

Heart Failure Factsheet

For health service planners, program directors and clinical staff

Evidence to support improved heart failure services

Health services can help patients with chronic heart failure (CHF) to stay productive and out of hospital after they have been diagnosed. There is overwhelming evidence that multi-disciplinary care is the most effective way to manage heart failure patients. Available services can be found heartfoundation.org.au/cardiac-services-directory.

The key issues

Prevalence

> 100,000
AUSTRALIANS
AGED 45+

More than 100,000 Australians aged 45 and over have heart failure representing 1.2% of the population aged 45 and over¹.

Deaths

> 2,800
AUSTRALIANS
EVERY YEAR

Heart failure is responsible for the death of more than 2,800 Australians every year¹.



59%

Women account for 59% of all heart failure deaths.

↑ 29%

Since 2005 (the last 10 years), heart failure deaths have increased by 29%, from 2,225 to 2,876¹.

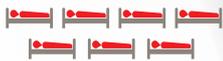
318 → **382**
2004 → 2013

In Queensland heart failure deaths increased from 318 in 2004 to 382 in 2013².

Hospitalisations

2013  **9,024**

In 2012/13 the number of hospital separations due to heart failure in Queensland has increased from 8,802 (2008/09) to 9,024³.



Average length of hospital stay for heart failure related admission is 7 days⁴.

50%

As high as 50% of heart failure patients are re-hospitalised within 3-6 months^{5,6,7}.

Of Australians who have chronic heart failure:



29% have high blood pressure (>140/90mmhg)



41% are obese (BMI>30)



36% do no exercise at all



17% are smokers



11% have diabetes⁸

Benefits of heart failure services

Health and clinical benefits¹⁰:

- Increased knowledge of risk factor management like healthier eating and increased physical activity.
- Better management of symptoms like salt restriction, fluid monitoring and fatigue action plan.
- Improved clinical management like reduced blood pressure and improved renal function.
- Improved clinical outcomes like decreased morbidity, mortality and hospitalisations.
- Strengthened adherence to medications.
- Enhanced mental health and quality of life.
- Improved palliative care support and decision making.

Economic benefits¹⁰:

- There is increasing evidence that guideline-based multidisciplinary CHF models of care provide significant cost savings, with sustained cost benefits from early intervention.
- Hospital care is the largest proportion of CHF care costs. Up to two-thirds of CHF related hospitalisations are preventable. Multidisciplinary CHF programs have been demonstrated to significantly reduce unplanned hospital admissions, including readmissions for CHF.
- Intensive case management interventions led by a specialised heart failure team, have been shown to reduce:
 - heart failure related readmissions at 6 and 12 months
 - all cause readmissions at 12 months and
 - all cause mortality at 12 months.

The greatest chance at reducing readmissions involves a multi-intervention approach. Learning from others to better understand the barriers, challenges and successes is paramount in reducing readmissions and improving poor clinical outcomes for people living with heart failure⁹.

References

1. Australian Bureau of Statistics. Causes of Death 2014(3303.0).March 2016.
2. Australian Bureau of Statistics. Cause of Death 2013(3303.0) March 2015.
3. AIHW. Australian Hospital Statistics. 2012/2013.
4. AIWH. National Hospital Morbidity Database. 2012/13.
5. National Heart Foundation of Australia. A systematic approach to chronic heart failure care: a consensus statement. Melbourne: National Heart Foundation of Australia, 2013.
6. Atherton JJ, Hickey A, Suna J. Striving to achieve best practice in heart failure disease management. BMJ Qual Saf 2012; 21:263.
7. Australian Institute of Health and Welfare and the National Heart Foundation of Australia. Heart, stroke and vascular diseases – Australian facts. Canberra: National Centre for Monitoring Cardiovascular Disease, 2011; p.88.
8. Australian Bureau of Statistics. Australian Health Survey 2011/2012.
9. Heart Foundation of Victoria. Heart Failure Toolkit- A targeted approach for reducing heart failure admissions.2016.
10. National Heart Foundation of Australia and the CSANZ. Guidelines for the prevention, detection and management of chronic heart failure in Australia. Melbourne: National Heart Foundation of Australia 2011.
11. National Heart Foundation of Australia. A systematic approach to chronic heart failure: a consensus statement. Melbourne: National Heart Foundation of Australia, 2013.

Opportunities to improve Heart Failure Services

With the incidence of chronic heart failure rising, there is increased demand for specialised, multi-disciplinary chronic disease management services.

Program Directors and clinical staff

- Compare your existing CHF programs with recommended best practice¹¹.
- Adapt Multidisciplinary CHF care to local needs and priorities within recommended best practice framework.
- Form constructive relationships with patients' family to encourage an active role in their care.
- Implement a range of multi-media resources to deliver patient-centred education (e.g. print, web, DVD).
- Evaluate program delivery using the key performance indicators – see Audit and Evaluation.

Audit and Evaluation

Data are critical to demonstrate the excellence of services. Queensland Cardiac Outcomes Registry (QCOR) has established a module for heart failure services to evaluate and report on performance and outcomes called HERO - Heart (Failure) Elevation Reporting Outcomes.

The minimal data collected allow for reporting of clinical performance. Sites are provided with outcome reports about:

- follow-up times.
- assessment of left ventricular function.
- prescription of beta blockers and ACEI/ARB.
- beta blocker titration status at 6 months post referral.

To become a HERO user or for more information contact Statewide Heart Failure Services:
qldheartfailure@health.qld.gov.au

Health Service Planners

- Identify resources, skills and networks required to establish or maintain multidisciplinary care.
- Ensure that existing structured CHF programs are aligned with recommended care.

Human Resource Management:

A Heart Failure Service needs to have a formalised process to ensure team members have access to educational and training opportunities to maintain competency.

This process should include access to opportunities for continual professional development.

Staff also need to be equipped with the latest evidence-based patient resources to deliver patient care under the recommended guidelines.

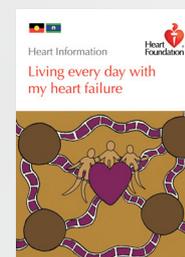
Patient access to self-management tools

Patients need access to quality information to help manage their condition. The Heart Foundation resources available for patients with CHF:

- *Living well with chronic heart failure*
- *Living every day with my heart failure - for Aboriginal and Torres Strait Islander peoples.*

Health Services can ensure that every patient receives these by securing funding through your Service. To order these contact our Health Information Service:

1300 36 27 87.



For clinical support visit

Heart Education Assessment and Rehabilitation Toolkit (HEART) Online is a web-based resource developed for clinicians by clinicians. heartonline.org.au

Use data to reduce CHF admissions

To learn more how data can be used to reduce CHF admission rates, refer to the Heart Foundation's *Heart Failure Toolkit: A resource for reducing 30 day readmission rates for patients with heart failure* heartfoundation.org.au/programs/the-heart-failure-toolkit/