

NICS Heart Failure Forum: improving outcomes in chronic care

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More than 170 clinicians from diverse healthcare backgrounds attended the National Institute of Clinical Studies (NICS) "Heart Failure Forum 2004: improving outcomes in chronic care", held in Canberra, 7–8 June 2004.

The purpose of the forum was to raise awareness of the growing burden of heart failure, engage with Australian and international experts in heart failure and chronic care management, and explore strategies for improving outcomes in chronic care.

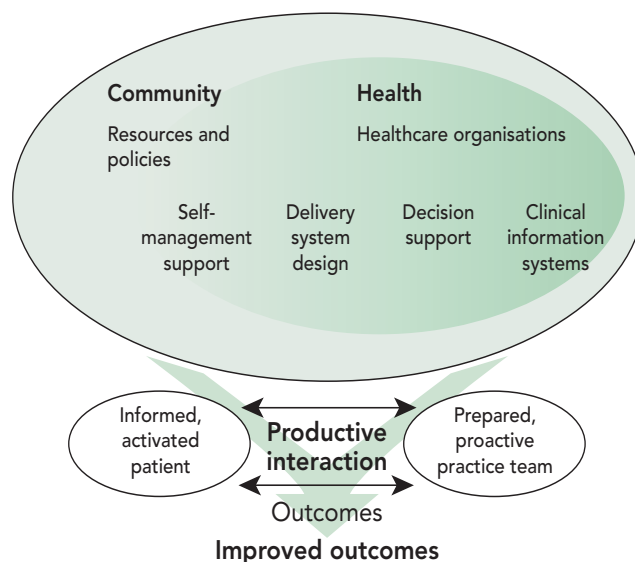
Successful models of care

Geoffrey Tofler (Chair of the NICS Heart Failure Advisory Group and Professor of Preventive Cardiology, University of Sydney) set the scene by highlighting gaps in the current medical treatment of heart failure. These gaps are most notable in the use of evidence-based drug therapies, such as angiotensin-converting enzyme (ACE) inhibitors and β -blockers, that reduce symptoms and hospital admissions and improve survival.¹ Chronic care expert Ed Wagner (Director, MacColl Institute for Healthcare Innovation, Group Health Cooperative, Seattle, Washington, US, and leader of the Robert Wood Johnson Foundation Improving Chronic Illness Care Program) argued that the current care system is not working adequately for either patients or healthcare professionals,² and emphasised the importance of redesigning care systems around the needs of patients with chronic illnesses. He described the essential elements of the chronic care model (Box 1),³ and illustrated how the model, combined with the Institute of Healthcare Improvement collaborative improvement method, enabled over 1000 US healthcare organisations to improve quality of care for patients with asthma, diabetes and chronic heart failure.⁴

Peter Didsbury (Chairman, New Zealand Guidelines Group, and Deputy Head and Manager of Integration, ProCare Health Ltd, Wellington, NZ) reported increased prescribing of ACE inhibitors, β -blockers and spironolactones following multifaceted intervention strategies, such as improved access to echocardiography, rapid access to cardiology advice, funding for β -blocker titration, access to a cardiac nurse specialist and 24-hour telephone triage. The results of an unpublished randomised trial he conducted involving patients with chronic obstructive pulmonary disease led him to suggest that improving the effectiveness of patient adherence through more structured care processes (such as holistic assessments, education about the condition, lifestyle therapy, action plans and active follow-up) may have greater effect.

The vital role played by nursing staff was highlighted by Simon Stewart (Chair, Cardiovascular Nursing, and Director of the Centre

1 The chronic care model



Source: Ed Wagner keynote address, NICS Heart Failure Forum 2004. Available at www.nicsl.com.au. For more information on the chronic care model, see reference 3.

