

Point/Counterpoint

Heart Failure Clinics Are Still Useful (More Than Ever?)

Tiny Jaarsma, RN, PhD,^a and Anna Strömberg, RN, PhD^{b,c}

^aDepartment of Social and Welfare Studies, Faculty of Health Sciences, Linköping University, Linköping, Sweden

^bDepartment of Medicine and Health Sciences, Division of Nursing, Faculty of Health Sciences, Linköping University, Linköping, Sweden

^cDepartment of Cardiology UHL, County Council of Östergötland, Linköping, Sweden

See article by Howlett, pages 276–280 of this issue.

ABSTRACT

Heart failure (HF) clinics have had an important role in optimal HF management and the effectiveness of these clinics has been studied intensively. A HF clinic is one of the various ways to organize a HF disease management program. There is good evidence that HF disease management can improve outcomes in HF patients, but it is not clear what the optimal components of these programs are and what the relative effectiveness of a HF clinic is compared with other forms of HF management. After initial positive reports on the effect of HF clinics, these clinics were implemented in many countries, although in different formats and of varying quality. In this article we describe the initial need for HF clinics, reflect on their development over time, and discuss the role of HF clinics in context of the current need for HF disease management.

RÉSUMÉ

Les cliniques d'insuffisance cardiaque (IC) ont joué un rôle important dans la prise en charge optimale de l'IC, et l'efficacité de ces cliniques a été étudiée de manière approfondie. Une clinique d'IC est l'une des diverses façons d'organiser un programme de prise en charge de l'IC. Des données fiables attestent que la prise en charge de l'IC peut améliorer les résultats chez les patients ayant une IC, mais on ne sait pas clairement ce que sont les composantes optimales de ces programmes et ce qu'est l'efficacité relative d'une clinique d'IC comparativement à d'autres formes de prise en charge de l'IC. Après les rapports initiaux positifs sur l'effet des cliniques d'IC, ces cliniques ont été mises en place dans plusieurs pays, quoiqu'elles soient de formes diverses et de qualité variable. Dans cet article, nous décrivons les besoins initiaux concernant les cliniques d'IC, réfléchissons à leur développement futur et discutons de leur rôle dans le contexte des besoins actuels de prise en charge de l'IC.

Heart failure (HF) is a major challenge in current health care with an increasing number of patients worldwide and with the aging of the population, the effect of HF is expected to increase.^{1,2} HF is an important contributor to health care costs, with more elderly people hospitalized because of HF than any other medical diagnosis. Based on a large body of scientific evidence, current HF guidelines stress the importance of a multifaceted approach to HF management consisting of optimal diagnosis, pharmacological, device, and non-pharmacological treatment, including lifestyle advice, optimal transition, and coordination of care.^{1,2} Along the HF disease trajectory, the condition of the patient often changes, symptoms might progress over time, and in most patients the course is unpredictable, with phases of crisis, chronicity, and the terminal stages. HF patients often have several exacerbations during their disease trajectory, which are mostly accompanied

by rehospitalizations or extra visits to a health care professional, resulting in high costs in health care and a negative effect on the quality of life of patients and their families.^{3,4} A HF clinic can play an important role in optimal HF management and the concept of these clinics has been studied intensively in the past years.^{5,6} An HF clinic can be defined as a unit providing access to multidisciplinary teams including specialist HF nurses and physicians delivering advanced diagnostic or treatment services,⁶ in hospital or in primary care. HF clinics are a tool for delivering care according to clinical guidelines and providing advanced diagnostic or treatment services.⁶ With newer forms of HF management in home care or primary care or by telemonitoring, one wonders if there is still a place for HF clinics and if they suit the state of the health care, patients' wishes, and costs.

This is especially relevant, since a recent Cochrane analysis⁷ concluded that although there is now good evidence that case management type interventions led by a HF specialist nurse improve outcomes in HF patients, they found it not possible to say that the HF clinic is superior to other forms of HF management. One might also argue that with the improving trends in the long-term prognosis after acute HF^{3,5} with declining overall 1-year mortality rate, these specialized HF

Received for publication September 5, 2013. Accepted September 22, 2013.

Corresponding author: Dr Tiny Jaarsma, University of Linköping, Department of Social and Welfare Studies, Faculty of Health Sciences, 58183 Linköping, Sweden.

E-mail: tiny.jaarsma@liu.se

See page 274 for disclosure information.

clinics are no longer needed. However, before ‘throwing out the baby with the bathwater,’ we would like to describe the initial need for HF clinics, reflect on their development over time, and discuss the role of HF clinics in the current need for HF disease management.

