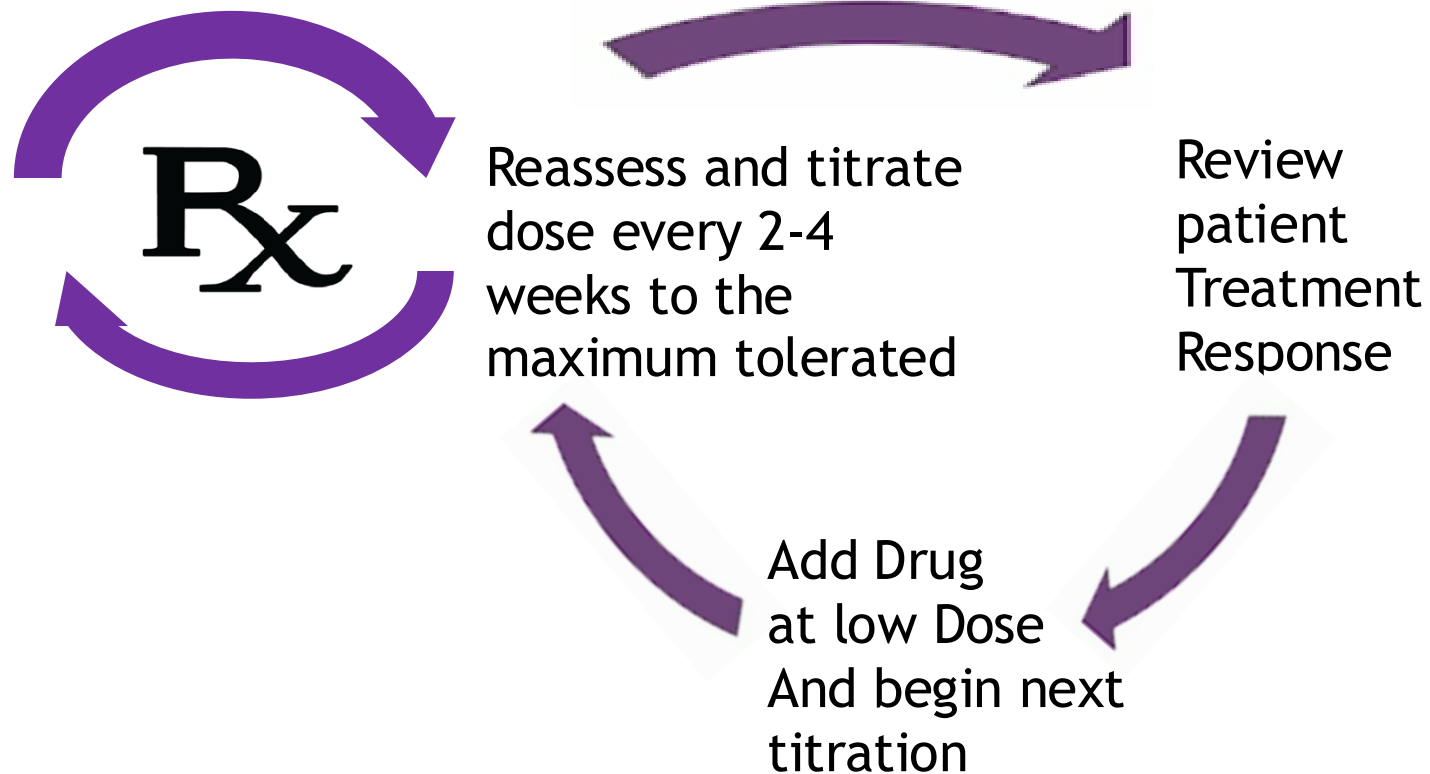
Multiple Pillars = Best Outcome



How Best to Get There?



Abandon the 'Old School' Approach



Clustered Care Step 1: The Easy Starts



New Canadian Guidelines Give Thumbs up for 'Clustered Care'

- ✓ **Begin with combinations**
- ✓ **Easy steps first**
- ✓ **Start Low**
- ✓ **Go up as tolerated**

Day 1 "The Easy Starts"

Patient Discussion and Contract

Heart BP, Weight HR diary

Start Easy pillars

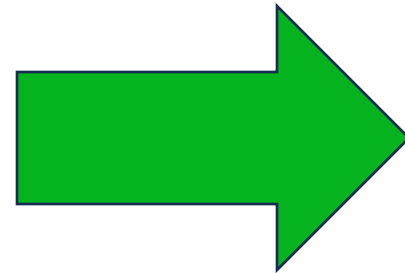
Spirolactone
SGLT2i
Lasix for edema

Engage Your Community Team

Team Nurse
Cardiac rehabilitation
Cardiologist
Pharmacy script

Clustered Care Benefits

- ✓ **Early initiation**
- ✓ **Faster completion**
- ✓ **Better tolerance**
- ✓ **Better compliance**
- ✓ **Fewer Visits**



- ✓ **Earlier Outcome Improvement**
 - ✓ **Functional class**
 - ✓ **Reduced Hospitalization**
 - ✓ **Mortality reduction**
 - ✓ **Ejection fraction**

Patient Contract: Patients Must 'OWN' their care

Own a Scale & BP cuff and Maintain a Daily Diary

- BP
- Heart Rate
- Weight
- Exercise

Self Manage the 'Ups and Downs'

- Daily Weight, BP, HR, edema check
- Evaluate their significance
- Take appropriate action
- SADMANS

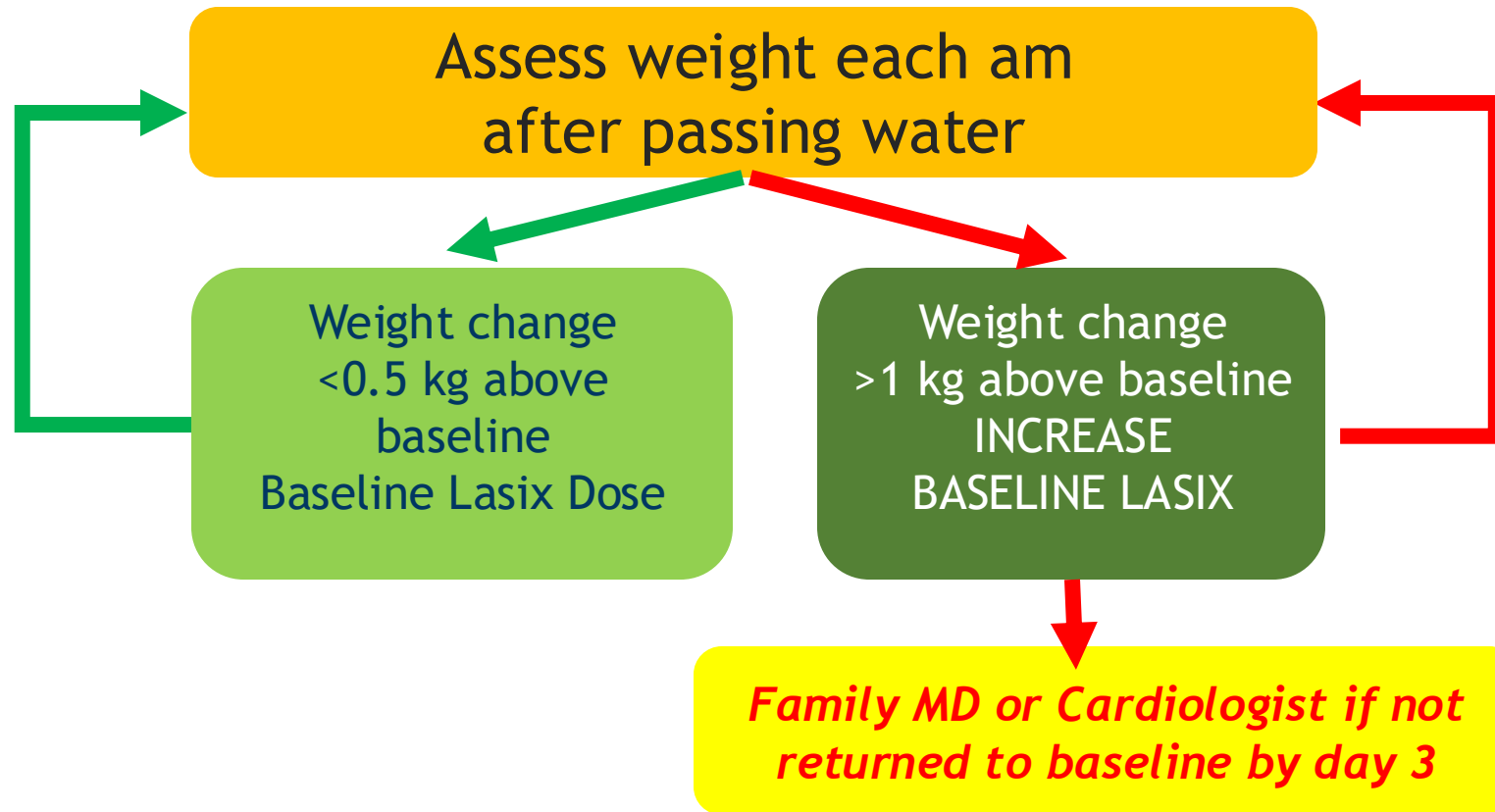


MY PERSONAL FOLLOW-UP

Date	Weight (kg or lb) *your median	Blood pressure (mm Hg)		Heart rate (bpm)	During the day have you experienced...		How much has your heart failure affected you during the day? For each topic below, place a cross on the symbol that most closely represents how you felt.													
		systolic	diastolic		Tiredness (YES or NO)	Shortness (YES or NO)	... hobbies & recreational activities	... your efficacy at work	... doing household chores	... visiting family or friends										

