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41 – Diagnosis and Management of Chronic Heart Failure: Are We Providing Quality Care?

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Introduction

In recent years, developed countries have focused their efforts in improving health care quality as a means to improve outcomes at a reasonable cost. Because of its increasing prevalence and chronicity, heart failure (HF) has received much attention as a potentially preventable cause of hospitalization. In spite of the advances made by programs like Medicare's Hospital Readmissions Reduction Program, the structural challenges faced by health services in Latin America (LA) have relegated quality of care to a second place among the priorities of the public and private sector alike. This text aims to provide a brief summary of the available data on the grade of adherence to standards of care in the management of HF in LA, and the basis for the development of quality improvement programs.

A scoping review of quality of care indicators

In LA, no community-based studies about management of HF have been published, which reflects the large gaps in primary care research in the subcontinent. A meta-analysis showed that in LA 59% of patients used Angiotensin-converting enzyme inhibitors, 71% used diuretics, 38% used Beta-blocker (BB) and 31% used mineralocorticoid receptor antagonists, in acute and non-acute settings (1). Although a study conducted in Mexico was included, all other studies had been conducted in Argentina (4 studies), Brazil (10 studies), Chile (2 studies) and Colombia (1 study), thus reflecting care in South America better than in the rest of LA.

The Brazilian Registry of Heart Failure revealed that only 63,7% of patients received structured orientations on drug therapy, with only 35% and 16% being correctly oriented on dietary measures and prescription of physical activity, respectively (2). In this study, the main cause for admission was lack of adherence to pharmacological treatment (30% of patients), with an additional 9% admitted due to inappropriate control of water and sodium ingestion. Also, data from the multicentre Heart Failure Registry of the Argentine Council of Cardiology Residents (CONAREC) showed that only 64% of admitted patients had their ventricular function previously evaluated (3).

Yearly hospital readmission rates in Argentina and Brazil range from 36% to 25,8% (3, 4), which are lower than in the US. However, this seems to depend not on better outpatient follow-up but on a longer in-hospital lenght of stay in Brazil (5).

This data reveal that treatment of HF patients in LA is not uniform, and suggest that

adherence to current evidence may be low. In comparison with data from the ACCLAIM trial, the use of BB, lipid lowering drugs, antiplatelet, anticoagulants, implantable cardioverter defibrillator (ICD), and cardiac resynchronization is lower in LA. A subanalysis of ASCEND-HF showed that quality of care for patients hospitalized with acute HF remains suboptimal even within a randomized clinical trial setting, with significant differences in LA in the use rate of BB and ICD (4). Although these studies were conducted in inpatients, the hypothesis that the same discrepancies in care exist in the context of primary care is likely to be correct, given that the causes for such differences between Europe, the USA and LA may be due to population and system-level factors. Fragmentation and underfinancing, low adherence to guidelines, different etiologies (particularly Chagas' disease and greater prevalence of hypertensive HF), and a case-mix derived from the largest socio-economic inequity worldwide that characterizes Latin-American societies are strong factors to be studied as responsible for this differences.

Opportunities for improvement

Improving quality of care is not a straightforward task that can be achieved through simple measures. It requires a comprehensive restructuration of health care work processes and the commitment of health care workers to adopt a patient-centred, quality-driven practice. In order to achieve such goal, governments in LA must promote the development of certain skills that form the basis of quality improvement programs. For example, problem-based learning (PBL) is a strategy that allows health care workers to continuously improve practice quality. Low adherence to guidelines could be better addressed through the promotion of patient-centred, evidence-based and community-oriented curriculums in public and private medical and nursing schools. Recently, a number of public universities in Argentina have adopted PBL and community oriented curriculums, but so far they have produced few graduates. The impact of this changes must be capitalized into quality programs in the next few years.

Health systems financing in LA has traditionally been disease-oriented instead of health-oriented. This financing model impacts clinical management in a way that raises ethical considerations that exceed this article. Quality-driven financing models in health care reimburse workers and organizations for the degree of preventable events they avoid, instead of reimbursing them for the events they treat whether these were preventable or not. During the past decade, most countries in LA implemented innovative programs to improve population health outcomes and to reduce inequalities in health access focusing on universal health coverage for vulnerable populations. Improvements in anthropometric measures of growth and health statuses in children younger than 5 years were observed after the implementation of Bolsa Familia in Brazil, Oportunidades in Mexico, and Familias en Acción in Colombia, which proves that in the context of fragmented systems, improvements in quality are feasible and effective.

The experience acquired with these primary care-based pay-for-performance programs, combined with the current experience in USA and Europe were HF readmission rate is being used as a quality outcome that reimburses hospitals, should be the starting point for the expansion of HF care towards the community, transferring responsibility for transitional care from the hospital to primary care and other outpatient facilities led not by hospitalists, but by primary care teams comprised by nurses, social and mental health workers, and family and general physicians. Therefore, some indicators must be shared and co-financed between hospitals and primary care, e.g. avoidable readmissions in HF and those pertaining to timely planned admissions for unstable angina revascularization. The establishment of this indicators, and the management of comprehensive quality programs, is up to national and regional governments in close partnership with scientific societies.

Take Home Message

- Treatment of heart failure in Latin America is not uniform.
- Adherence to guidelines in Latin American countries is low.
- Outcomes could be improved with comprehensive quality programs.
- Previous pay-for-performance programs in Latin America have been successful.
- Quality measures regarding transitional care must be shared between hospitals and primary care.

Original Abstract

http://www.woncaeurope.org/content/ab786-%C2%A0-%C2%A0-%C2%A0-%C2%A0-diagnosis-and-management-chronic-heart-failure-are-we-providing-quality-care

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