



EDITORIAL

Primary and Specialist Care: a necessary relationship for the implementation of a Heart Failure programme



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Nowadays, heart failure (HF) is a real epidemic. The improved treatment of cardiovascular diseases, together with the ageing population, has led to an increase in this disease, which signifies the final phase of numerous cardiovascular conditions. It is estimated that 1-5% of the population suffers from HF, but this percentage increases exponentially with the age of the patient, and may exceed 10% in individuals over the age of 70.^{1,2} This is of considerable significance, taking into account that in Spain life expectancy is increasing. It was estimated in a recent article that by 2040 Spain will be the country with the highest average life expectancy in the world (85.8 years), and that cardiovascular diseases will continue to be the leading cause of death.³

Given that it is a chronic and progressive disease, reducing hospital admissions is one of the greatest challenges. Currently, HF is the main cause of hospital admission in patients over the age of 65, which in turn is the main health cost in relation to the disease, without including the costs of informal care (family members, carers, days of work lost, etc.), which are even greater.⁴⁻⁶ Each admission significantly affects the patient's quality of life, with similar perceptions to those that a cerebral stroke may entail. Furthermore, the prognosis is worse as the patient has a greater risk of mortality.^{7,8} And what is even more worrying is that Spanish

national data (RECALCAR project) show how this cardiovascular disease is the disease which is increasing the most, among the different reasons for hospital discharge due to a cardiovascular cause.⁹

However, we know that hospital admissions are not distributed homogeneously over time. Instead, there are times in the patient's progression when he/she is particularly vulnerable, as this is when the majority of admissions are concentrated. This occurs mainly in the first few weeks after hospital discharge and in the terminal phase of the disease.^{7,10} In this sense, in addition to the correct treatment of the patient, an adequate transition of care between the hospital phase and the outpatient phase is required, with planning of the discharge, an early visit after the discharge and a structured follow-up plan, as well as transmitting specific information to the patient about the disease so that he/she can carry out good self-care, where nursing has a fundamental role.^{10,11}

Multiple organisational models have been designed and implemented regarding HF, some of them with very good outcomes in Spain.¹¹⁻¹⁴ A recent meta-analysis highlights the following as determinants of the success of these programmes: greater use of ACE inhibitors/angiotensin II receptor blockers at baseline; greater number of professionals and intervention components; specialisation of the cardiologist and the nurse; education which follows a protocol and which is assessed; self-monitoring of signs and symptoms; recognition of decompensation; flexible regimen of diuretics; early warning and care; psychosocial intervention; coordination of professionals and duration of the programme.¹⁵ Nevertheless, HF care is unequal throughout the Spanish national territory, with less than 40% of centres in Spain having HF units, most

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of which are Cardiology-led units with a high presence of nursing staff, but with a variable dedication to the unit, meaning that there is still ample room for improvement.^{9,16}

As a consequence of the above-mentioned information, the clinical practice guidelines advise, with the highest grade of recommendation and evidence (class IA), the creation of multidisciplinary programmes to reduce the risk of hospitalisation for HF and mortality.¹⁷ Despite the fact that there are many ways to organise the treatment of HF, the fundamental aspects to take into account are: knowing which situation you are starting from; identifying indicators to measure and including Primary Care in the organisational model. Accordingly, the study by Tárrega López et al. reveals the baseline situation in their area of reference, from the perspective of the Primary Care professional.¹⁸ This is a differential aspect, given that some of the national registries, which we draw data from, obtain data from HF (hospital) units, with evident inclusion biases. The authors obtain a population prevalence for HF of close to 1% (somewhat below that observed in other studies, but that may be related to population variations, underdiagnoses or poor coding), which is similar to more recent national studies.^{1,2} They then describe the prevalence of the different cardiovascular risk factors (with good control) and comorbidities. As we already know from other studies, it is highly common to experience comorbidities, with four or more being presented in 90% of patients. They describe the prescribed medication and the degree of adherence by determining the ratio between the percentage of drugs prescribed and the percentage of drugs withdrawn from the pharmacy. These are relevant data, but it is striking that they have not included mineralocorticoid receptor antagonists among the drugs to assess, as well as the low use of ACE inhibitors/angiotensin II receptor blockers and to a greater extent beta-blockers. It is our understanding that a possible explanation for this would be that a large percentage of the population studied (average age of 81 and 95% with HTN) has preserved LVEF, which means that the use of these drugs is lower, with a clear prognosis benefit not having been demonstrated in this population. And, accordingly, we miss out on the fact that the population has not been sub-classified according to LVEF, which we have already seen occurs in many of the population studies. However, that would help us to have a truer perspective of HF in this area. We observed how the rate of annual readmissions is high (34.25%), in line with studies that we have mentioned previously.¹

It is interesting how the authors describe 20 quality criteria in the management of HF and compliance with these criteria in the reference area. Of these, the annual echocardiogram and advice on diet and exercise are the criteria with the worse compliance. There is no doubt that the hygienic-dietary measures are of great importance, as is physical exercise. However, while the echocardiogram is fundamental in the diagnosis, we disagree with the need to perform it annually if no clinical variables have occurred in the patient, or if it is not needed to make a decision on the management, as recommended by the clinical practice guidelines.¹⁷ Accordingly, the *Sociedad Española de Cardiología* [Spanish Society of Cardiology] has described a series of indicators and quality standards for HF units

according to their classification. These are very useful, and can be used for the homogenisation of the different units throughout the Spanish national territory.^{19,20} The purpose of these documents is to establish the requirements for heart failure units within the framework of the SEC-Excelente project.²⁰

Finally, the authors make an imaginative joint proposal between the Primary Care specialist and the Cardiologist, proposing strategies for an improved approach to HF such as: a greater recording of anthropometric variables and vital signs in the medical record; increasing the hygienic-dietary recommendations; increasing the flu and pneumococcal vaccination rate and implementing the relationship between Primary Care and Cardiology by institutional email, online and telephone consultations and joint clinical sessions.

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