The Patient Contract

PROVIDE PRACTICAL ADVICE TO PREVENT HARD LANDINGS



The 'Easy' Pillars

Furosemide

Target Therapy: Dose adjusted to normalize Volume 20+

Practical tips:

- A little end of Day edema is good to prevent over diuresis
- Require Daily weights
- Teach Patient to monitor Weight and adjust lasix

The 'Easy' Pillars

Mineralocorticoid Receptor Antagonist

Goal: Spironolactone 50 mg (Alternative Eplerenone 50 mg
if gynecomastia occurs)

Practical tips: No benefit of higher or lower doses
Value not dependent on diuresis
Caution with CKD or elevated K+
Lytes, BUN, Cr at next visit 2-4 weeks

The 'Easy' Pillars

SGLT2 inhibition

Target Therapy:

Canaflagozin 100 mg

Dapaflagozin 10 mg

Empaflagozin 10 mg

Practical tips:

approved for low EGFR > 20

No advantage for high dose in HF

Expect initial fall in EGFR up to 20%

GLP1 agonist not a problem (maybe good in fact)

The Easy Steps

Avoid Harm



High Salt Diet/Processed foods



Non-dihydropyridine CCBs : Verapamil, Diltiazem



- negative inotropic effect

NSAIDs and COX-2 inhibitors :



- sodium and water retention, worsening renal function and worsening HF

ARB + ACE-I together



- renal dysfunction and hyperkalemia

The Easy Steps Connect To Community Partners

1. Cardiologist for lifelong collaboration
2. Cardiac Rehabilitation Services
3. Pharmacists for medication support
4. Team nurse support if available (more Later)

The Easy Steps

Cardiac Rehabilitation



17 SITES

SCARBOROUGH

Scarborough Health Network (SHN) Centenary hospital
2867 Ellesmere Road

Toronto Pan-Am Sports Centre
875 Morningside Avenue

Stephen Leacock Community Recreation Centre
2500 Birchmount Road

PICKERING

Pickering Soccer Centre
1975 Clements Road

AJAX

Ajax Community Centre
1975 Clements Road

Complete Performance Centre
72 Orchard Road

WHITBY

Abilities Centre
55 Gordon Street

OSHAWA

Oshawa Civic Complex
99 Thomson Road South

Delpark Homes Centre
1661 Harmony Road North

BOWMANVILLE

Bowmanville Indoor Soccer Complex
2375 Baseline Road West

COBOURG

Cobourg Community Centre
750 Darcy Street

LINDSAY

Ross Memorial hospital
10 Angeline Street North

PORT PERRY

Scugog Community Recreation Centre
1655 Reach Street

BOBCAYGEON

Kawartha Lakes Retirement Residence
60 West Street

PETERBOROUGH

Peterborough Sport & Wellness Centre
775 Breakley Drive

HASTINGS

Hastings Field House
97 Elgin Street

EVERY HF PATIENT SHOULD BE REFERRED

24 sessions over 6 months with

- Education
- Exercise training and supervision
- Heart failure oversight
- Medication support

The Easy Steps

Cardiac Rehabilitation



HARMONIZED REFERRAL

Ensure equitable access to all patients with vascular disease



Regional Cardiovascular Rehab Referral

Patient Information

Last name: _____ First name: _____ Gender: Male Female

Street address: _____ City: _____ Postal code: _____

Health card number: _____ Date of birth (DD/MM/YY): _____

Phone number: _____ Email: _____

Indication for Referral (Established vascular disease or heart failure)

<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Non-debilitating stroke or TIA
<input type="checkbox"/> Angioplasty or Bypass surgery	<input type="checkbox"/> Heart transplant	<input type="checkbox"/> Carotid stenosis
<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Valve surgery	<input type="checkbox"/> Renovascular disease
<input type="checkbox"/> Admission acute coronary syndrome	<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Diabetes > 55yo + 2+ risk factors

Risk Factors

<input type="checkbox"/> Family history	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> History of smoking	<input type="checkbox"/> Obesity	<input type="checkbox"/> Sedentary	

Referral by

Referred by: _____ Date: _____

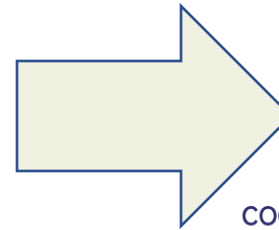
Name (print please): _____

Phone number: _____ Fax number: _____ Work email: _____

Referral to cardiovascular rehab **includes** a fitness assessment

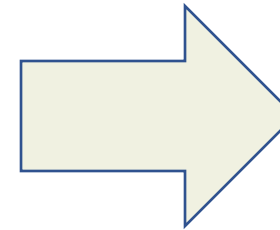
Please send completed referral and clinical notes to cardiacrehabbooking@shn.ca or fax to 416-281-7280
Please use One Mail Direct or password encryption for email transmission
For any other enquiries, please phone 416-281-7022 or (Toll Free) 1-855-448-5471

getthehealthy.ca



CENTRALIZED COORDINATION CENTRE

Manages and triages referrals for patients from across the region



COMMUNITY BASED

Community programming close to home



REGIONAL WORKFORCE

Specialists on-site in patient communities to deliver care



STANDARDIZED PROGRAM

Aligns with Canadian cardiac care guidelines

Cluster Therapy: Step 2 'The Long Game'



Start Clustered Beta Blockade and ARNI

Sactubtril Valsartan 24/26 bid staggered
Carvedilol 24/26 bid staggered

The Long Game

Beta Blockade

Goal: Carvedilol 50 mg po bid
Bisoprolol 10 mg po od

Practical tips: Stagger with ACE/ARB/ARNI (qid schedule) to avoid hypotension
Heart rate goal 50-70 bpm
Caution with CKD or elevated K+

The Long Game

Sacubitril-Valsartan

Goal: Sacubitril-Valsartan 97/103 bid

ACE/ARB IF ARNI NOT TOLERATED

Practical tips: Stop ACE x 3 days

Start low Sacubitril-Valsartan 24/26

Titrate slowly

in 3 steps every 3-4 weeks to max tolerated

Expect 20% fall in eGFR (that's good 😊)

Fall back to ACE/ARB if not tolerated due to Low BP

Target Therapy:

7.5 mg po bid

Role

When sinus HR > 77 despite maximum tolerated BB

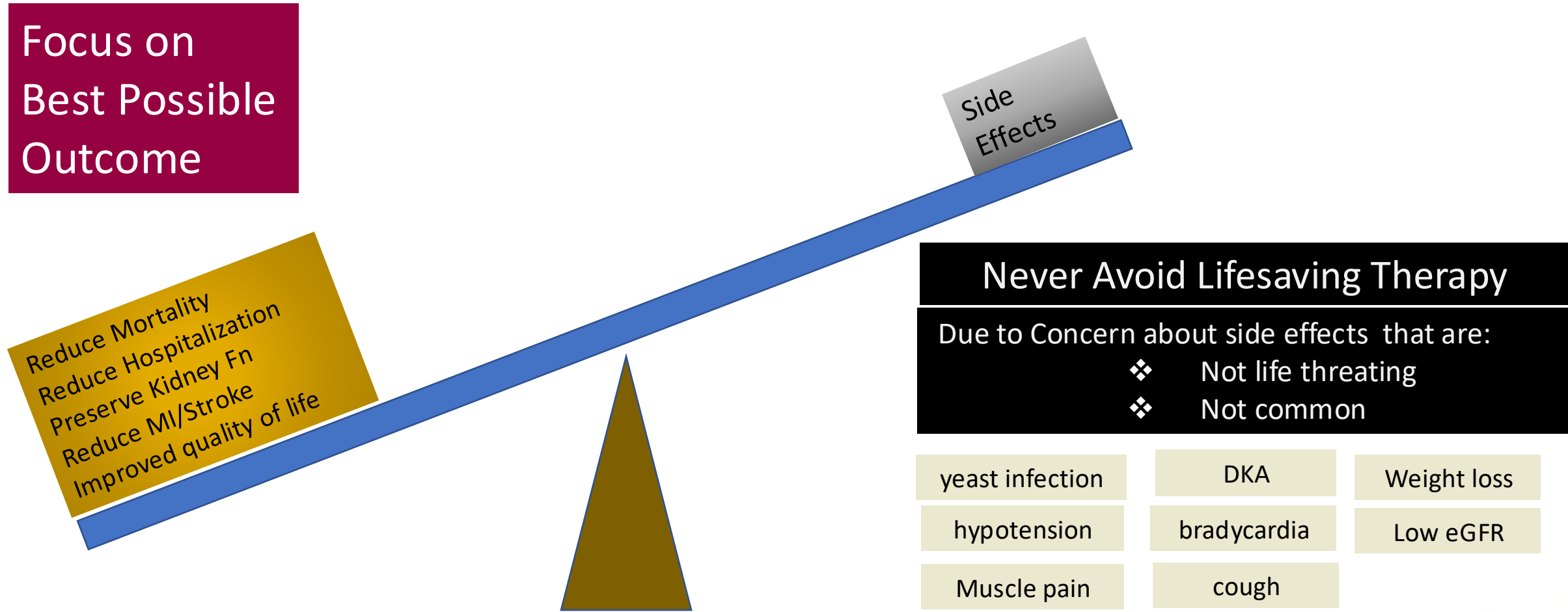
Practical tips:

