A comprehensive approach to heart failure care in Spain: from national strategy to local reality

A guide for local and regional decision-makers

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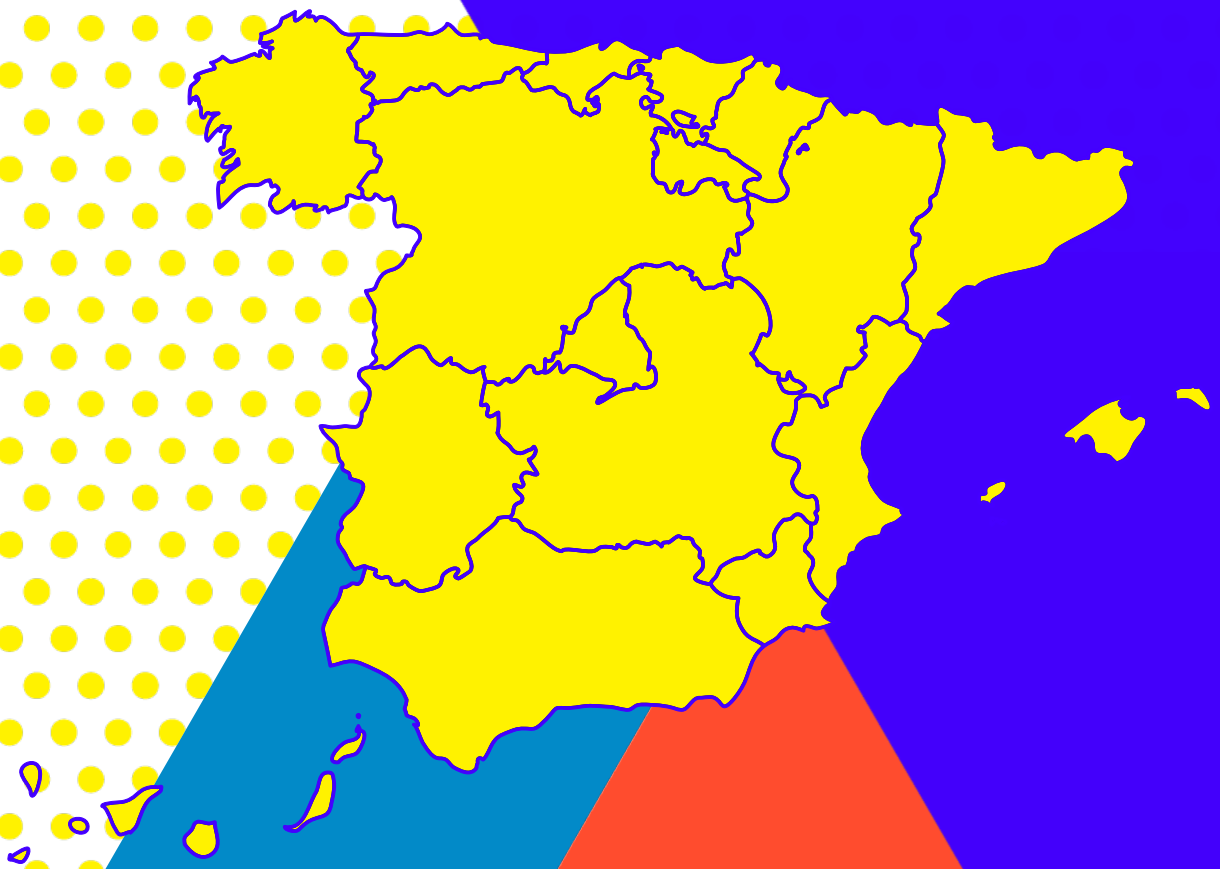

The Heart Failure Policy Network

European Heart Failure Mission

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About this report

The National Cardiovascular Health Strategy – published in 2022 – is a comprehensive plan to address four major conditions in Spain. Given that healthcare services are usually organised and administered by the regions, this guide aims to bridge the gap between national heart failure recommendations and their local delivery. It equips regional policymakers and local healthcare decision-makers with an overview of the recommendations and the key considerations and resources needed for their implementation.