for Innovation in Health, University of South Australia). He presented evidence from a recent systematic review of randomised trials of multidisciplinary strategies for the management of patients with heart failure at high risk for admission. This review showed that programs that incorporate follow-up by a specialised multidisciplinary team (in either a clinic or a non-clinic setting) reduce mortality, heart failure hospitalisations and all-cause hospitalisations.⁵ Stewart emphasised the need for a more systematic implementation of specialist nurse-led, home-based, follow-up services after discharge for patients with heart failure. Such services are currently available to less than 10% of those needing them. Whether this form of care is applicable in rural and remote locations is not certain, according to Henry Krum (Director, NHMRC Centre of Clinical Research Excellence in Therapeutics, Monash University), who described the computerised, telephone-based patient support system ("Telewatch") his research group is trialling in Australia. The system allows healthcare providers to closely monitor symptoms of patients with chronic heart failure and to track progress, respond to deterioration and make suggestions to improve overall management. Specific questions relate to diet, exercise, alcohol use, smoking, use of drugs for chronic heart failure, use of prescribed and over-the-counter medications unrelated to chronic heart failure, mood state and current coping. Results are expected by the end of 2005.

The role of GPs in management of heart failure

Although heart failure is a leading medical cause of hospital admissions in older people, Justin Beilby (Head, Department of General Practice, University of Adelaide) noted that patients with

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2 Matrix of key strategies and interventions for a patient with heart failure

Stage	Prevention	Early stage	Acute exacerbation	Ongoing care	Palliative care
Issues	Identification of high-risk patients	Recognition of early signs and symptoms, when and whom to refer for echocardiography Use and availability of echocardiography, particularly in rural areas Use of BNP in primary care to be further defined	In-hospital initiation of appropriate therapy and discharge to community with management plan, including dose titration schedules Comorbidities, diagnostic issues, systematic patient education and support	Need research on the education of practice nurses in chronic care management and effectiveness in improving patient outcomes Changing roles in general practice	Need research on access to palliative care services and how to extend these to patients with heart failure
Model	Prevention and management of coronary artery disease and hypertension	Consumer Education (NICS Online directory of quality information for patients with heart failure) Appropriate use of echocardiography in diagnosis and assessment of heart failure in primary care (NICS education module in preparation)	Clinician-led quality improvement programs Heart failure nurse-led, home-based management programs (Alternatives include hospital-based rehabilitation, heart failure clinics)	Chronic care management model Study and implement self-management models Targeted interventions aimed at implementing best practice management of heart failure in primary care (NICS, NPS and NHFA joint heart failure program)	Need research on appropriate palliative care model and extrapolation of palliative care and nursing principles
Consumer role	Awareness of risk factors (SNAP)	Awareness of early symptoms and precipitants, especially in high risk individuals	Working in partnership with healthcare professionals Access to self-management education and support, particularly post-discharge	Self-management education and support, ongoing monitoring, adherence to treatment Heart Failure Action plan	Consider advance directives Access to self-management and support
Provider role	Identification and treatment of high-risk patients by GPs, cardiologists, general physicians	Assessment of patients with early signs and symptoms by GPs Referrals to cardiologists or general physicians, where appropriate	Emergency physicians, cardiologists, general physicians, geriatricians, cardiac nurses, hospital pharmacists	GPs, practice nurses with training in chronic care and support from cardiac nurses, allied health, community nurses and pharmacists	GPs, community nurses, palliative care teams
Government role	Heart failure health promotion campaign, and systems in place to support this	Access to echocardiography, access to cardiologists Need heart failure prevalence study and minimum heart failure dataset Need initiatives for improved outcomes for cardiovascular disease in primary care	Ongoing resourcing for cardiac nurse role in acute settings and post-discharge (state) Testing and implementation of chronic care model in general practice and system redesign issues (Commonwealth)	Mechanism for funding comprehensive care programs More practice nurses Capacity building for quality improvement	Extend palliative care entitlements to patients with heart failure (eg, access to medicines, oxygen and home nursing services)

BNP = Brain natriuretic peptide. NICS = National Institute of Clinical Studies. NPS = National Prescribing Service. NHFA = National Heart Foundation of Australia. SNAP = Smoking, Nutrition, Alcohol, Physical activity.