Sinus rhythm required

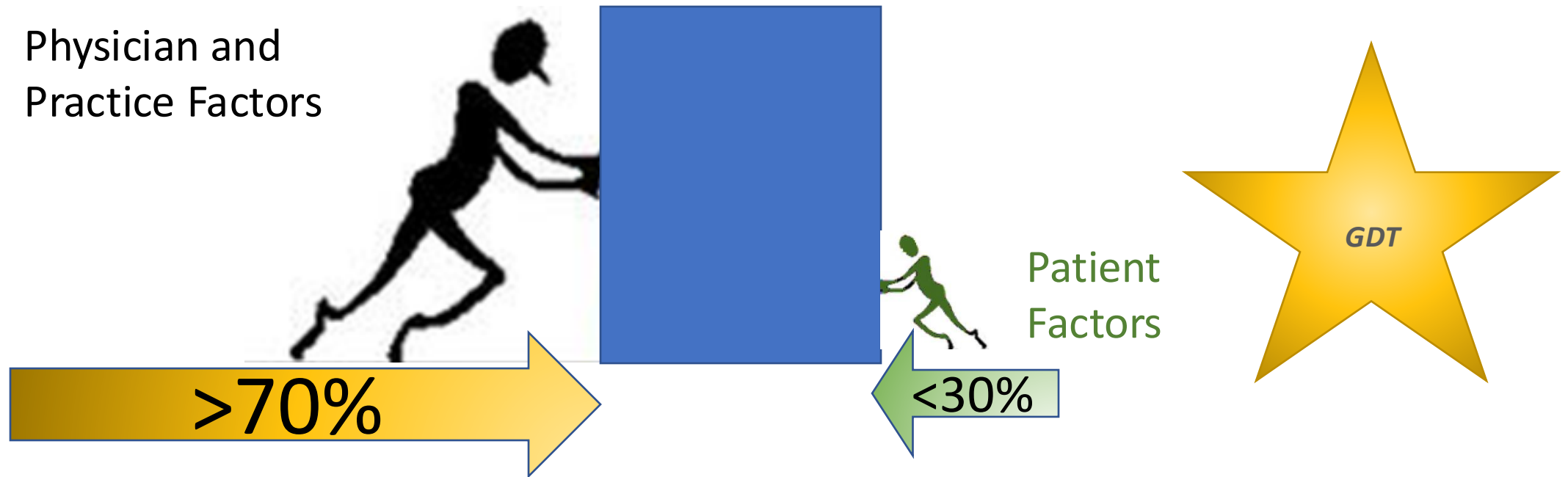
use early if HR >70 and don't tolerate more Beta blockers

EGFR must be over 25 ml/min

'Softs risks' do not justify withholding GDMT

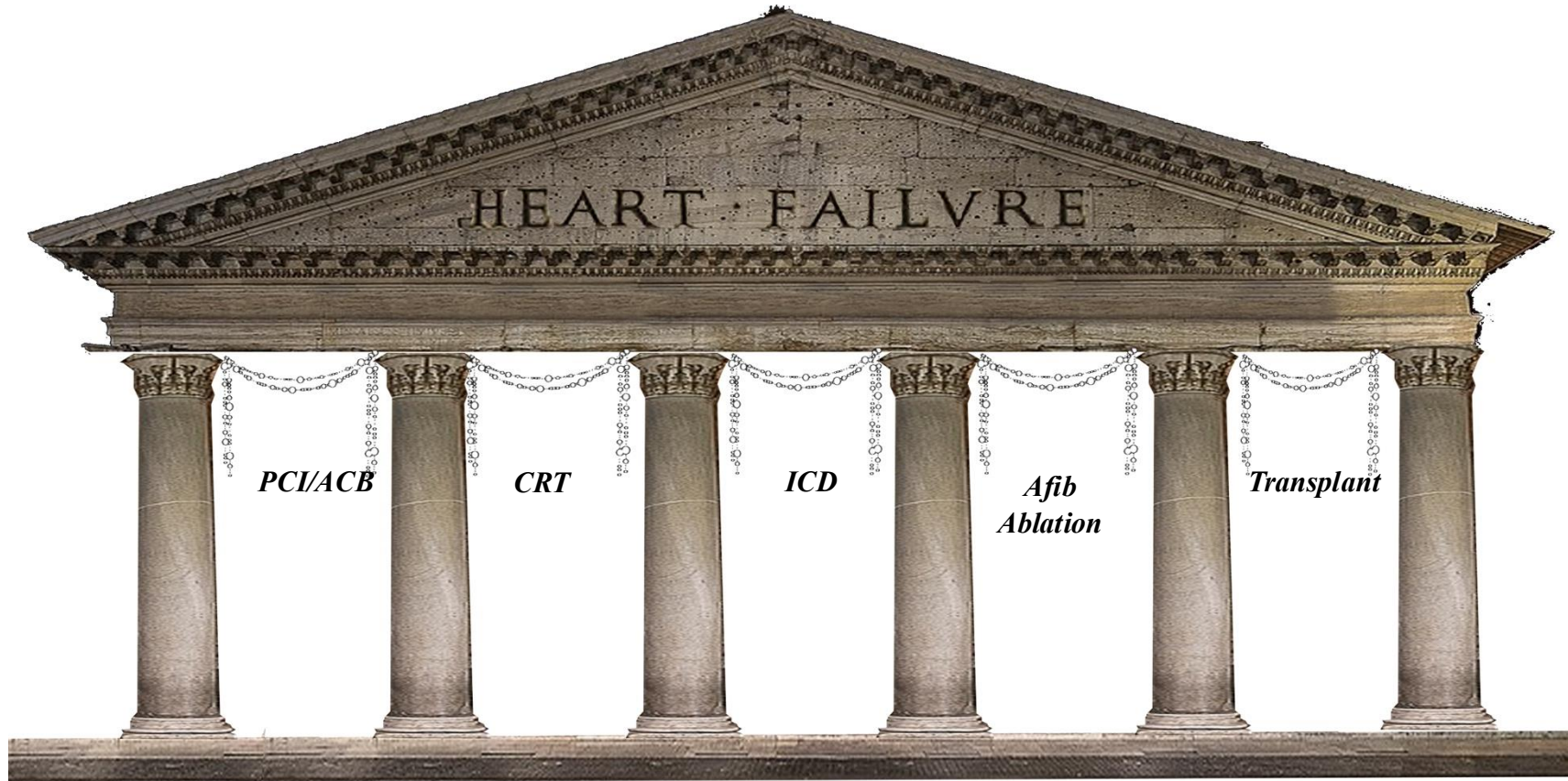


Recognize and Avoid Inertia



Physicians **NOT** Patients are Main Drivers of Outcome for Patients

Specialized 'Tertiary' Tools



How often should HF patients be seen?

- Acute change in symptoms **24-48 hours**
- After a HF ER visit or hospitalization **1-2 weeks**
- After an initiation or change in medications **2-4 weeks**
- Stable on optimized therapy **3-6 months**

**My Patient has HFpEF.
Which of the Following are of NOT of Value?**

- a) Beta blockers
- b) Sacubatril Valsartan, ACE inhibitors or ARB
- c) Spironolactone
- d) SGLT2 inhibitors
- e) Cardiac ATTR amyloid Scan
- f) A and B
- g) None of the above

What about HFpEF?

HFpEF has is a less uniform entity with fewer therapies that improve outcome

The Evidence to date supports

- ✓ To improve outcomes
 - ✓ SGLT2 inhibitors
 - ✓ Spironolactone
 - ✓ Weight reduction
 - ✓ Exercise and Cardiovascular Rehabilitation
 - ✓ Tafamidis in ATTR Amyloid Heart Disease

- ✓ To manage symptoms
 - ✓ Salt reduced diet
 - ✓ Diuretics to manage edema and congestion

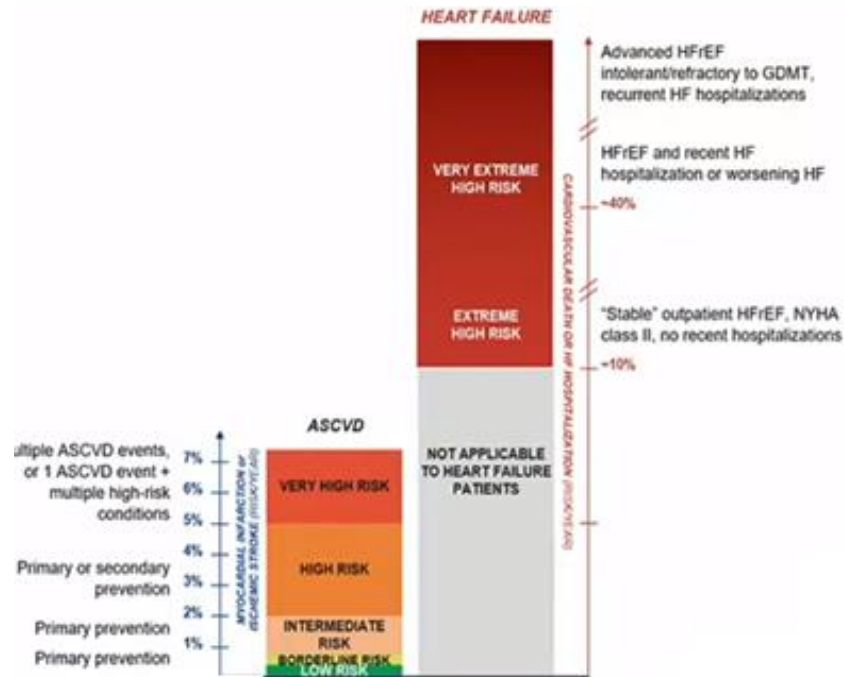
Large Demands Need Scalable Solutions

- >23,000 Chronic HF patients in Scarborough/Durham**
- > 3,000 New diagnosis of HF each year**