The Heart Failure Policy Network (HFPN) developed this guide in close consultation with a Project Advisory Group of experts in heart failure and health services in Spain. It complements the national strategy, but does not replicate or supersede any regional, national or European guidelines or recommendations. Policymakers, service managers, clinicians and patients should consult established guidance as appropriate.

This guide is accompanied by region-specific summaries that highlight available data on the impact of heart failure and international examples of best practice in diagnosis and care.

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Heart failure is a policy priority in Spain

Why is heart failure a policy priority?

Heart failure is a common chronic condition in Spain, affecting 2% of the population.[1] It is one of the major causes of mortality[2] and has a high rate of hospital readmission, leading to high healthcare costs.[3 4]

- Heart failure is estimated to affect 16% of people aged 75 and older in Spain.[5]
- Nearly 1 in 3 people with heart failure are rehospitalised within one month of discharge.[3]
- Heart failure costs the Spanish health system an estimated €2.5 billion per year.[4]

Further data about the burden of heart failure on each region can be found in the regional summaries that accompany this report.

Definitions

Autonomous communities: these represent the top tier of Spain's administrative structure; each of the 17 divisions has its own government that is responsible for the administration of healthcare services within that region, such as setting policies and allocating budgets.

Cardiovascular Health Strategy (CVHS): known as Estrategia en Salud Cardiovascular del Sistema Nacional de Salud (ESCAV) in Spanish, CVHS is a comprehensive national initiative that aims to improve cardiovascular health across the country.

Health areas: these are territorial divisions within an autonomous community that are responsible for organising and delivering public healthcare services. They ensure local implementation of regional health policies, and coordinate primary care, hospitals and specialised services.

Heart failure: occurs when the heart becomes too stiff or weak to effectively pump blood around the body.[6] This leads to breathlessness, fatigue, reduced capacity to exercise, and fluid retention.

Heart failure and the Cardiovascular Health Strategy

The CVHS identified heart failure as one of four cardiovascular conditions requiring comprehensive action due to its significant impact on the health system and the general population. The strategy sets four key objectives to improve heart failure care in the country:[7]

1. Promote early diagnosis of heart failure across all care settings
2. Develop protocols and/or systems that facilitate the early diagnosis of heart failure
3. Promote the implementation of multidisciplinary care models across all settings
4. Organise a network system at the regional level to facilitate advanced treatment for cardiogenic shock.

From national strategy to local implementation

Despite the CVHS recommendations, best-practice care models for heart failure are yet to be implemented at the local level.[7] The Interterritorial Council of Spain's National Health System, which is responsible for coordinating and aligning healthcare services across autonomous communities, approved the CVHS in 2022. This sparked a process of implementation at the regional level, with autonomous communities developing more specific strategies that are tailored to the needs of their populations.[8] However, the development of regional implementation plans currently remains inconsistent and local implementation is scarce.[9]

Implementation of the CVHS depends on the leadership of local stakeholders to improve healthcare services for heart failure. While the national strategy provides a shared vision for heart failure, its successful implementation is dependent on a bottom-up approach that reshapes heart failure care at the local level. Local decision-makers, healthcare professionals and patient advocates must take ownership of the implementation of the strategy's objectives to drive meaningful change for people living with heart failure.[10]

A guide to implementing the CVHS locally

About this guide

What does the guide include?

This guide provides key components, considerations and resources to facilitate the development of programmes for the local improvement of heart failure care. It includes:

- a framework encompassing a three-step process for the local implementation of a comprehensive approach to heart failure: preparation, setting a foundation and additional opportunities
- objectives, indicators and standards set by the CVHS and the Spanish Society of Cardiology (Sociedad Española de Cardiología).

The guide also signposts additional resources and initiatives that can further support local implementation and tailoring to local realities.

How can you use the guide?

