I have heart failure – what happens now, Doc?

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It has been said one of the truest measures of a society is how its most vulnerable members are treated. I was reminded of this midway through last year. I received a call from a rural family physician regarding a very pragmatic 79-year-old patient, Mrs B, who he wished me to see. He explained to me that he had just seen her and thought she had severe new-onset heart failure (HF) after having followed her for several years with hypertension and atrial fibrillation. When she asked him why he wanted to refer her case, he explained to her that she had a very serious disease and she was at risk for worsening symptoms, hospitalization and death. At her insistence, he explained her life expectancy. When he told her that he was not certain when she would be seen, she asked, "If I have such little time, why can't I see someone soon for help?" He then called to enquire if I could see her urgently, which I did. It turned out she had occult mitral stenosis, and did well with intervention.

As Canadians, we take great pride referring to our universal health care system. Despite this, significant ambivalence toward our health care system exists; grave concern is expressed about excessive wait times – even to the extent of citing the term 'medical tourism', where patients travel to other countries to receive procedures they cannot receive within the standard waiting period here.

While significant efforts have been undertaken in Canada to shorten wait times for selected medical procedures, the same cannot be said for wait times for specialist referral. For example, most provinces report wait times for coronary artery bypass graft surgery. However, the wait time is calculated only after a patient has been placed on the waiting list for that surgery. From a patient perspective, this is only the latest in a long list of health system encounters, beginning with development of symptoms and continuing successively with a visit to the family doctor, referral to a specialist, and culminating with diagnostic testing (or even referral to another specialist). Each of these components is associated with its own separate wait list, but most of these are not recorded. Indeed, from a patient perspective, the reported wait time for coronary artery bypass graft surgery represents a small portion of the delay experienced by the patient.

HF carries a very high risk: patients hospitalized with this condition suffer a one-year mortality in excess of 30%, and a life expectancy of approximately three years (1,2). With such an outcome expectation, surely individuals with HF can be considered vulnerable members of society who need medical assistance. Specialist involvement in the care of patients with HF improves the usage rate of treatments known to improve mortality rates (3). In addition, outcomes are improved when collaboration between primary and specialist caregivers occurs (4), although recent Canadian data indicated only a minority of patients with HF are followed by a specialist (5).

That is why a patient-centric approach to wait times is essential, and why the Canadian Cardiovascular Society (CCS) has been insistent on the collection of more comprehensive wait time data (6). This is especially important for HF patients, who are among the sickest patients. In 2006, the CCS was the first society to publish recommendations for standard wait times to assessment of HF by a specialist with expertise in that disorder (6,7). For instance, a standard referral for a patient with new-onset HF should be made and the patient seen within four weeks. However, until now, referral rates to specialists for

patients with new-onset HF – a clear indication for referral – have not been reported.

In the present issue of *The Canadian Journal of Cardiology*, Ehrmann Feldman et al (8) provide the first report of specialist referral rates for patients with new-onset HF. In their administrative physician claims database, which covers all residents of the province of Quebec, patients were identified as having visited a physician for the diagnosis of HF, without having been associated with this diagnosis in the previous three years. They then determined whether patients were seen by a cardiologist, or either a cardiologist or internist during the next six months. Their data show that of 13,523 patients first diagnosed by a nonspecialist, only 54.9% were seen by a cardiologist within 2.5 years, and 67.4% were seen by either a cardiologist or internist. Furthermore, for those who did see a cardiologist, the mean wait time was more than 158 days (nearly half a year). Finally, older patients, women, and patients living in a lower socioeconomic class and away from urban areas were less likely to see a cardiologist. These findings provide sobering insights into the state of outpatient care for HF patients in Canada, and for this, the authors should be commended. These data are also consistent with previously published work outlining the type of physician involvement in acute cardiac conditions such as HF, where the most responsible physician is usually a family physician, and where urban residence, male sex and younger age are associated with increased specialist involvement in their care (5).

Several limitations of this study are apparent, such as inaccuracies in diagnosis, lack of documentation of legitimate reasons for nonreferral and lack of patient agreement or compliance with referral, to name a few. The authors were cognizant of these limitations and were careful to interpret their data conservatively by including any referrals to specialist care within six months as meeting an acceptable referral time. In addition, they included only patients who did not have a previous claim code for HF in the past three years – it is rare for a patient with HF to not be seen for this diagnosis over a three-year period. We can thus be reasonably sure that this was indeed a new-onset HF cohort. These data provide us with two important lessons: a large segment of the newly diagnosed HF patient cohort does not receive specialist assistance with their care in a timely fashion, and factors playing a role in this issue include geography, socioeconomic status, sex and age. Further studies are required to provide a more in-depth understanding of why referrals do not occur in these subgroups.

The Canadian Heart Health Strategy and Action Plan, released February 24, 2009, is meant to serve as a comprehensive blueprint for change in our cardiovascular health care system and includes six major themes – two of which are access to care and disease management. The philosophy of timely access to the proper care provider at the right time and the need for integrated information systems that allow for tracking of wait times from a patient-centric perspective are addressed (9). Hopefully, stakeholders such as the federal and provincial health ministries, and the CCS, among others, will act to make meaningful change. As health care providers, we have to buy into and integrate ourselves with this process. One such step will be to create a national registry of patients with HF that will not only provide important and timely information about our patients and our performance, but will also link with other data registries to enable better mobilization of resources, track the

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changes we make (and their effects) and even enhance efforts for prevention of HF. If we are able to implement solutions to these problems, we will have achieved a large measure of success in improving care for outpatients, like Mrs B, who have HF – they are truly among the most vulnerable members of our society.

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