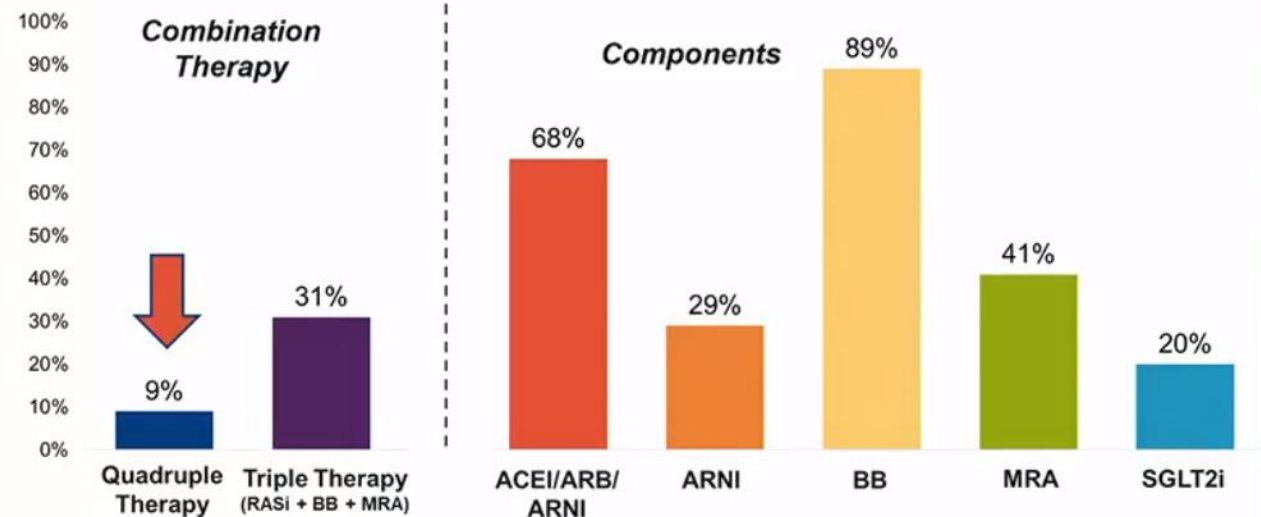
To date: We Have Not Met The Challenge

Failure to Respond with the Urgency it Deserves

Failure to Respond Adequately to HF as a Chronic Disease

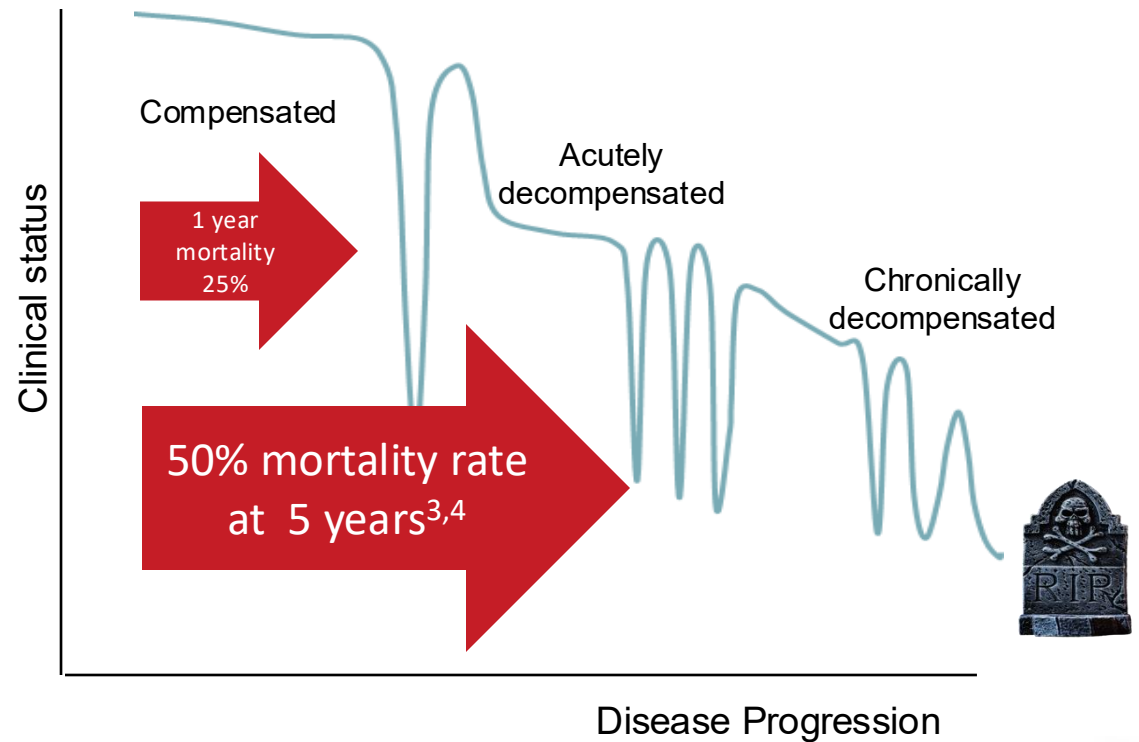


GDMT for HFrEF in the US (2021-2022)*

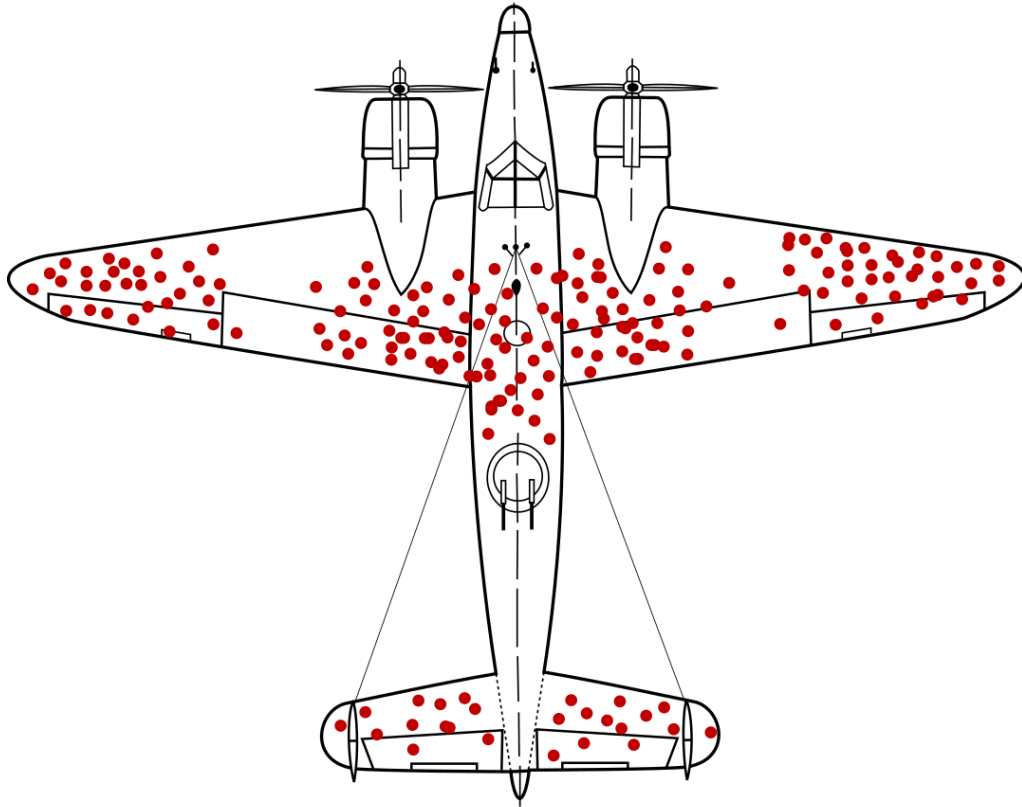


The Historic False Narrative: Observer Bias

X The Traditional Focus on HF as an End Stage Disease is False



What is Survivor Bias?