This guide aims to support the local implementation of the CVHS national recommendations for heart failure. While local health areas should adhere to the standards established by the CVHS, they need to take an approach best suited to their needs and resources. This guide can be used to ensure adherence to the CVHS by:

- supporting the development of a regional proposal for a quality improvement programme for heart failure
- guiding the development of a detailed plan for the local implementation of the CVHS in a health area
- serving as a discussion guide for meetings between regional healthcare managers and local clinical leads.

Who can use this guide?

This guide can be used by individuals with the capacity to influence the approach to heart failure at a local level. For example, the guide is aimed at:

- regional healthcare managers involved in the administration and financing of health services
- clinical leaders in hospital, primary care and community settings
- patient advocates seeking to support improved heart failure care at the local level.

How can you implement the cardiovascular health strategy (CVHS) in your local health area?

Heart failure objectives in the CVHS:

- Early diagnosis across care settings
- Protocols or systems that facilitate early diagnosis
- Multidisciplinary care models across settings
- Network system for cardiogenic shock

Preparing for local implementation

☑ Who needs to be involved?

A designated clinical lead, a strategic committee and an operational committee

☑ What are the available resources?

e.g. services, human resources, ongoing education programmes, equipment and procedures, and clinical protocols

☑ What data are available?

Key indicators for heart failure e.g. prevalence, access to natriuretic peptide analysis in primary care, hospital mortality rates

Putting local implementation into practice

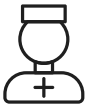
Building an integrated care pathway for heart failure for early detection and multidisciplinary care

Integration with primary care via access to diagnostic tests, efficient communication, education and training

Ongoing monitoring and improvement with the help of digital tools, regular meetings and educational materials

System-wide opportunities for optimal care

Incorporating digital tools across healthcare settings e.g. virtual consultations, remote monitoring, shared medical records and digitalised care pathways



Developing the healthcare workforce e.g. nurse coordinators, pharmacist education

Prioritising the needs of people with heart failure e.g. collaborating with patient organisations and implementing shared decision-making practices

Preparing for local implementation

Implementing the CVHS in health areas requires a local multidisciplinary alliance with a thorough understanding of the resources available in the health area and the performance of the healthcare service.

Who needs to be involved?

A designated clinical lead/coordinator

Healthcare managers should consult with clinical teams to identify a clinical lead for heart failure in every health area.

Requirements:

- extensive experience in delivery of heart failure care, ideally with training in healthcare management
- commitment to the local implementation of the CVHS.

Responsibilities:

- coordinating the programme
- establishing a working group (including strategic and operational committees)
- serving as key contact for heart failure services across different healthcare settings.

A strategic committee

The local clinical lead/coordinator should convene a strategic committee.

- Responsibilities: defining the quality improvement programme's vision for heart failure care and goals for the healthcare service; aligning and coordinating across the healthcare service; analysing areas of improvement and ongoing monitoring of the service's performance; developing proposals for the acquisition of new services where needed.
- Members: heads of departments that treat people living with heart failure, including cardiology, internal medicine, primary care, emergency departments and nursing.

An operational committee

The local clinical lead/coordinator, with the support of the strategic committee, should convene an operational committee.

- Responsibilities: the day-to-day delivery of the quality improvement programme; educating and coordinating all healthcare professionals who treat people with heart failure.
- Members: leading healthcare professionals across disciplines and healthcare settings who are involved in the management of people with heart failure.

What are the available resources?

Assessment of existing resources

The strategic committee should map the available services, protocols and human resources relevant to the diagnosis and treatment of people with heart failure, and the gaps that need to be addressed.