heart failure represent a low proportion of the total patients that each general practitioner treats. Of concern to GPs is the need to identify people with early heart failure, who would benefit from more aggressive intervention. This point was reinforced by Michael Feneley (Chair, Cardiac Society of Australia and New Zealand Echocardiography Working Group), who stressed that new shortness of breath with no other obvious cause is often a symptom of early heart failure and should trigger investigation. He believes echocardiography is the most useful investigation in confirming or ruling out heart failure and is critical for determining the underlying cause and guiding therapy.⁶

Mark Harris (Professor, General Practice, University of New South Wales) detailed the important role of Divisions of General Practice in providing support and feedback to practices in the

collection and analysis of data and in the use of patient registries — key elements of proactive chronic care patient management.

The forum heard from Judith Mackson (Prescribing Program Coordinator, National Prescribing Service [NPS]) that the NPS, the National Heart Foundation of Australia (NHFA) and the NICS have formed a collaboration to improve targeted elements of heart failure diagnosis and management in general practice. This joint program will deliver key messages on drug use for treating heart failure and will emphasise the importance of echocardiography to confirm the diagnosis and guide treatment.

Current government initiatives in chronic care

The importance of adopting a more systematic approach to chronic care management in Australia was reinforced by Andrew

Tonkin (Director, Health, Medical and Scientific Affairs, NHFA), who argued that the effective management of heart failure represents an excellent paradigm for improving the care of people with other chronic conditions. The value and cost-effectiveness of management programs that can support patients with heart failure in the home and community and prevent hospitalisation have been demonstrated. Programs and information systems for patients with heart failure, once established, could be easily adapted to the needs of other chronically ill patients.

Jane Halton (Secretary, Australian Government Department of Health and Ageing) highlighted recent Budget initiatives. Funding is provided for 1600 more primary care nurses and a new Medicare Benefits Schedule item number linked to the Enhanced Primary Care multidisciplinary care plan for services provided by allied health professionals. Ms Halton outlined the government's plans for a national chronic disease strategy, following development and consultations by the National Health Priority Action Council's Chronic Disease Strategy Group.

The forum heard about different state heart failure programs. Craig White (Deputy Chair, Victorian Hospital Admission Risk Prevention Program, and Executive Director, Clinical Services, Austin Health) and Kym Scanlon (Assistant Director, Chronic Care Program, NSW Health) presented figures showing encouraging reductions in hospital admissions for chronic heart failure since the commencement of statewide chronic care programs, such as the Victorian Hospital Admission Risk Prevention Program and the NSW Chronic and Complex Care Program.^{7,8} Clearly, more patients need to access these programs, with only an estimated 15% of eligible patients enrolled in Victoria (Andrea Driscoll, Deakin University). NSW Health is currently addressing implementation and spread of issues through a statewide chronic care collaboration that focuses on heart failure and chronic obstructive pulmonary disease. The change principles of the collaboration are based on the key elements of Wagner's chronic care model, as well as policy components from the World Health Organization's Innovative Care for Chronic Conditions Framework.⁹

Conclusion and the way forward

In the concluding plenary session, Didsbury and Wagner suggested strategies that would facilitate implementation of the chronic care model in Australia. They emphasised the need to reward care planning, support efforts to encourage practice system change, and make patients a part of the planning. Using the patient journey as a framework, Geoffrey Tofler presented a matrix of key strategies and interventions that patients, clinicians and govern-

ments should consider to improve outcomes and quality of life for patients with heart failure (Box 2). The matrix indicates areas where best-practice models of care are known, such as cardiac nurse specialists for post-discharge heart failure patients, and areas where more research is needed, such as the best use of practice nurses in chronic diseases. Finally, the matrix suggests areas where enhanced government support is needed (such as in creating mechanisms for funding comprehensive care programs and in further funding for practice nurses).

The range of participants at the forum reinforced the broad approach needed to improve outcomes in heart failure. Furthermore, strategies adopted successfully with heart failure could have major effects when extrapolated to other chronic conditions.

The forum presentations and a more detailed report are available on the National Institute of Clinical Studies website (www.nicsl.com.au).

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