During World War II

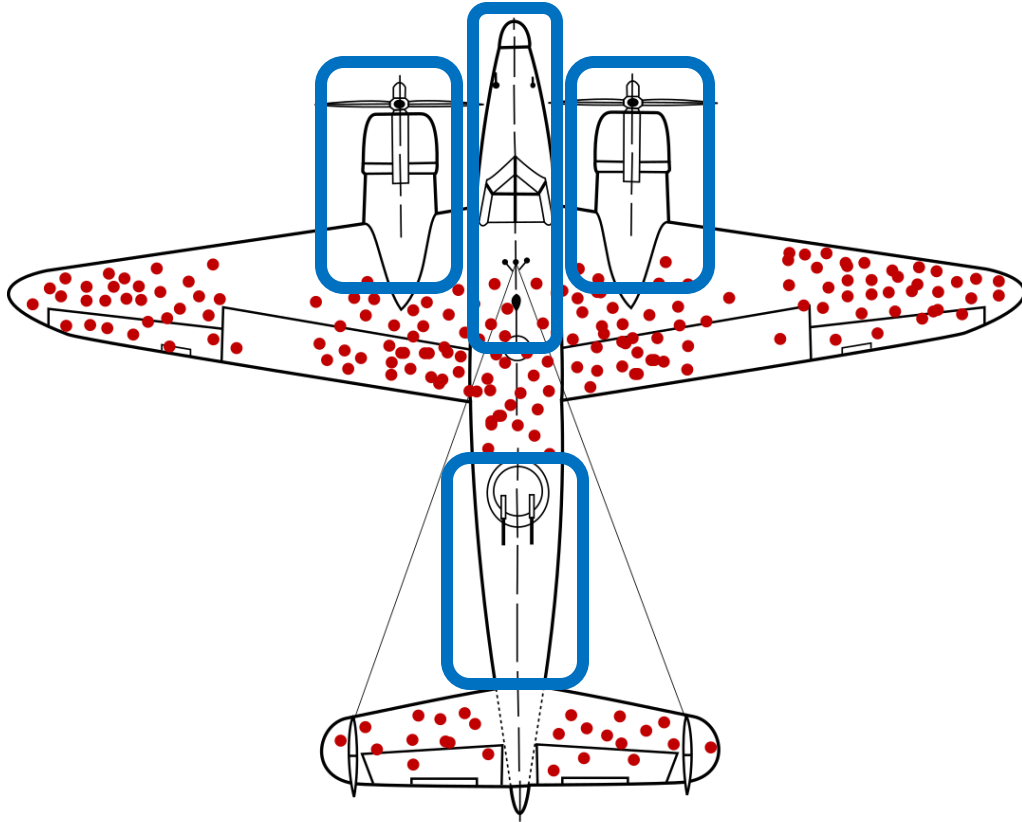
The US military studying returning warplanes noted that most of the airplanes returning from battle had bullet holes on the wings and tail.

Engineers began planning to reinforce those areas in the next generation of aircraft.

A decision that would have cost hundreds of airmen's lives, planes and outcome of WWII !

Why?

What is Survivor Bias?



Abraham Wald, as statistician proposed a counter intuitive solution

He reasoned that that returning planes had bullet holes that were not fatal

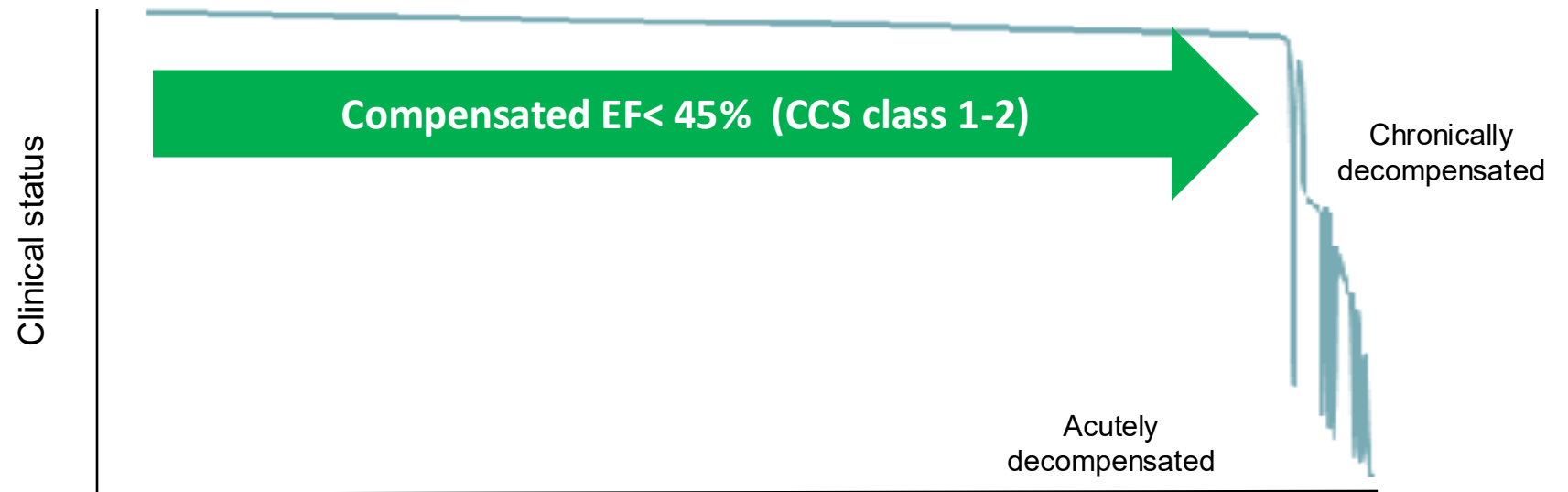
He reasoned that the planes that did not return had bullet holes on the engine and cockpits

The Allies began reinforcing the crew cabins and engines

Saving countless planes and lives and possibly WWII

....Needs to Be Reframed

- ✓ Reframe Reduced Ejection Fraction as a Chronic Condition requiring Early and lifelong preventative care



“We cannot define a trajectory for individual heart failure patients”

Robert McKelvie

Reframing Survivor Bias toward Prevention

- ✓ Reframe Reduced Ejection Fraction as Chronic Condition requiring Early and Lifelong Preventative Care



“We cannot define a trajectory for individual heart failure patients”

Robert McKelvie

What is a Health Care System?



Systems are
Collaborative Care Processes
where Patients & Providers
Manage care together
with shared tools and goals
For the best long term outcomes.

What Does A System Paradigm require

- ✓ Reframing Reduced EF as a chronic disease requiring lifelong care
- ✓ Accountability for GDMT as a standard by **both** Patients and Providers
- ✓ Collaboration by Community Care providers **with Shared Goals**
- ✓ Institutional accountability for institutional and Tertiary interventions
- ✓ Seamless transitions

Systems are People Working Together with shared tools and goals.

- ✓ Primary care engagement with Cardiology and Health Care Resources



Family

Patient

*Primary
Care
MD*

*Cardiology
Specialist*

*Cardiac
Rehab*

*Hospital
Care*

The Roadmap from A Preventative Perspective

- ✓ Reframe Reduced Ejection Fraction as Chronic Condition requiring lifelong care

OUTPATIENT

Bumps in The Road

Support and Palliation

Diagnosis

Disease Modifying Therapies Tertiary Options



PRESENTATION

Primary Care + Specialist Collaboration	
Cardiovascular Rehab	ICD/CRT
Lasix	
Mineralocorticoid antagonist	
SGLT2i	
Beta Blockers	
ARNI	
Ivabradine (HR >70)	
	PCI/ACB
	Transplant



Our Region has the Resources To Treat HFrEF Well!

High Quality Team Members

✓ Health Care Providers

- ✓ Primary Care network >1000 physicians
- ✓ > 50 well trained specialists
- ✓ Allied health professionals

✓ Facilities

- ✓ 11 Hospitals
- ✓ Regional Cardiac Care systems
- ✓ Regional Cardiac Rehabilitation

High Quality, High Impact Evidence

✓ Effective Therapies

- ✓ Multiple effective GDT

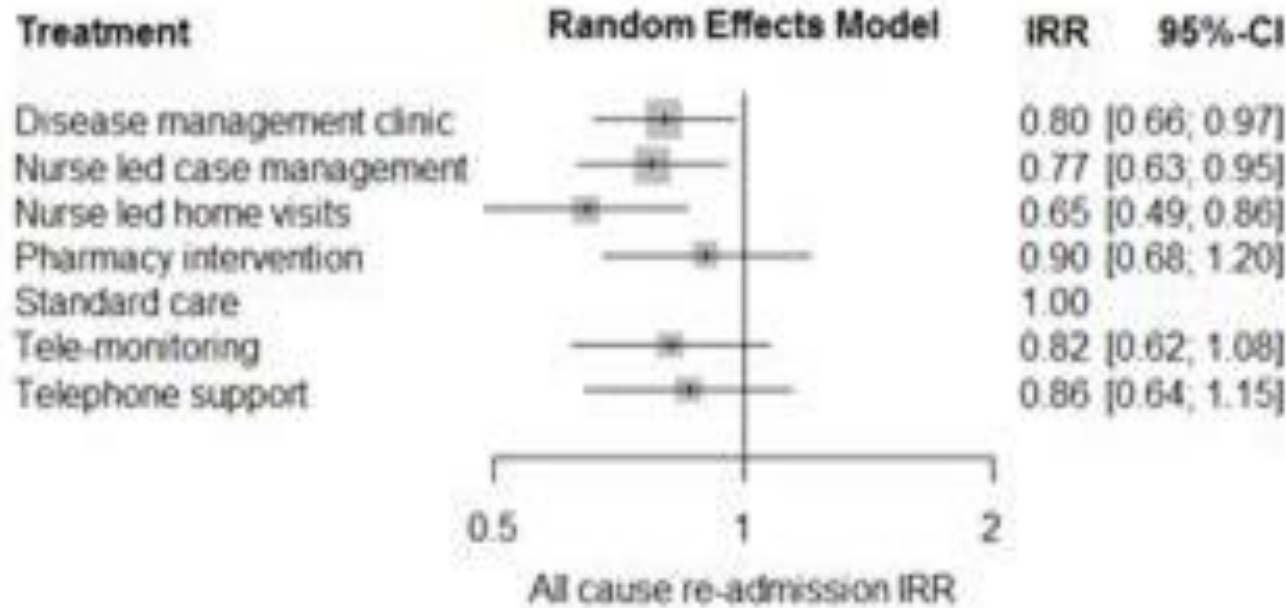
✓ Effective Delivery Approaches

- ✓ Early Therapy
- ✓ Clustered therapy
- ✓ Protocol Guided GDMT
- ✓ Early post discharge reassessment

