

SHARED CARE:

an important goal in the development of optimal heart failure

Dr Ken McDonald
Dr Mark Ledwidge

Introduction

The continuing problems with heart failure management have been well documented. Prognosis remains a concern, application of proven therapies is far from optimal and patient understanding and involvement in the management of their problem is poor. Hospitalisation is a very frequent occurrence, often as a direct result of issues highlighted above. As a result, expenditure on heart failure remains high, consuming as much as 2% of the national healthcare budget.

Are these the features of an end-stage disease which modern medicine cannot alter? Or, are they a reflection of a syndrome, which lacks appropriately structured care programs along the lines of other chronic illnesses such as diabetes? The fact that dramatic improvements in prognosis have been witnessed in clinical trials in the pharmacological management of heart failure argues against these features being unalterable aspects of an end-stage syndrome. Furthermore, the failure to apply these same advances in pharmacotherapy underline the need to develop proper effective structures of care.

Structured care of heart failure

Over the last number of years, there have been several studies demonstrating the benefit of structured care in heart failure. These programs have concentrated on patients admitted to hospital with class IV New York Heart Association symptoms. The repeated findings of these programs have been that structured outpatient follow up involving a specialist nurse, doctor (hospital and/or general practitioner) reduces the tendency to readmission, which historically has been very high in this patient subset (50% six-month readmission reduced to rates varying from 10% to 30% with structured care). These impressive results are most likely due to better clinical supervision, more effective prescription of proven therapies and a better-educated patient population.

Analysis of our experience with such a program at St Vincent's University Hospital indicates that there may be defined roles for the hospital and the community in caring for patients with heart failure. For example, following admission to hospital with heart failure, the period of maximum vulnerability for readmission is within three months of discharge. In our experience, a hospital-based clinic can significantly reduce this, but only with close clinical follow-up (weekly telephonic contact by a nurse specialist with clinic visits at two, six and twelve weeks following discharge) and intensive one-on-one education of the patient to explain the importance of medication compliance, daily weight monitoring and the early reporting of impending problems (education time approximately eight hours per patient). The success of this approach, coupled with the clear demands on

time and resources underlines that this period of patient care should remain at hospital level. Beyond the three-month time point, continuing heart failure management at hospital level in the manner described above does not provide any additional benefit. The major at-risk period has passed and education has been imparted to the patient and their family members. This is the time point to hand over the management to the general practitioner. However, for effective community heart failure care to proceed, certain developments are required to assist the general practitioner. These primarily include the support of practice nurses, with additional access to other allied health care professionals such as nutrition experts, pharmacists, counsellors, physiotherapists etc. It is also envisaged that the practice nurses would have a close liaison with the hospital heart failure nurse to allow for continuing education on nursing aspects of heart failure management. With such a team in place, it is likely that continued effective care of heart failure could be provided with a lower level intensity of clinical contact.

Conclusions

Now is the time to develop this shared-care approach to heart failure. As an initial step, admitting hospitals need to initiate a formal service to manage patients during admission and during the early months following discharge. For this to develop, regional health authorities need to give this problem a far greater level of priority than that assigned at present. As this is occurring, the required changes in general practice structure also need to emerge. The above discussion has focused exclusively on the management of the patient discharged following an admission with heart failure. However, the bulk of the heart failure population remains stable in the community, often for years before hospitalisation is required. The development of this shared-care approach will also result in more effective care of this patient subset, thereby reducing the likelihood of clinical deterioration and admission. The long-term goal with this approach is to allow for the development of a screening program for those at risk of developing heart failure, because this will always be the most effective approach to the management of this syndrome.

Dr Ken McDonald, Chairperson, Council on Heart Failure, Irish Heart Foundation and Director of the Heart Failure Unit, St Vincent's University Hospital.

Dr Mark Ledwidge, Vice-Chairperson, Council on Heart Failure, and Director of Heart Failure Research, St Vincent's University Hospital.