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

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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,
based on patient education and coordination of care in ad-
dition to a medicosocial approach, in patients representa-
tive 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 reduc-
tion 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 tradi-
tionally 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 dura-
tion 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 prescrip-
tion 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 medicoso-
cial approach, patient education and coordination of care.
A control group of patients was followed using a conven-
tional approach from January 2001 to February 2002, a study
group, followed according to a disease-management pro-
gramme, 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 (rehospitaliza-
tion 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 hospi-
talization 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 develop-
ment 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 dis-
ease. Education goes far beyond information and is probably
the most efficient means to consider long-term and effi-
cient self-management. Education should be based on the
exchange of knowledge between patients and caregivers,
promote the concept of global health and help the real-
ization 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 coordina-
tion 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 pecu-
liarities, which will determine the likelihood of success, it
should follow the keys to success represented by the mul-
tidisciplinary 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 maintain-
ing 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 impor-
tant and help us to delineate the future organization of
care.

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