Systems engage Multiple resources

Function enhanced by the sum of the parts not the form

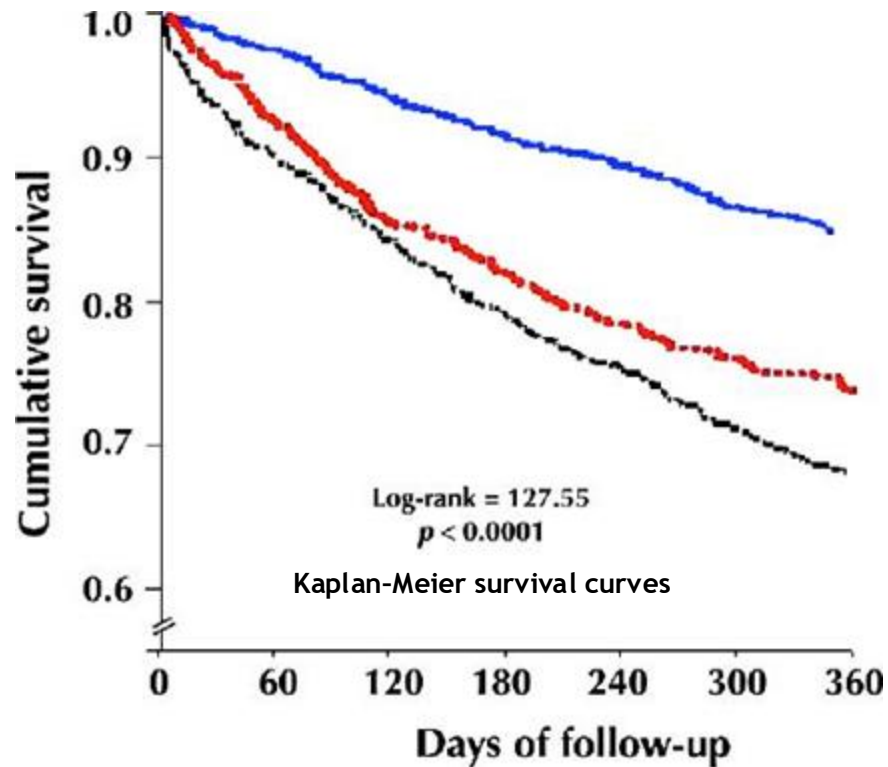
- ✓ Primary care engagement with Cardiology and Health Care Resources



Collaborative Care Is Enhanced By Multi-faceted systems

Collaborative is More Effective In Our Canadian System

- ✓ Primary care engagement with Cardiology and Health Care Resources



Blue = *combined care* (both specialist and family physician),

Red = *care by family physician only*,

Black = *no follow-up care*

The Standard of Community Care

- ✓ Accountability for GDMT as standard by both Patients and Providers



THESE ARE STANDARDS
OF CARE

***They ARE NOT
GUIDELINES***

*BETA
BLOCKER*

ARNI

MCA

SGLT2I

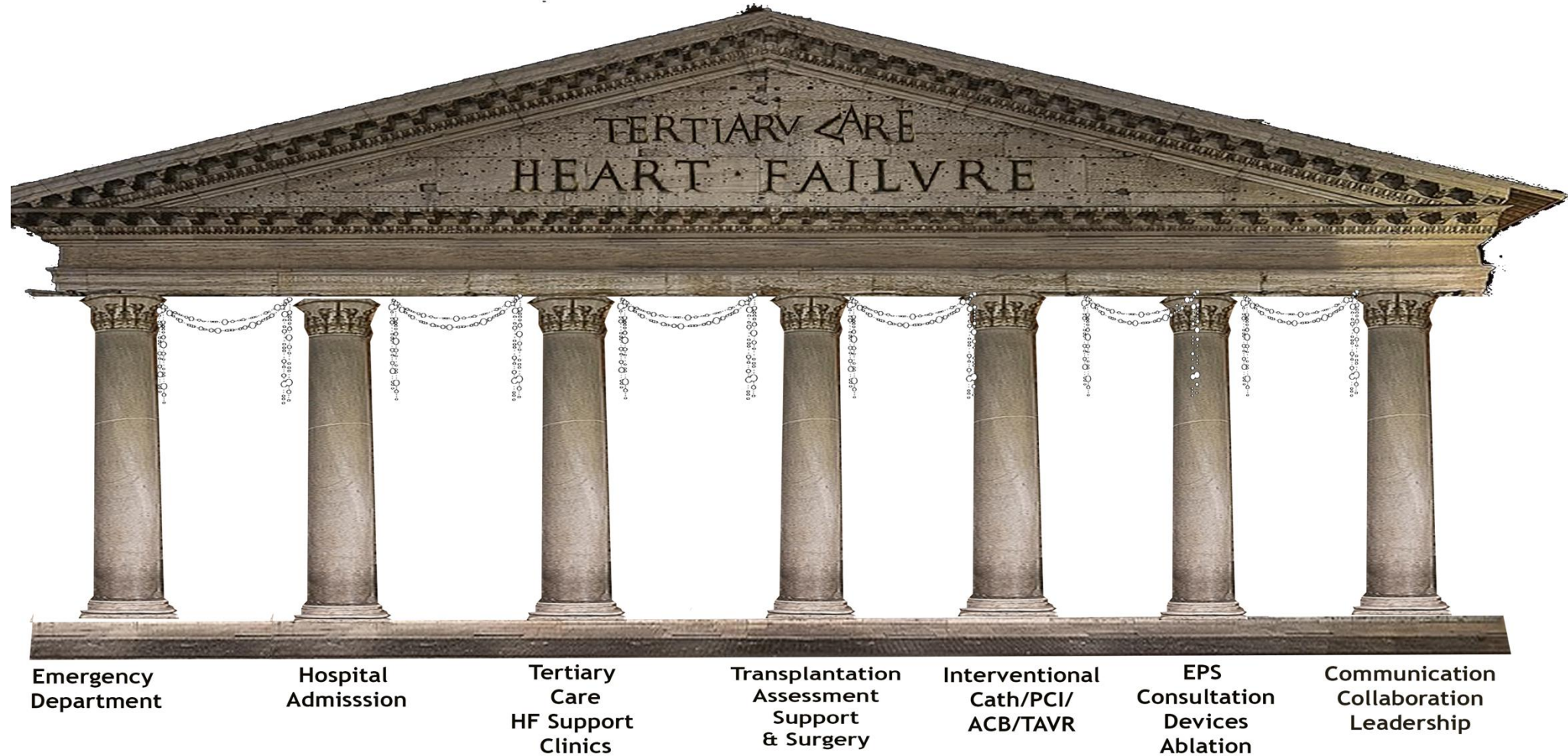
IVRABADINE

REHAB

*STATIN**

*DIGOXIN**

Access to 'Tertiary' Tools



The Corcare Quality Protocol

The Corcare Heart Function Optimization Protocol: A Structured Quality Improvement Intervention To Improve Goal Directed Targets For Patients With Reduced Ejection Fraction.

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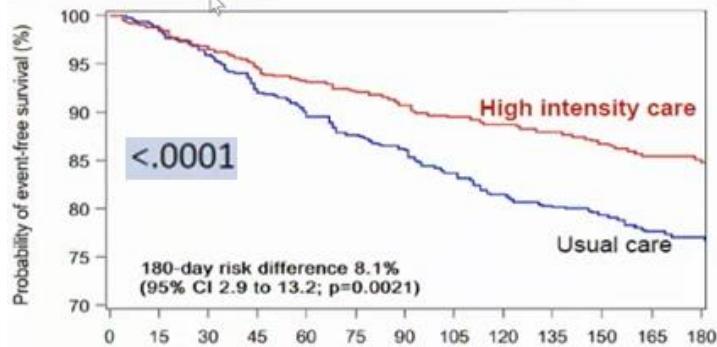


Heart Failure: We Have Evidence for What Works

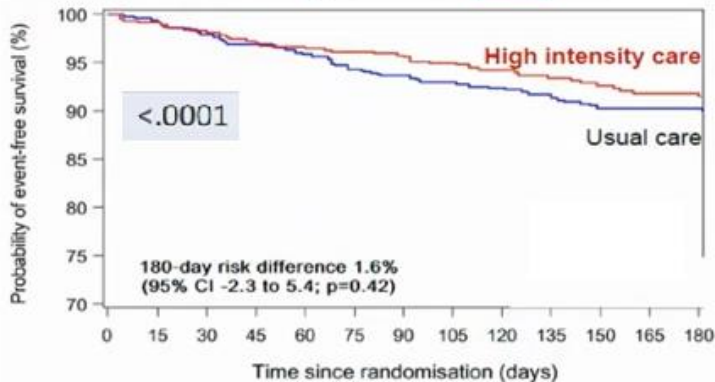


Safety, tolerability and efficacy of up-titration of guideline-directed medical therapies for acute heart failure : a multinational, open-label, randomized, trial

