Nurse-led management of heart failure outpatients

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Since its establishment in 1999, the Heart Failure Outpatient Clinic (at Department of Vascular Diseases, University Medical Center in Ljubljana, Slovenia) supplemented cardiovascular diagnostic assessment, therapeutic management and follow-up with a structured and comprehensive nurse-led heart failure education program aimed at empowering outpatients with chronic heart failure.

In 2012, a pilot program of nurse-led heart failure management (including education, but also follow-up and heart failure medication optimization with uptitration of baseline therapy and adjustment of diuretic dosage) was started. The pilot program of nurse-led heart failure management consisted of at least 4 visits every 2–3 weeks and included 100 patients (mean age 80±6 years, 39% female); the program accomplished an increase in patients taking optimal heart failure medication (i.e. 38% on maximal ACE inhibitor dose as compared to 18% in the usual care group, $p=0.002$) and a decrease in patients with congestion/weight gain (12 vs. 42% in the usual care group, $p<0.001$).

From 2015, the nurse-led heart failure management program was implemented as the standard of care at the Heart Failure Outpatient Clinic (3 days/week – once a week for first visits/intake and twice a week for follow-up visits). At first visit/intake, outpatients referred for evaluation of suspected heart failure undergo thorough cardiovascular examination (including cardiologist assessment, echocardiography, blood analysis, 6-minute walk test) and if heart failure is confirmed, appropriate therapy is initiated by the managing cardiologist and education is carried out by a dedicated nurse. A structured and comprehensive education program addresses heart failure natural history, signs/symptoms, precipitating factors and signs of impending worsening, management, diuretic therapy, lifestyle intervention etc. Also, follow-up appointments with managing nurse are arranged and patients are followed at 2–3 weeks interval, with basic check-up (symptoms, adherence to medication, blood pressure, heart rate, body weight) and therapy dosage optimization (uptitration of ACE inhibitors/ARBs, beta blockers, MRAs and sacubitril/valsartan, and dose adjustment of diuretic therapy) under supervision and in consultation with managing cardiologist.

Nurse-led heart failure management programs improve outpatients follow-up yielding to better medication adherence and better optimization of both, diuretic therapy and lifesaving heart failure medication (thus possibly decreasing hospitalization rates and even mortality).¹ Also, continuous education through frequent follow-up visits enables better outpatient empowerment and possibly improves quality of life.

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LITERATURE

1. Young JB. Evolution of heart failure management: Miles to go. *Cleve Clin J Med.* 2016;83(10):766-8.
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