Phase 1: First Need and Development

The first HF disease management programs were established in the 1990s as a solution to the high readmission rate of patients and their poor prognosis. Readmissions were often seen as preventable and were related to nonadherence, inadequate medical treatment, or inadequate reaction of patients and health care providers to deterioration. HF clinics in the first landmark studies included several components such as patient education, optimization of medication, and close follow-up, either in outpatient HF clinics or at home.⁸⁻¹¹ In the years after these first positive reports, HF management programs were increasingly evaluated and implemented in several countries worldwide. Meta-analysis confirmed the effectiveness of HF disease management programs that were often hospital-based, with care delivered at outpatient clinics, sometimes with outreach to patients’ homes by HF nurses.¹²

Phase 2: Implementation and Reflection

After the first successful trials and positive meta-analysis, major guidelines recommended HF management programs for recently hospitalized HF patients and for other high-risk patients.^{1,2} Because delivery of care varies in different health care systems worldwide, the organization of a HF management program was advised to be based on patient needs, financial resources, available personnel, and administrative policies, and adapted to local priorities and infrastructure,¹³ implying that it is difficult to prescribe 1 optimal format across the whole world. Different models might have advantages and disadvantages that might be more applicable to some countries than to others (Table 1). In the course of time, an

increasing number of meta-analyses and first cost-effectiveness studies led to further implementation of HF programs across the world. However, substantial disparity in access to HF care was found internationally, nationally, and also regionally, with a large range in the complexity of services offered.^{14,15} A wide range of models was offered. However, the most common model was hospital-based and specialty-only, resulting in a limited availability to the oldest, frailest, and those with multimorbidity, in almost every country. For example, in a European survey we found that half of the programs were located in outpatient clinics and others as home-based programs.¹⁵ Furthermore, even if HF clinics are available, the referral to and subsequent enrollment in HF clinics is far from optimal^{14,16} with estimation that one-seventh of HF patients were referred to an HF clinic,¹⁴ suggesting that implementation is far from optimal.

Meanwhile, although most HF management programs aim at optimization of pharmacological and nonpharmacological management, the most optimal model for HF management is not known. Recent large-scale studies show that not all models are equally successful to improve outcomes.^{17,18} These results indicate that a sophisticated approach to HF management is needed and questions remain on the optimal ‘dose’ and format of follow-up.

Phase 3: Current State and Future Challenges

Several challenges remain in optimal care delivery and the HF management programs need to consider issues related to the place of delivery, quality, and new patient groups. In addition, HF clinics need to be adaptive for patients over time because they will need more or less of the components in a HF clinic during their HF trajectory.

Place of delivery: clinic or/and home?

The recent Cochrane analysis⁷ reviewed clinical service organization for HF patients by analyzing 25 trials (5942 people) and it was concluded that it is not possible to say what

Table 1. Strengths and weaknesses of various heart failure disease management models

	Strengths	Weaknesses
Clinic visits	<ul style="list-style-type: none"> • Medical expertise available • More options in diagnostic tools • Facilities and equipment available to adjust treatment • Ability to deliver acute care 	<ul style="list-style-type: none"> • Travel might be difficult for frail, nonambulatory patients • Clinic facilities might be overburdened/overcrowded
Home care	<ul style="list-style-type: none"> • Access to nonambulatory patients • Realistic assessment of the patient’s needs, capabilities, and adherence to treatment in their home environment • Suitable for a follow-up visit shortly after hospitalization • Patient- and caregiver-friendly 	<ul style="list-style-type: none"> • Time-consuming for the heart failure team • Transportation and mobile equipment required • Challenges might exist in medical responsibilities
Telephone support	<ul style="list-style-type: none"> • Low costs • Time efficient • Convenient, for the team and for the patient 	<ul style="list-style-type: none"> • Difficult to objectively assess symptoms and signs of heart failure • Difficult in case of hearing problems • Difficult to provide psychosocial support, educate patients and caregivers • Challenges to implement large adjustments in treatment
Remote monitoring	<ul style="list-style-type: none"> • Facilitates informed clinical decisions • New equipment and technology becoming rapidly available • Low cost, depending on its use (replace vs add to existing care) 	<ul style="list-style-type: none"> • Requires education on the use of the equipment • Requires clear communication and development of protocols on responsibility for incoming data • Can be time-consuming for the heart failure team • Difficult for patients with cognitive disability • Most helpful measurements not known • Reduced opportunity to individualize education for patients and caregivers

Adapted from Dickstein et al.¹³

Download English Version:

<https://daneshyari.com/en/article/2721793>

Download Persian Version:

<https://daneshyari.com/article/2721793>

[Daneshyari.com](https://daneshyari.com)