Who Should Deliver Medical Therapy for Patients With Chronic Heart Failure?

An Immediate Call for Action to Implement a Community-Based Collaborative Solution

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Ever wonder who cares for the 5.7 million patients in the United States with heart failure? Most are initially assessed by a family physician or internist, who after making the diagnosis, often refers them to a cardiologist—not for the treatment of heart failure—but for the evaluation of possible coronary artery disease. When the diagnostic and therapeutic issues regarding a patient's coronary anatomy have been clarified and after all procedural opportunities have been exhausted, the patient is dutifully returned to the family physician, with a recommendation that he/she implement guideline-directed medical therapy. It is a generalist who cares for most patients with chronic heart failure.[1]

When we communicate with our colleagues in primary care medicine, why do we convey only a broad philosophical directive rather than a detailed list of specific actionable recommendations? The management of chronic heart failure is not simple. Optimal treatment requires the skillful orchestration of as many as 7 different classes of drugs, together with the appropriate application of different types of devices.[2] Heart failure is generally more disabling and lethal than cancer,[3] and its comprehensive management is frequently far more challenging. When chemotherapy is given to patients with cancer, its administration is tightly controlled by medical oncologists, who prescribe antineoplastic drugs aggressively and under close supervision, generally at doses and durations that closely resemble those used in randomized clinical trials. Serious adverse effects are expected, but patient compliance and provider enthusiasm is enhanced by societally reinforced fears about the need for aggressive therapy to prevent the silent spread of malignant cells. In contrast, although heart failure with a reduced ejection fraction also progresses silently and requires complex multidrug regimens over long periods of time, specialists are generally not involved, and intensive pharmacological strategies and doses are rarely achieved in clinical practice.[4] Continued pursuit of optimal regimens often ceases at the first hint of patient intolerance or reluctance. As in the management of cancer, the treatment of patients with heart failure requires knowledge, experience, and perseverance, which necessitates a multidisciplinary team of healthcare providers that can deal effectively with each patient's individual circumstances. Those who care for patients with cancer are richly rewarded for creating these conditions; those who care for patients with heart failure are not.[5]

Think about what happens to most patients with heart failure every day. A family physician or internist is advised to achieve guideline-directed medical therapy, but which guideline should he/she be following? The American College of Cardiology (ACC), the American Heart Association (AHA), and the Heart Failure Society of America (HFSA) have worked diligently and collaboratively to develop thoughtful recommendations for the care of patients with heart failure.[2,6,7] Yet, the American Academy of Family Physicians (AAFP) is wary of clinical practice guidelines that are established by specialist-led organizations. It characterizes these documents as long and comprehensive, generally tainted by conflicts of interest and lacking

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

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Key Words: cardiologist ■ coronary artery disease ■ fear ■ heart failure ■ oncologists

a succinct, clinically based summary that would be relevant to primary care physicians.[8,9] Perhaps, because of the AAFP's lack of support for specialist-driven guidelines, adherence to recommended practices for the management of heart failure by family physicians is low.[10] Yet, primary care physicians are largely responsible for the care of these patients, and, thus, we might expect the AAFP to issue and support its own guideline statements. Interestingly, with respect to heart failure, it has never done so.

Sixteen years ago, the AAFP adopted a document developed at the University of Michigan by Chavey et al.[9] The AAFP did not describe the process by which this 2001 document was developed; it did not indicate whether there was any systematic external critical review by a broad range of knowledgeable healthcare providers; and it did not explain how this document served the needs of primary care physicians more than existing guidelines. Since that time, even though it has been directly involved in the development of ACC/AHA/HFSA heart failure guidelines, the AAFP has not issued any formal or informal recommendations on the management of heart failure. The AAFP has periodically provided short summaries of ACC/AHA/HFSA guidelines after their issuance, but these have routinely been accompanied by the disclaimer that the documents were developed by specialists with ties to industry and that coverage of such guidelines did not imply endorsement by the AAFP.[8]

In January 2017, the American Family Physician published a review article of the management of patients with chronic heart failure by the same authors from the University of Michigan who published the 2001 recommendations.[11] Although noting that the ACC/AHA/HFSA guidelines had recommended the use of an angiotensin receptor neprilysin inhibitor as a first-line alternative to angiotensin-converting enzyme inhibitors, the article stated that the AAFP did not endorse the ACC/AHA/HFSA guideline in this regard because of concerns about its methodology and insufficient evaluation of harms. No explanation for these concerns was provided. Interestingly, the statement that questioned the validity and integrity of the ACC/AHA/HFSA guideline process was not part of the original article as submitted to the journal by the authors but instead was inserted at the request of the editors of the American Family Physician.[12] Despite its active participation in the development of the 2016 ACC/AHA/HFSA guidelines document,[6] the AAFP decided to reject it. Dr Jennifer Frost, medical director of the Health of the Public department at AAFP, explained that her group treats the whole patient: "To tell me a subspecialist knows better based on their knowledge of an organ system is incorrect."[12] So, without any reason, the AAFP distanced itself from the optimal care of patients with chronic heart failure.

The response of the AAFP is not a sensible solution to the problem of heart failure, and the lack of outcry from the ACC, AHA, and HFSA has not been helpful. If national organizations do not provide leadership and guidance, it becomes essential for those who care for patients with heart failure in each community to forge alliances to achieve the most effective treatment for all patients. Immediately, primary care physicians and heart failure specialists in towns and neighborhoods need to create a special bond; we must establish relationships based on trust, respect, and collaboration. We need to talk constantly, in a nonjudgmental manner, always with the patient's interest in mind. We must understand that heart failure is a serious but manageable disease; that the treatment of heart failure is complicated; and that no specialty can address the issues confronting patients by acting alone. Above all, we need to forego our predilections to minimize engagements for which we are not paid, and we must establish centralized support to help practices overcome burdensome preauthorization requirements — similar to those that support oncology practices. If heart failure specialists want to be proud of the progress that we have made during the past 30 years, we cannot earn that feeling that by tallying the number of specialized procedures we perform on a small minority of patients. We achieve nothing by allowing millions of people to fall through the cracks while physician organizations battle for turf; we must not remain idle when we know that most patients are not provided the opportunity to benefit from our major therapeutic advances. If we both care for and about patients with heart failure, we cannot simply identify ourselves as heart failure specialists; we must act as heart failure patient advocates.

DISCLOSURES

During the past year, Dr Packer has consulted for Amgen, Boehringer Ingelheim, Cardiorentis, Gilead and Relypsa. Dr Packer has no financial relationship with any pharmaceutical company that manufactures any product that is mentioned in this article.

AFFILIATION

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FOOTNOTES

Circ Heart Fail is available at http://circheartfailure.ahajournals.org.

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Circulation
Heart Failure

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Circ Heart Fail. 2017;10:
doi: 10.1161/CIRCHEARTFAILURE.117.004332
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

Print ISSN: 1941-3289. Online ISSN: 1941-3297