Team-Based Care for Outpatients with Heart Failure

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KEYWORDS

- Disease management • Multidisciplinary heart failure team
- Outpatient heart failure medical therapy • Telemonitoring • Advanced care options

KEY POINTS

- Concentrated, team-based outpatient heart failure programs may be able to provide more focused care that could improve the quality of care and patient-center outcomes.
- There has been a growing recognition of the role of team-based care for enhancing the management of heart failure.
- Implementing team-based care for outpatients with heart failure significantly reduces rehospitalization and cost, and improves functional status and quality of life.
- Effective and safe use and optimization of guideline-directed therapy are critical in reducing mortality and rehospitalization.

INTRODUCTION

Heart failure (HF) is a concerning health care problem associated with significant morbidity, mortality, and costs. There are approximately 825,000 new HF cases annually. An estimated 5.1 million Americans older than 20 years have HF. Eighty percent of patients with HF are elderly (≥65 years). In 2010, there were 676,000 emergency department (ED) visits and 236,000 outpatient visits with an estimated 1,801,000 physician office visits having the primary diagnosis of HF. Projections show that the prevalence of HF will increase 46% from 2012 to 2030, resulting in more than 8 million Americans older than 18 years with HF. Survival with HF has improved over time, but mortality remains high at 50% at 5 years.[1–3]

Furthermore, the diagnosis of HF carries a tremendous financial burden, with an estimated cost of $30.7 billion annually. The annual cost of HF will increase considerably to an estimated $69.7 billion by 2030.[3–5] HF treatment costs can be divided into several major components. In the United States in-hospital care is responsible for 60% of HF-related costs[6] while regular outpatient follow-up by general physicians, cardiologists, and/or specialized HF nurses and chronic medication are far lower.

The rising costs are in part due to patients with HF living longer because of the increased use of guideline-directed medical therapy (GDMT), development of advanced strategies for outpatient HF disease management, and other life-prolonging

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therapies such as devices (ie, implantable-cardioverter defibrillator [ICD], mechanical circulatory support [MCS]) with proven impact on morbidity and mortality.[6,7] Owing to the prevalence and rising costs, a variety of outpatient team–based HF management programs have been created over the past few decades. With the high volume of patients, HF clinics in the ambulatory care setting are in demand and their numbers continue to grow. These clinics treat the spectrum of HF from acute episodes to chronic management in outpatient settings. Clinics were designed to improve HF-related outcomes by decreasing readmissions and increasing survival.[8,9] Programs that apply team-based multidisciplinary care were consistently superior to that supplied by just an individual.[10,11]

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Improving outpatient HF management comes with significant responsibility to patients and health care systems. Practitioners who treat patients with HF are challenged to manage numerous comorbidities requiring multiple medications and lifestyle changes in an older, sometimes cognitively and psychologically affected patient group. Hospital readmissions or worsening HF symptoms are often preventable, and have been associated with modifiable factors such as insufficient use of GDMT, poor medication adherence, and poor adherence to fluid or salt restriction.[12–14] As a result, several initiatives were started to address and overcome the challenges in outpatient HF management.[15] Team care has generally been embraced by most as a criterion for high-quality care.[16] A multidisciplinary team-based approach to health care has been recognized for more than a decade as providing value through comprehensive, integrative management that encompasses use of best practices, clinical practice improvement, information technology, patient-centered outcomes, and chronic disease management. The goal of the interdisciplinary team is to deliver safe, effective, cost-containing, and culturally and linguistically appropriate interventions within and across care settings.[17–19]

Disease management programs (DMPs) were born out of the necessity for a multidisciplinary framework for treatment of chronic diseases that required complex medical and socioeconomic considerations.[20] Essential attributes, as suggested by the American Heart Association (AHA) Disease Management Taxonomy Writing Group, included clearly defined use of individualized, disease-targeted, evidence-based guideline interventions delivered through multidisciplinary team care, comprehensive patient education, medication management with consideration for environment, method, delivery, intensity, and frequency of communication with providers, and assessment of outcomes measures (**Table 1**).[20,21] Furthermore, national HF guideline writers recommended a team model of care to facilitate adherence to evidence-based practices and outlined key components of an HF DMP.[22,23] HF DMPs typically include 3 overlapping components: HF clinics, home care, and telemonitoring, or a combination of these methods (**Fig. 1**).[15,18,24]

The specialized HF clinic has become a vital element in comprehensive care and chronic management in outpatient settings for patients by practitioners with expertise in HF. Patients' management plans are formulated through an integrated multidisciplinary team approach beginning with patients and caregivers/family members.[18]

The earliest description of specialized HF clinics was in 1983.[25] However, greater development did not take significant shape until a landmark pilot study by Rich and colleagues[26,27] in 1993 when they demonstrated fewer hospital readmissions and a decreased number of hospital days in the HF multidisciplinary intervention group.[28] Later studies implementing team-based HF clinic interventions also reported improved functional status, quality of life, and HF medication optimization, and reduction in hospital readmissions, length of hospital stay, and health care costs.[29–37] Reduction in mortality and HF hospitalizations were further supported by subsequent meta-analyses evaluating HF clinic care in comparison with usual care.[28,38–40]

A systematic review of 29 randomized trials (5039 patients) incorporating multidisciplinary strategies for HF management reported reduced mortality, HF hospitalizations, and all-cause hospitalizations.[41] Furthermore, improving patient self-care reduced hospitalizations but not mortality, although strategies that used telephone contact with referral to primary care physicians reduced only HF hospitalizations. Multidisciplinary strategies saved costs in 15 of 18 trials that evaluated cost-effectiveness.[20,41] A meta-analysis by Whellan and colleagues[40] demonstrated that hospitalizations (HF and all-cause) and length of stay in hospital were decreased if patients attended follow-up with a cardiologist; this was not demonstrated with general internist management (see **Table 1**; **Table 2**).[42]

Home-Based Programs

In a home-based model, care is provided through home visits, telephone monitoring, or both. Home

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