Integrated approach to the management of heart failure: Role of outpatient programmes

Approche intégrée du traitement de l’insuffisance cardiaque dans des programmes de prise en charge ambulatoires

Jean-Noël Trochu

Clinique cardiologique et des maladies vasculaires, institut du thorax, CHU de Nantes, boulevard Jaques-Monod, 44093 Nantes, France

Received 16 October 2008; accepted 17 October 2008
Available online 29 January 2009

The prevalence of heart failure (HF) is between 2 and 3% in the general population, rising to 10 to 20% in individuals aged 70 to 80 years [1]. Despite, or because of, notable improvements in the medical management of cardiovascular diseases, the incidence of HF has increased consistently over the past decades [1], and represents a considerable economic burden in developed countries. The guidelines for the treatment of acute and chronic HF, based on an evidence-based approach, are well defined but our patients frequently remain hospitalized [2]. Surveys and registries have shown that patients are still undertreated, with the use of lower dosages than recommended in guidelines, and that age remains an independent predictor of under-prescription of efficacious medication for patients with HF [3] despite improvement in medical education and information. In fact, non-HF specialists (i.e., general practitioners, internists, hospital physicians, geriatrists and nurses) are often the first medical contact in the management of HF patients, whereas drug titration and controlling side effects can be considered as a matter for experts. Moreover, many patient-related factors may explain the gap between guidelines and everyday practice since drug titration can be difficult, for instance in the case of hypotension, bradycardia and renal insufficiency, particularly in elderly patients. Patient compliance with treatment is often poor and the proportion of hospitalizations related to poor self-management has reached 40% in some studies [4]. In the mid 1990s, it appeared clearly that HF management had to be supervised to prevent rehospitalizations and improve quality of life and survival, and required the involvement of different specialties of caregiver. In 1995, Rich et al. [5] reported the first study focusing on the impact of a multidisciplinary approach,

© 2009 Elsevier Masson SAS. All rights reserved.
doi:10.1016/j.acvd.2008.10.017
based on patient education and coordination of care in addition to a medicosocial approach, in patients representative of our everyday practice. Since then, several randomized studies have confirmed the results in terms of reductions in rates of rehospitalization. Several meta-analyses have also shown that this global approach brings a significant reduction in HF and all-cause rehospitalizations, and in all-cause mortality [6].

Hence, it was important to study the effects of a disease-management programme in the context of the French healthcare system, which is characterized by a high density of general practitioners and cardiologists, and a traditionally low involvement of nurses in the follow-up of patients with HF. Two main studies have been performed in France to assess the feasibility and efficacy of a HF disease-management programme. The first was conducted in Nantes, Lorient and La Roche-sur-Yon and demonstrated in a randomized study of 200 patients with a mean age of 77 years, that a disease-management programme for elderly patients with HF reduced the number and duration of rehospitalizations due to HF, whereas no effect was observed on mortality in comparison to a conventional approach. This effect was associated with an improvement in patients’ quality of life, in the optimization of medical treatment, with a clear impact on beta-blocker prescription and titration, and a reduction in medical costs [7]. The RESICARD study, reported in this issue of the journal [8], enrolled 429 patients with a mean age of 73 years, in a pragmatic prospective “before/after scheme” study, to evaluate the impact of a HF network based on a medicosocial approach, patient education and coordination of care. A control group of patients was followed using a conventional approach from January 2001 to February 2002, a study group, followed according to a disease-management programme, was included from February 2002 to July 2003. The main objectives of this work, conducted by Assyag et al., were to observe the difference between the two periods of time in, firstly, the number and secondly, the time to occurrence of major cardiac events (rehospitalization or cardiovascular death). No differences were found between the two groups. Despite the limitations of the study methodology, this paper brings important insights, underlining the difficulty of implementing a HF network, and emphasizing the importance of the role of the nurses in the context of a multidisciplinary and organized patient care plan involving cardiologists and general practitioners. This collaboration between physicians and nurses is a key point, and avoiding one component of the team leads to a decreased efficiency. The COACH study recently showed that neither moderate nor intensive disease management by a nurse specializing in the management of patients with HF reduced the combined endpoint of death and hospitalization for HF compared with standard follow-up by a cardiologist [9]. The quality of healthcare has always been viewed in terms of the quality of education and development of medical students, physicians, and care givers in general, but patient education will also act on one of the main parameters of disease management: the patient him- or herself. Patient education is fundamental to the success of a long-term approach in the context of a chronic disease. Education goes far beyond information and is probably the most efficient means to consider long-term and efficient self-management. Education should be based on the exchange of knowledge between patients and caregivers, promote the concept of global health and help the realization of a life project, take into account the patients’ psychosocial needs, and favour the emergence of patient skills.

Hence, patient education is a key point in the long-term management of HF patients in combination with coordination of care. It is important to point out that the French Working Group on Heart Failure has implemented a large nationwide programme, I-CARE [10], since 2005 to train physicians and caregivers in this innovative approach, which included at this time more than 200 multidisciplinary teams. However, implementing a HF network represents a large amount of work and an initial sizeable outlay. While it should of course take into account local or regional peculiarities, which will determine the likelihood of success, it should follow the keys to success represented by the multidisciplinary approach: coordination of care and patient education.

Besides the progress made in the prevention of disease, and innovations in the field of pharmacology and techniques, which are essential, the issue of the management of chronic diseases is an important challenge for the future. A global and multidisciplinary approach is mandatory for maintaining the efficiency of our healthcare system in the context of the growing epidemic of HF. These first experiences, including the one reported by Assyag et al., are very important and help us to delineate the future organization of care.

References
