The heart failure journey:
Multidisciplinary teams and informed patient choices

Dr. Loreena Hill

The 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure recommend that all patients diagnosed with heart failure are managed within a multidisciplinary team (MDT) care programme.[1] Heart failure nurse specialist, Doctor Loreena Hill (Queen's University, Belfast, Northern Ireland, UK), talks here about the importance of communication and collaboration within the MDT and the need to ensure patients are provided with the necessary knowledge to make informed treatment choices.

"The majority of patients referred from primary care with suspected heart failure require the expertise of a secondary-care MDT to confirm or reject their preliminary diagnosis," says Dr. Hill. "The MDT within a hospital setting includes a cardiologist, a heart failure nurse and allied health professionals, for example pharmacist, cardiac physiologist and dietician. Additional team members may be required to assist in the management of a range of comorbidities that many patients now experience, for example a nephrologist or oncologist. Patients can be referred for cardiac rehabilitation, requiring the expertise of cardiac rehabilitation nurses and physiotherapists." Dr. Hill emphasises the need for integrated care across the management continuum, explaining, "Ideally, there should be a seamless transition of MDT working across primary and secondary care boundaries, with the patient's needs remaining paramount. General Practitioners (GPs) are important members of MDTs and play a vital role in the identification, management and long-term follow-up of patients with heart failure. As the disease progresses, a palliative approach may be appropriate, with involvement of palliative care specialists, district nurses, etc. In the interests of best patient care, it is important that all members of the MDT communicate and collaborate effectively."

She continues, "Traditionally, specialist MDT programs were based within secondary care; however, with the rise in prevalence, particularly within the elderly population, there is greater emphasis in managing patients closer to their home and within a primary care setting. This generates a future challenge, which the MDT is aiming to address through, for example, the emergence of virtual clinics, whereby the consultant and heart failure nurse hold a telecom discussion with the community GP to discuss a particular caseload of patients. In addition within the UK, a number of pharmacist-led clinics and ambulatory heart failure units have been developed, designed to meet the needs of today's patient diagnosed with heart failure."

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Dr. Hill discusses how patient preferences should be incorporated into treatment plans. "There is a move towards improving patient ability for self-care through better education and, if appropriate, remote monitoring. The use of remote monitoring is likely to increase as the prevalence of heart failure rises and resources (financial and personnel) remain limited. We should also be cognisant that many of our patients have comorbidities requiring multiple trips to different clinics. We should recognise this and try to minimise it as much as possible". She is keen that patients and their family members are adequately informed about their condition and treatment. A strategic initiative within the ESC is the ESC Patient Forum, which aims to encourage healthcare providers to listen and learn from patients. "Patients should be actively involved in their management plans and be provided with the necessary information to make informed treatment choices and decisions throughout the disease trajectory," says Dr. Hill, continuing, "This is particularly relevant during advanced palliative stages of care, when quality of life should take equal consideration to length of life and the meeting of patients' holistic care needs."

1. Ponikowski P, et al. Eur J Heart Fail 2016;18:891-975.