Summary

# The handbook of multidisciplinary and integrated heart failure care

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## Executive summary

Heart failure

#1

cause of unplanned admissions

1 in 5

can expect to live with HF at some point in their lives

+50%

rise in hospital admissions due in the next 25 years

Best-practice care achieves

↓30%

reduction in hospitalisations

**Heart failure (HF) is a healthcare sustainability challenge.**

- **HF is a common condition.** It occurs as a result of the heart becoming too weak or stiff,[1] affecting its ability to pump enough blood around the body.[2]
- **At least 15 million people live with HF in Europe.**[3] One in five of us can expect to live with HF at some point in our lives.[4]
- **The burden of HF is high.**[5 6] Quality of life and survival remain poor – worse than for most common types of cancer.[7]
- **HF is the leading cause of unplanned hospital readmissions.**[8] It is also the most common cause of admissions in people over 65.[9]
- **The burden of HF will rise.** This is partly due to an ageing population and improved survival from other cardiovascular and chronic diseases.[10 11]
- **Hospital admissions due to HF are projected to rise by 50%** over the next 25 years.[9]

**Although the prognosis is poor, the right package of care makes a huge difference to people living with HF.**

- **The right care and support can allow people with HF to recover many years of life**, and quality of life.[12 13] Hospitalisation can also be reduced by up to 30%.[14-17]
- **Care and support must be flexible to the individual needs and preferences** of the person living with HF. This can improve clinical outcomes and patient activation to live and self-manage HF.[2 6 18]
- **The best model of care is an HF management programme:** a package of person-centred care, which includes self-management support, rehabilitative and preventive care, routine reviews and escalation in the event of crisis.[8 19]
- **Best practice is for multidisciplinary care to be led by specialists,** including cardiologists (ideally with a sub-specialty in HF) and HF specialist nurses, working out of HF clinics.[6 12] Other vital roles include GPs, cardiac rehabilitation specialists, physiotherapists and pharmacists.
- **Home visits and structured telephone support (led by HF specialist nurses) are innovative models** in reducing HF-specific admissions and mortality.[17]

**European health systems are currently unprepared for HF.**

- **Healthcare systems often struggle with a chronic disease model,** and HF is no exception. Care is often fragmented[9 19] and guideline-based care too rare.[2 9 20]
- **The greatest challenges and missed opportunities lie at five points across the HF journey:** presentation and diagnosis; hospital discharge and follow-up; clinical management; patient empowerment and self-care; and advance care planning.
- **We need to train new roles and reinforce existing ones** if we are to keep patients out of hospital. In particular, we lack HF specialist nurses,[19] and need to better train and involve GPs and pharmacists. Every healthcare professional should recognise basic symptoms.
- **We need to overcome inertia, low awareness and low scrutiny at all levels**, including among policymakers, government agencies, professionals, patients and the public.

## Call to action

### We call on governments to recognise heart failure (HF) as an urgent sustainability challenge for 21st-century healthcare systems. Governments across Europe must:

- **Have a formal strategy on HF** and the changing impact it will have on the healthcare system and society, including future scenario-modelling. This should be developed in close consultation with patient and clinical advocates.
- **Invest in sustainable, specialist HF care models** outside of acute care, for example HF specialist nurses and HF outpatient centres. They should also promote professional education and, where appropriate, additional specialist accreditation for GPs, internists, primary care nurses and expert patients.
- **Ensure national guidelines and local care pathways embed the vision of quality in routine delivery**, working with professional societies, patient advocacy groups and healthcare providers to do so.
- **Prepare robust and public national audits of performance** to ensure accountability to citizens on patient survival, quality of life and experience of care, and to guide investment and incentives. The safe reduction of hospital readmissions should be a major strategic goal, indicating a sustainable approach to HF care.

### We call on governments to demonstrate measurable improvement for the following minimum standards and core indicators of quality for all HF patients:

- **Specialist-led diagnosis.** It is vital to achieve a definitive diagnosis with an echocardiogram, ensuring the underlying causes of HF are fully understood, addressed and communicated to patients.
- **Natriuretic peptide testing.** This should be a routinely available tool in both primary and secondary care settings.
- **Specialist-led care in hospital.** Patients should receive input from a cardiologist and HF specialist nurse.
- **Hospital discharge with a care plan.** Discharge plans should include clear points of contact and timely follow-up by specialists.
- **Cardiac rehabilitation, patient therapeutic education and psychological support.** HF care must be built on the maximum engagement of patients.
- **A shift in management of HF from the acute to primary care setting.** This shift should occur wherever it is safe and effective to do so.

The following organisations support and endorse this handbook.

**The handbook of multidisciplinary and integrated heart failure care and supplementary material are available at www.hfpolicynetwork.eu**

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# What is multidisciplinary and integrated care in heart failure?

## Multidisciplinary and integrated care is about delivering the best care possible

Integrated care has been defined as realising the potential of multidisciplinary teams to promote person-centred and coordinated care, tailored to the needs and preferences of the patient, their family and carers.[21] Effective care of HF should ensure management of comorbidities, changing needs and support throughout different care settings, involving HF specialists.[6] Team members are expected to work in close coordination with one another – including the patient – with mutual respect, clear communication and clear division of responsibilities.[19] This is especially important when a person with HF transitions between care settings.

## Multidisciplinary and integrated care changes across the HF journey

Every person living with HF has a unique journey. However, there are three very typical phases of HF: diagnosis; care and follow-up; and living with HF.[2 22] The last phase represents the long-term experience of people who learn to live with the condition and self-care. Depending on progression of the disease, people with HF may have episodes that require return to acute care or enhanced medical supervision.


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**Figure 1. Multidisciplinary and integrated heart failure care journey: key components of quality**

Seamless transitions of care are required across moments of crisis and changing need, in all settings and stages of the patient journey.[2 6]

**Key**

**Pressure points are well-known problematic areas where care and support fail many patients. Not all journeys are the same. Not all patients will be treated in hospital. Pressure points 4 and 5 may occur anywhere after diagnosis.**