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Multidisciplinary Management Programs for Heart Failure: The French Perspective.

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The 2021 guidelines of the European Society of Cardiology for the management of heart failure with impaired LVEF list eight class I interventions (Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective), with a level of evidence A (resulting from multiple randomized clinical trials or meta-analyses). (1)

Four of these eight class IA recommendations relate to drugs (ACEI/ARNI, Beta blockers, ARM, SGLT2-I), two relate to implantable devices (ICD and CRT, for selected patients) one to physical exercise rehabilitation, and a class IA recommendation concerns the "Multiprofessional management of the disease". (TAB I)

The objective of this article will be to illustrate the concept, relatively new in its centrality, of “Multi professional management of chronic heart failure” and to propose specific methods of implementation for the organization of the healthcare offer. in France.

Multi professional management of chronic heart failure: its reasons for being.

It is widely recognized that, beyond the optimization of pharmacological treatments and implantable devices, it is necessary to pay attention to how this care is deployed (2-4).

According to ESC definitions, multi-professional heart failure management programs aim to ensure that patients have the right investigations, an accurate diagnosis, adequate and evidence-based therapy, education, and appropriate follow-up. The optimal implementation of a multiprofessional heart failure management program requires a multidisciplinary team active throughout the heart failure patient's trajectory, from the onset of the disease, through critical episodes, periods of apparent stability, up to its terminal stages (1).

Multiprofessional management of chronic heart failure: a concept to be applied in the different realities, national and local.

While a high level of evidence exists on the improvement in all-cause mortality obtained by the implementation of PMM-IC (5), these programs can be heterogeneous in terms of content, intensity, stakeholders (6,7). It is therefore recognized that the organization of a PMM-IC must be specific to each health system, to the available resources (infrastructures, centers, staff, funding), to the administrative policies, and adapted to the specificities of each patient (1).

Heart failure management program: the key points according to the ESC 2021 Recommendations

CHARACTERISTICS of a Multiprofessional Heart Failure Management Program:

- Centered on the patient/individual; - Multidisciplinary
- Its focus is flexible and includes:

a) prevention of disease progression; b) symptom control.

c) maintaining the patient in the preferred place of care in the end stages of heart failure.

- competent and well-trained staff.
- encouraging the patient/caregiver to understand and manage their condition.

COMPONENTS of a Multiprofessional Heart Failure Management Program:

- Optimized management: lifestyle, drugs, implantable devices.
- Patient education, with particular attention to self-care and symptom management.
- Offer of psychosocial support to patients and family caregivers.
- Follow-up after discharge from hospital (ambulatory, home visits, telephone assistance, remote monitoring);
- Ease of access to the health system, in particular to prevent and treat decompensation.
- Evaluation (and appropriate reaction if necessary) of a modification unexplained weight, or nutritional or functional status, quality of life, sleep disturbances, psychosocial problems, or other findings (for example, laboratory tests);
- Access to advanced treatment options, supportive or palliative therapies.

TOOLS for optimizing the patient journey and specific to the healthcare offer in France.

Under the impetus of the health authorities, new programs and new professional figures are emerging and developing in France. It is possible to see it as tools to be deployed in a coordinated way, and ideally within the framework of a process of global management of these patients, aiming to structure itself in the form of a PMM-IC and achieve the objectives (TAB II).

In 2007: Therapeutic education programs in chronic disease, which expresses the need to reinforce, in a multidisciplinary way, the management of patients with heart failure (HAS-INPES 2007 methodological guide Available online at https:// www.has-sante.fr/upload/docs/application/pdf/etp_-_guide_version_finale_2_pdf.pdf on 15/5/2022).

In 2010: The 2010 "border" Circular makes it possible to reassess patients with chronic heart failure in the context of day hospitalization, for assessment, deployment of therapeutic education, or specific treatments (iron infusions).

https://www.atih.sante.fr/sites/default/files/public/content/982/Ins_frontiere_2010.pdf available online on 15/5/2022

In 2013: Support program for returning home (PRADO). First at the level of a few pilot departments, then generalized, the CPAM offers one, to patients hospitalized for heart failure. https://www.ameli.fr/sites/default/files/Documents/3920/document/suivi-decompensation-experimentation_assurance- Maladie.pdf available online on 05/15/2022

In 2017: Semi-Urgent Consultation for Heart Failure: In Ile de France, on the initiative of the ARS, the Cardiology Services of the ARS are invited to organize the Semi-urgent Consultation for Heart Failure,

In 2019: Cooperation protocol "Telemonitoring, titration consultation and unscheduled consultation, with or without telemedicine, of patients treated for heart failure, by a nurse" published in the Official Journal (https://www.legifrance.gouv.fr/download/pdf?id=w7IOLPaagUUCaZ7Kuw5AZJyAQaVA5usIDgF2rB4vOkU=, available online on 15/5/2022)

This protocol provides a framework for delegating the monitoring and adaptation of heart failure treatments to nurses trained in this protocol.

Between 2018-2021: As part of the ETAPES experience, then from 1/7/2022 under common law, remote monitoring of heart failure is supported https://solidarites-sante.gouv .fr/soins-et- Maladies/prises-en-charge-specialisees/telesante-pour-l-acces-de-tous-a-des-care-a-distance/article/la-telesurveillance-etapes available online at 15/5/2022

In 2021: ARS Ile de France granted funding for the creation, by the Cardiology Departments, of a consultation for titration of basic treatment for heart failure, the creation or maintenance of a semi-urgent consultation for heart failure,the creation of an IDEC position in the heart failure sector.