180-Day Readmission for HF or All-Cause Death



180-Day All-Cause Death



1078 Patients 89 hospitals 14 countries.

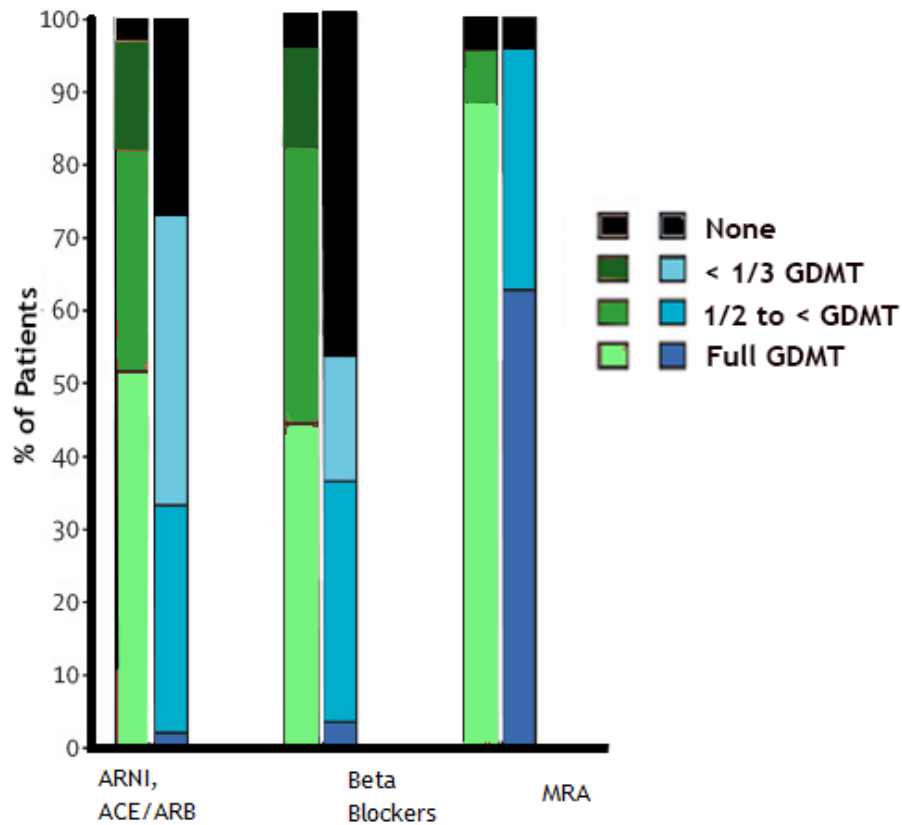
Randomly Assigned after Admission to either

- usual practice
- Protocol mandated rapid up titration of GDMT

Heart Failure: We Have Evidence for What Works



Safety, tolerability and efficacy of up-titration of guideline-directed medical therapies for acute heart failure : a multinational, open-label, randomized, trial



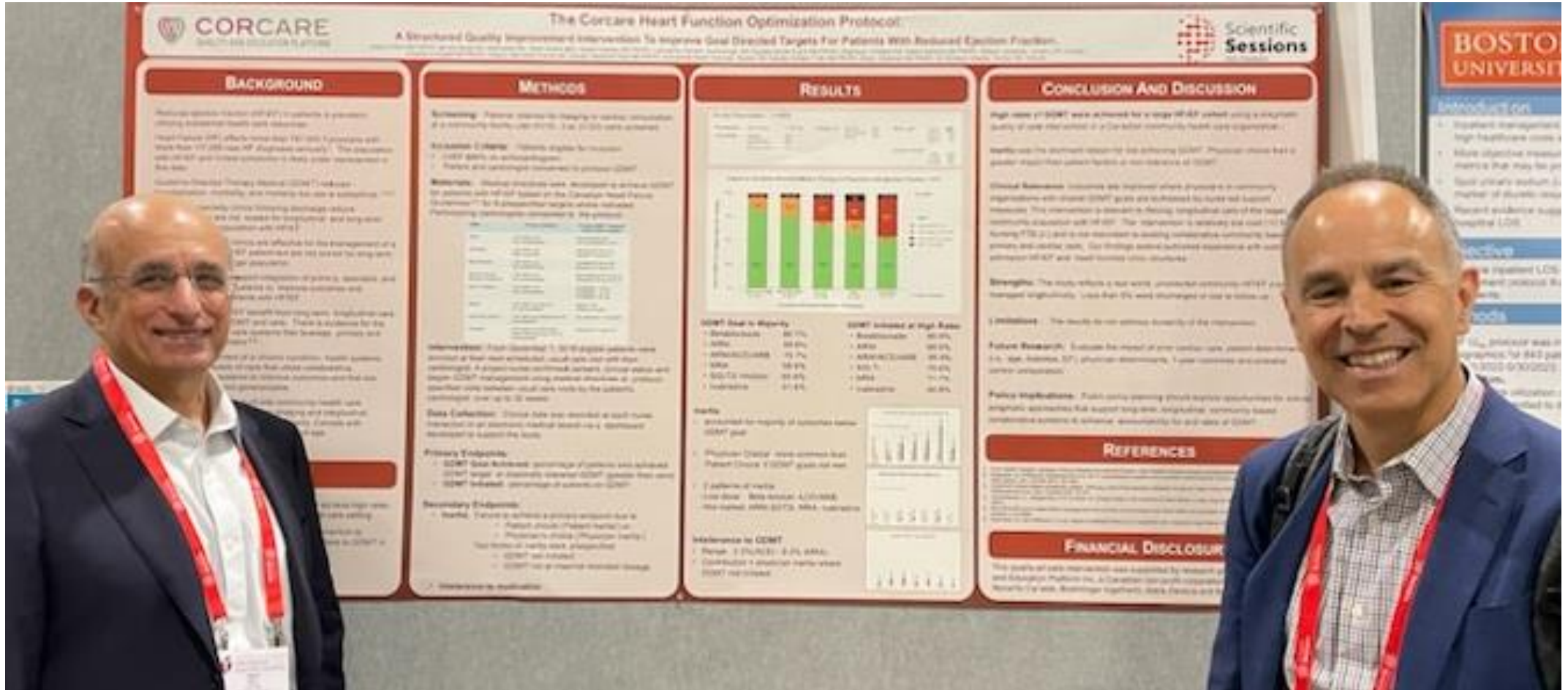
High Impact Despite Limitations

- ✓ 50% at Full Protocol Guided GDMT
- ✓ ARNI Not Mandated
- ✓ Beta Blockade difference main Driver

Strong Proof Of Concept for Value of Protocol Driven GDT

The Corcare Optimization Protocol

5 year longitudinal Intervention in 983 Patient with $EF \leq 40\%$



Abstract: Su2145

Sunday, November 19, 2023, Philadelphia

GDMT Protocol Guided Longitudinal Care

All Patients between January 2015, and March 31, 2023

- LVEF \leq 40% on echocardiogram and
- Consent

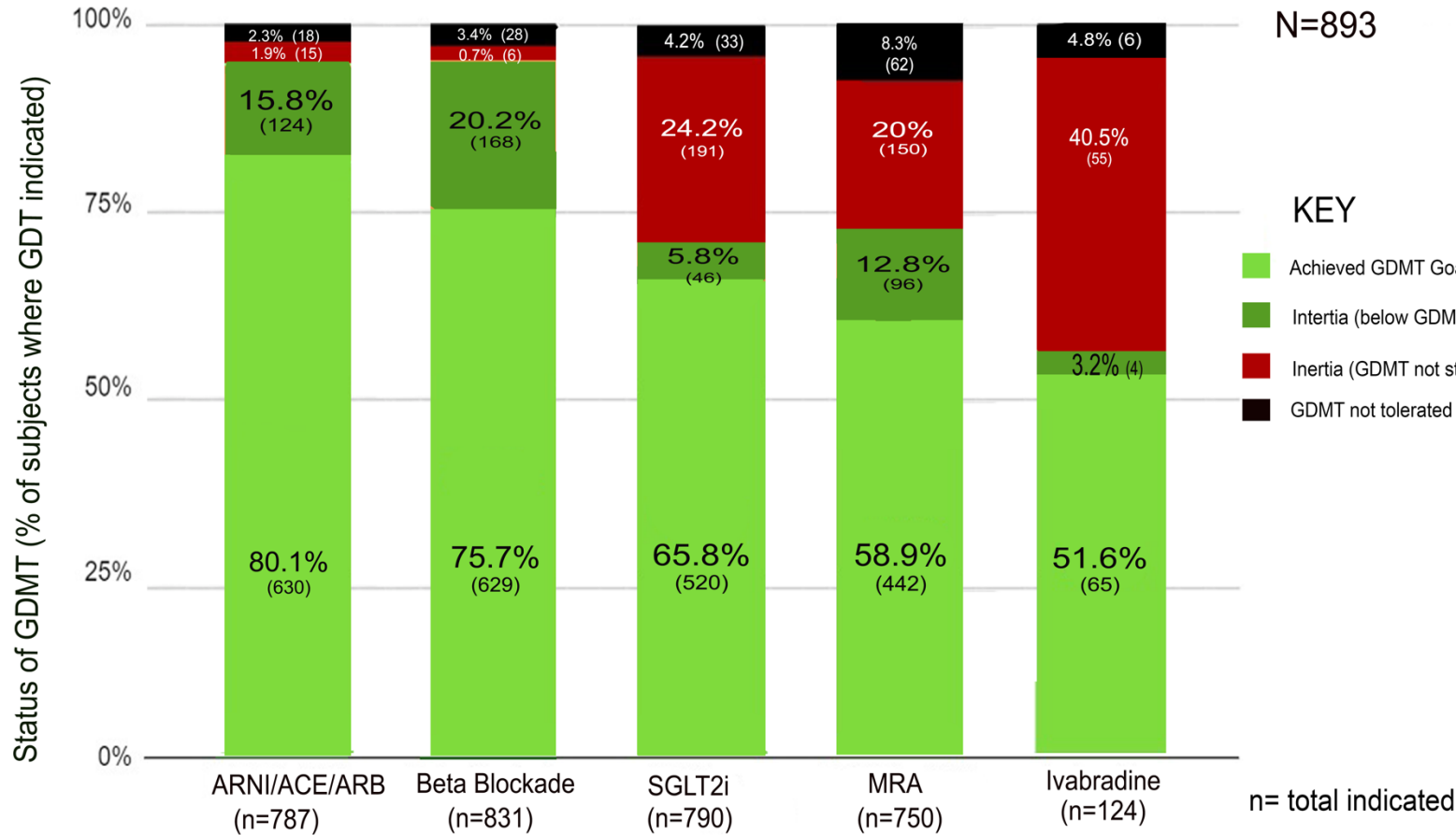
Project RN support at protocol-specified visits between usual care visits up to 32 weeks