Heart failure resources	Key examples
Portfolio of services	Assessment of natriuretic peptides (NPs), a blood test to rule out heart failure
Human resources	The recommended rate of cardiologists or internists with training in heart failure, and nurses with experience in the condition, is 1 professional per 100,000 inhabitants
Ongoing education programmes	Heart failure education programmes for primary care physicians and nurses
Equipment and procedures	Availability of echocardiograms
Clinical protocols	Structured patient monitoring and early detection of heart failure exacerbation

***Tip:* use the quality standard checklists developed by the Spanish Society of Cardiology**

The SEC-EXCELENTE programme of the Spanish Society of Cardiology has developed detailed checklists with quality standards for the three types of heart failure units – community, specialised and advanced – depending on the local level of complexity.[11-13] These checklists can be used to identify the resources available in each health area and document the quality standard.

Resource planning

Based on the map of available resources, the strategic committee should:

- identify gaps in the healthcare service that are preventing the delivery of high-quality care for people with heart failure
- develop and submit a business proposal for resources that would support the delivery of a comprehensive approach to heart failure
- establish annual goals that the healthcare service must achieve, with support from the operational committee.

What data are available about the heart failure service?

Identifying available data

The strategic committee should assess available data on the healthcare service, referring to the key indicators for heart failure in the CVHS:[7]

- Prevalence of heart failure in primary care
- Access to NP analysis in primary care
- Multidisciplinary teams per hospital in each autonomous community
- Existence of specific protocols for referral from primary care to hospital care, after heart failure is confirmed by NP
- Rate of deaths in hospital among people admitted for heart failure
- Percentage of hospitals with specific multidisciplinary teams for heart failure
- Specific cardiogenic shock network existing and functioning at the level of the entire autonomous community
- Rate of deaths in hospital among people admitted for cardiogenic shock.

Developing data collection

In cases where there is a lack of data, and the indicators are not being monitored, the strategic committee should:

- develop a collaborative plan to establish appropriate systems for data collection across the healthcare service
- identify key questions and additional quality indicators for heart failure that should be collected (such as 30-day readmission rate) in addition to the CVHS indicators.

Utilising data

Once a data collection system has been established, it is essential to nominate an individual or working group to:

- coordinate regular data analyses and the development of performance reports to identify key areas for improvement
- share insights with the strategic and operational committees to ensure the ongoing improvement of the healthcare service.

Putting local implementation into practice

After identifying gaps and goals in the heart failure service, the operational committee can improve the delivery of heart failure care. While the process may vary depending on the health area, the core foundation should include an integrated care pathway, further integration with primary care, and ongoing monitoring and improvement.

Building an integrated care pathway for heart failure

The operational committee, under the leadership of the designated clinical lead/coordinator, should:

- develop a care pathway (adapted to the local context) that specifies how people with heart failure are cared for at all levels of care, when and where they should be treated, which procedures must take place and who would perform the procedures
- ensure the care pathway addresses two of the critical points in the CVHS (improving early detection and diagnosis of heart failure, and organising heart failure care through multidisciplinary heart failure units/programmes).

Furthermore, the care pathway should include the following:

- clear criteria for inclusion in, and exclusion and exit from, the care pathway
- follow-up protocols after discharge to prevent hospital readmission
- optimising treatment with the four medications recommended for heart failure
- education and psychosocial support for people living with the condition.

***Tip:* develop protocols with support from the SEC-primary care (SEC-AP) and SEC-EXCELENTE initiatives**

SEC-AP published a document on the process of developing a care pathway for heart failure, along with the standards and indicators to evaluate the care process.[14]

SEC-EXCELENTE has also developed a heart failure process standard, which includes the characteristics of the integrated care process, performance indicators, and standards for the management of heart failure.[15]

***Tip:* learn from existing heart failure protocols for other areas**

The Units of Integral Management of Patients with Heart Failure (UMIPIC) programme has published a document outlining its experiences in implementing a programme for heart failure. It includes criteria, the structure of the UMIPIC's work agenda and other characteristics of its care model.[16]

The Heart Failure and Atrial Fibrillation Group of the Spanish Society of Internal Medicine has developed a protocol for managing acute heart failure, including considerations for admission, management of the congestive and stable phases, considerations before discharge, and management of the post-discharge transition period.[17]

Integration with primary care

The strategic and operational committees should work together to ensure the optimal integration of primary care in the treatment of people with heart failure. The following areas should be addressed:

- access to key diagnostic tests in primary care, such as NP testing, and efficient referral for echocardiograms
- efficient communication between primary care and hospitals, for example through shared protocols, virtual multidisciplinary heart failure meetings and digital record-sharing systems (see also **Incorporating digital tools across healthcare settings**)
- heart failure education and training programmes for primary care professionals.