The structuring of a Multi professional Heart Failure Management Program.

Multi professional management programs for heart failure are a tool for managing the complexity of these patients and their care. Table 3 helps to give an overview of the needs of these patients, in terms of cardiological and extra cardiological treatment, long-term support and reoperation in the event of progression.

Ideally, each Center for the management of chronic heart failure must prepare upstream the responses to be provided to the expected needs of these patients, activate the existing specific monitoring programs financed by the Health Insurance, and create and formalize the gateways with both non-cardiologist specialists for the management of the typical comorbidities of these patients, and referral cardiology centers.

These elements will represent a frame of reference that will make it possible, for each patient, to develop a flexible and personalized multiprofessional management protocol, which therefore takes into account the systematic requirements of patients with heart failure, and individual requirements, but typical and frequent, by creating in anticipation, gateways and support circuits.

TAB I

Interventions listed in class I A in the management of heart failure with impaired LVEF (according to (1)

I: pharmacological interventions

a) ACEI/ARNI
b) Beta blockers
c) Aldosterone receptor antagonists
d) SGLT2I

II: Implantable devices (for selected patients)

a) ICD
b) CRT

III: Exercice Réhabilitation

IV: Multi-professional disease management.

TAB II

- Tools for optimizing the patient journey and specific to the healthcare offer in France.
- Support program for the return home of hospitalized patients (PRADO);
- Heart Failure Day Hospital;
- Semi Urgent Consultation for Heart Failure
- Remote monitoring of heart failure
- Therapeutic Education Program in Heart Failure
- Cooperation protocol “Remote monitoring, titration consultation and unscheduled consultation, with or without telemedicine, of patients treated for heart failure, by a nurse »
- Advanced Practice Nurse
- IDE Coordinator of the heart failure sector.

TAB III

Considerations for Creating an Individualized Multi-Professional Chronic Heart Failure Management Program

Professional Needs Program Condition Concerned

Coordination of actions ci Generalized IDEC nurse coordinator below

Long-Term Systematic Monitoring and Monitoring Actions:

Background treatment titration

Early follow-up consultation

Personalized follow-up at home Remote follow-up

Systematic monitoring; special treatment (iron iv)

Therapeutic education

Early reaction if decompensation signal

Surveillance in EHPAD Optimization of vaccination status

Screening for sleep apnea Screening for iron deficiencies

Cardiologist; API; nurse delegate on the basis of a cooperation protocol

Cardiologist; IPA?

City nurses

Remote monitoring platforms

Multidisciplinary hospital team (cardiologist, dietician, sports educator-physiotherapist) and technical platforms

Multidisciplinary hospital or extra-hospital team: Nurse trained in therapeutic education Referent cardiologist (if remote monitoring).

Hospital cardiologist (if semi-urgent consultation) Coordinating physician and IDE of nursing homes

Titration consultation

PRADO

STEPS (common law from July 2022)

Day hospital

Therapeutic education

Remote monitoring protocol; Semi-urgent consultation

Being created

(ARS IdF)

If LVEF impaired

For all heart failure patients

If direct return home

Under condition of gravity

Under condition of complexity

For all patients with heart failure and/or their caregivers

For all heart failure patients

For EHPAD patients for all patients

For all patients If LVEF impaired

Specific Or One-Off Actions

Doctor

Coordinating doctor HPAD, IDEC, Vaccination center

Trained pulmonologist or cardiologist Coordination with Hematologist, Internist, Gastroenterologist

To be defined locally

To be defined locally To be defined locally

Coordinations for the Management of Typical Comorbidities

Management of renal failure Geriatric assessment Management of diabetes Management of anemia

Palliative care

Cross-sectional imaging Coronary assessment, revascularization Electrical equipment Cardiac rehabilitation

Expert center in advanced heart failure

Nephrologist

Geriatrician; Mobile geriatrics team Endocrinologist

Hematologist, Nephrologist, Internist

Palliative care team To be defined locally For some selected patients

Coordination and Bridges with Technical Platforms , CT, MRI

Reference center in interventional cardiology

Reference center in Rhythmology Specialized centers (intra- and extra-hospital)

Interventional center for mechanical circulatory assistance and heart transplantation.

Abbreviations used in the text:

ACEI/RNAI: Angiotensin converting enzyme inhibitors / Neprilysin inhibitor - angiotensin receptor

ARM Mineralcorticoid receptor antagonist

SGLT2-I Inhibitors of Sodium Glucose Cotransporter 2

ICD Implantable Cardioverter Defibrillator

CRT Cardiac Resynchronization Therapy

ESC European Society of Cardiology

PMM-IC Multi-professional heart failure management program

PRADO Support program for returning home CPAM Primary health insurance fund

HAS-INPES High Authority for Health - National Institute for Prevention and Health Education

ARS Regional Health Agency IPA Advanced practice nurse

STEPS Telemedicine experiments to improve healthcare pathways;

IDEC Coordinating nurse

MULTIDISCIPLINARY MANAGEMENT PROGRAMS FOR HEART FAILURE: THE FRENCH PERSPECTIVE

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