Primary Endpoints: (Intention to Treat)

- ✓ **GDMT achieved (% at target, Initiated)**
- ✓ **Failure to achieve primary endpoint**
 - **Clinical Inertia**
 - patient choice ('Patient Inertia')
 - physician's choice ('Physician Inertia')
 - **Intolerance to medication**

GDMT	GDMT Goal
ARNI	97 mg sacubitril with 103 mg Valsartan po bid
ACEi/ARB (if not on ARNI)	Perindopril 8 mg po od Ramipril 10 mg po od
Beta-blockade	Carvedilol 25 mg po bid Bisoprolol 10 mg po od
MRA	Spironolactone 25 mg po od Eplerenone 25 mg po od od
SGLT2 inhibition	Empafligozin 10 mg Dapafligozin 10 mg Canafliozin 100 mg
Digoxin if Afib	Digoxin: NA
LDL < 1.8 if ASCVD	LDL threshold < 1.8 mg liter
Ivradabine	Ivabradine 7.5 mg po bid

Primary Outcomes



Longitudinal Care Universal

Longitudinal care 97.2%
Lost to fup 2.8%

GDMT initiation at High Rates

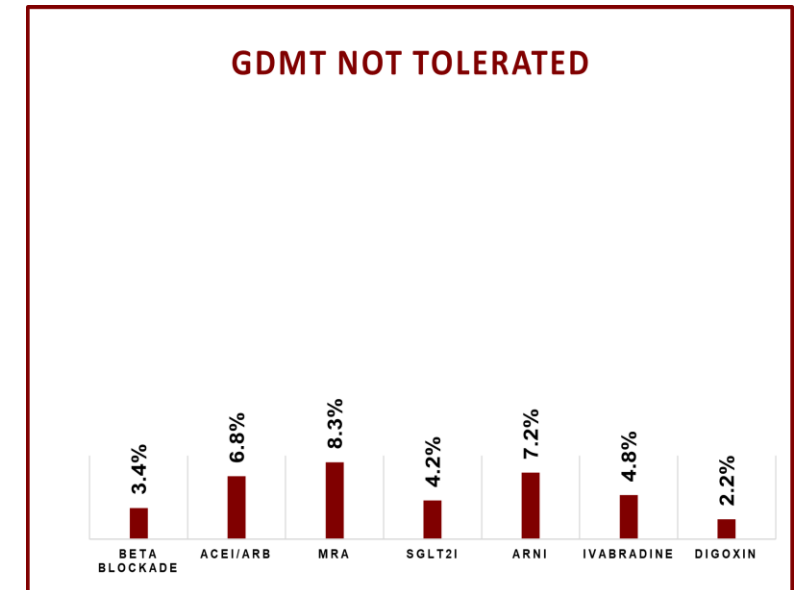
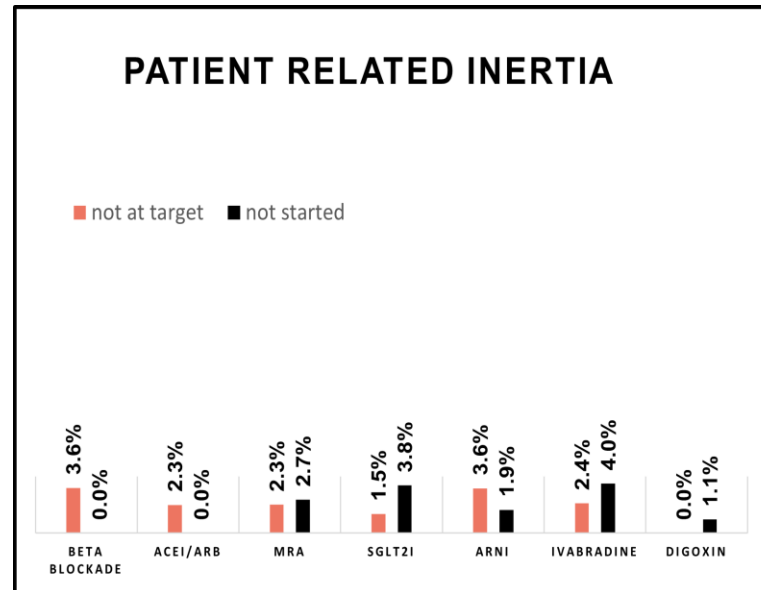
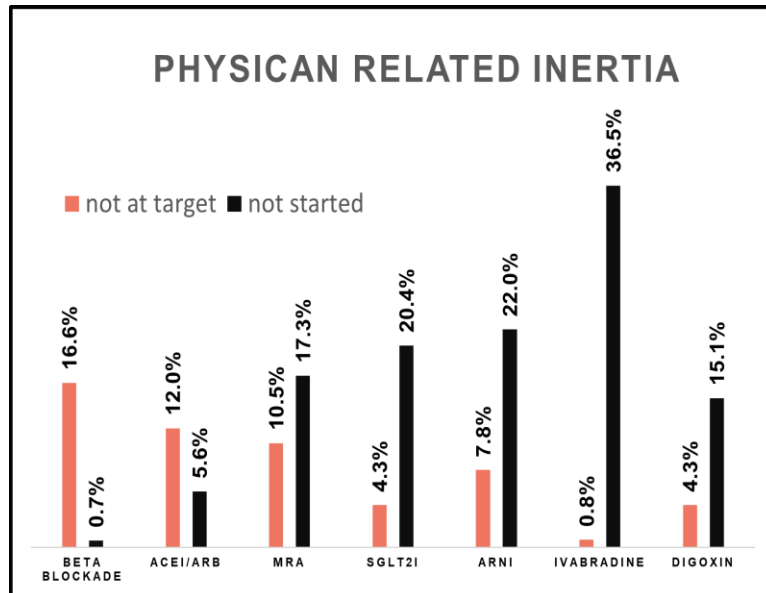
Betablockade 95.9 %
ACE/ARB/ARNI 95.9 %
SGLT2i 70.6 %
MRA 71.7%
Ivabradine 54.8 %

GDMT At Target in Majority

ARNI/ACE/ARB 80.1 %
Betablockade 75.7 %
MRA 58.9 %
SGLT2i inhibitor 65.8 %
Ivabradine 51.6 %

Inertia: Physicians Are The Key Drivers

Consistent with Published Literature: 70:30



Key Finding:

Inertia is not common

Intolerance of Medication is not Frequent

Two main patterns

Lower dose : Beta blockers, ACE/ARB.

Not started : ARNI, SGLT2i, MRA , Ivabradine

suggest that Clinical Judgement NOT avoidance

Heart Failure in An Integrated Health System

Life long Support for the Entire rEF Population

- ✓ Reduced EF managed as a chronic disease with lifelong care
- ✓ Accountability for GDMT as a standard **by both Patients and Providers**
- ✓ Collaboration by all Community Care providers **with Shared Goals**
- ✓ Institutional accountability for institutional and Tertiary support
- ✓ Seamless transitions management across the Community

Summary

- Heart failure remains an important public health issue
- Guideline Directed therapies improve outcomes for our patients
- Best outcomes are achieved through integrated community based care
- Optimizing Care of Our Patients is best achieved through
 - system wide accountability
 - GDMT applied early and consistently
 - Scalability to support lifelong, longitudinal care for the entire rEF population
 - Integration of Services
 - community resources (primary care <> Specialists <> Rehab <> Pharmacies <> etc)
 - community and Hospital services

If Toronto Can Win an NBA championship, We Can Treat Heart Failure Better



Thank You



SUPPORT AVAILABLE 24/7



**Have a patient question?
Reach out to our
Corcare Cardiologist directly**

416-COR-CARE



THANK YOU