Heart failure factsheet

Evidence to support your case for improved heart failure services

We need to 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 heart failure care helps to manage patients effectively. For this reason it is important for each health service to enhance heart failure services.

What is the issue?

- Many individuals are not diagnosed with heart failure in a timely manner, and once a diagnosis is made, treatment is frequently sub-optimal and costing the system unnecessarily[1].
- Heart failure is a chronic and complex clinical syndrome that affects an estimated 300,000 Australians, with another 30,000 new cases diagnosed each year[2]. Prevalence is known to increase with age, reaching 10% among those aged 65 years or older and 50% in people aged 85 years or more.
- Heart failure care places a major burden on the health care system, accounting for more than 4,000 deaths annually.
- Hospital admissions for CHF have increased by 24% between 2002-03 and 2011-12[3]. Between 2007-08, CHF was a primary diagnosis in 45, 212 hospitalisations and a contributory diagnosis in 94, 599 hospitalisations[2].
- The average length of stay is 5 days within the public sector and up to 8 days in the private sector[2].
- The annual cost of CHF in Australia has been estimated at over $1 billion per year, with hospital care being the largest expenditure[4]. A significant portion of this cost is associated with preventable CHF readmissions.
- Within three to six months of initial discharge following heart failure hospitalisation, 30-50% of patients are rehospitalised[2,5,6]. Currently, there are limited available data on a national basis, but Victorian data highlight that readmissions within 30 days of discharge can be as high as 20%.
- The 2006-07 average cost of a hospital admission in Victoria for simple heart failure (diagnostic-related group 62B) and complex heart failure (diagnostic-related group 62A) was $3440 and $7260, respectively[5].
- Chronic heart failure has been recognised nationally as a potentially avoidable hospitalisation - an admission to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services.

What do the guidelines recommend?

- National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand (CSANZ) guidelines for heart failure[7] recommend that people with chronic heart failure should be educated about lifestyle changes (e.g. increase physical activity levels, reduce salt intake, symptoms and how to manage fluid load and weight). They should also be supported to make these changes, including a management plan and routine psychosocial assessment.

- The guidelines recommend that all patients hospitalised for heart failure should have post-discharge access to best-practice multidisciplinary CHF care. This ensures that clinical problems are detected and addressed proactively to manage the disease. This also ensures that patients or carers can control and manage symptoms, medications are titrated as required, patients undertake exercise training, and a pharmacy review is conducted. Care may consist of home visits, phone followup, clinic visits and tele-health. Every service has a medical sponsor who is either a cardiologist or general physician[5].

- Multidisciplinary chronic heart failure care is distinguishable from generic chronic disease management programs by the special needs of patients with chronic heart failure such as ongoing medicines titration, symptom monitoring and management of devices. This necessitates specialised evidence-based treatment strategies associated with optimal outcomes. Accordingly, effective chronic heart failure care often requires access to specialised knowledge and expertise[5].

What are the benefits?

Health and clinical benefits of multidisciplinary heart failure management[7]

- increased risk factor knowledge (e.g. healthy eating and physical activity)
- better symptom management (e.g. salt restriction, fluid monitoring and fatigue action plan)
- improved clinical management (e.g. blood pressure and renal function)
- Improved clinical outcomes (eg, decreased morbidity, mortality and hospitalisations)
- strengthened adherence to medications
- enhanced mental health and overall quality of life
- improved palliative care support and decision making

Economic benefits[7]

There is increasing evidence that multidisciplinary guideline-based CHF failure models of care provide large cost savings, with sustained cost benefits from early intervention.

As the number of admissions per patient rises, so do the associated costs for the healthcare system. There are reliable data to suggest that up to two-thirds of CHF-related hospitalisations are preventable. Multidisciplinary 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, reduce heart failure related readmissions at six months and 12 months, all cause readmission at 12 months, and all-cause mortality at 12 months[5].

For more information on heart failure models of care download the Heart Foundation consensus statement on heart failure[5].

How are we doing?

- Since 2006, Queensland has led Australia in implementing a systematic, coordinated, evidence-based model of care shown to improve clinical outcomes for patients with symptomatic chronic heart failure[6]. Metropolitan areas of Queensland have world class heart failure multidisciplinary care, and through a coordinated network, patients in rural and regional areas are supported by tertiary and cardiac medicine services.
- This coordinated approach has enabled continuous quality improvement, particularly in the areas of outreach via tele-health, medication titration, maintaining a skilled work force through annual training opportunities and specialist workshops, and benchmarking of follow-up times, activity and patient flow.
- Despite this:
  - Many patients are not being referred to these services; and
  - Services in metropolitan, rural, regional and remote areas need adequate resourcing to meet local demands.

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For heart health information

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