Ongoing monitoring and improvement

The operational committee should include a working group that is responsible for ensuring the ongoing monitoring and improvement of the heart failure service by, for example:

- using digital tools to monitor and assess the key indicators in the CVHS on a regular basis, and setting clear plans to adjust protocols and trainings so identified gaps are addressed
- scheduling a quarterly or annual meeting with the committees to identify gaps and suggest improvements to ensure the delivery of optimal care across all healthcare settings
- developing educational materials and training as needed to ensure the implementation of new protocols or ways of working. The training can be developed based on the courses and recommendations established by the Spanish Society of Cardiology, and adapted to the local needs of healthcare personnel.

Tip: incorporate lessons from the OPTIMISE-IC project

The OPTIMISE-IC project is an initiative of the Cardiology and Primary Care Working Group of the Clinical Cardiology Association of the Spanish Society of Cardiology; it aims to optimise a diagnostic and therapeutic plan for people with heart failure, and ensure comprehensive management between specialties.[18] The project analysed the initial performance of heart failure care after integration to identify difficulties and propose recommendations for optimisation. The major challenges that were identified included a lack of training in and access to diagnostic tests, and a lack of communication and shared protocols across healthcare settings.

System-wide opportunities for optimal care of people with heart failure

Health system leaders at the regional and national levels should consider how quality improvement initiatives can be supported and harnessed most effectively. The delivery of best-practice care for heart failure requires wider system improvements, such as healthcare digitalisation, an expanded workforce and increased patient involvement.

Incorporating digital tools across healthcare settings

Regional healthcare managers can incorporate digital platforms for heart failure as part of broader work to digitalise the health system. The digitalisation of the healthcare service is a broad and complex process that is being carried out in Spain's autonomous communities.[19] For heart failure care in particular, the incorporation of the following would be helpful:

- **virtual consultations and remote monitoring** with multidisciplinary teams to individualise treatment and promptly recognise the signs and symptoms of heart failure exacerbation
- **shared medical records** between hospitals and primary care to facilitate the monitoring and treatment of people with heart failure
- **digitalisation of the clinical pathway** in information systems to facilitate the automation of high-quality comprehensive care for heart failure.

Developing the healthcare workforce

Regional healthcare managers and strategic committees should support the development of the healthcare workforce to further support the optimal care of people with heart failure. Additional measures could include:

- **nurse coordinators** to lead integrated heart failure programmes; such programmes have been shown to reduce hospitalisations and mortality in a Spanish health area[20]
- **educating and collaborating with pharmacists** to improve community care; this has been shown to reduce hospital readmissions among people with heart failure.[21 22]

Prioritising the needs of people with heart failure

Regional healthcare managers and local clinical committees should incorporate patients' needs and priorities in the process of improving heart failure services. Taking a person-centred care approach – one in which people with heart failure are active participants – is a key component of quality healthcare and can improve patient outcomes.[23] This should be implemented by, for example:

- **collaborating with patient organisations** to ensure the inclusion of people with lived experience of heart failure in the optimisation of heart failure services
- **implementing shared decision-making practices** such as providing materials (e.g. patient decision aids) for people with heart failure and educational programmes for healthcare professionals.[24]

Conclusion

Regional and local authorities, such as health departments and health area management bodies, must facilitate compliance with the CVHS by providing the financial and human resources needed to implement the strategy. We hope that this guide will help improve the standard of healthcare and ensure the best quality of life for people with heart failure in Spain.

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