

# Optimising access to heart transplantation

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8 September 2019

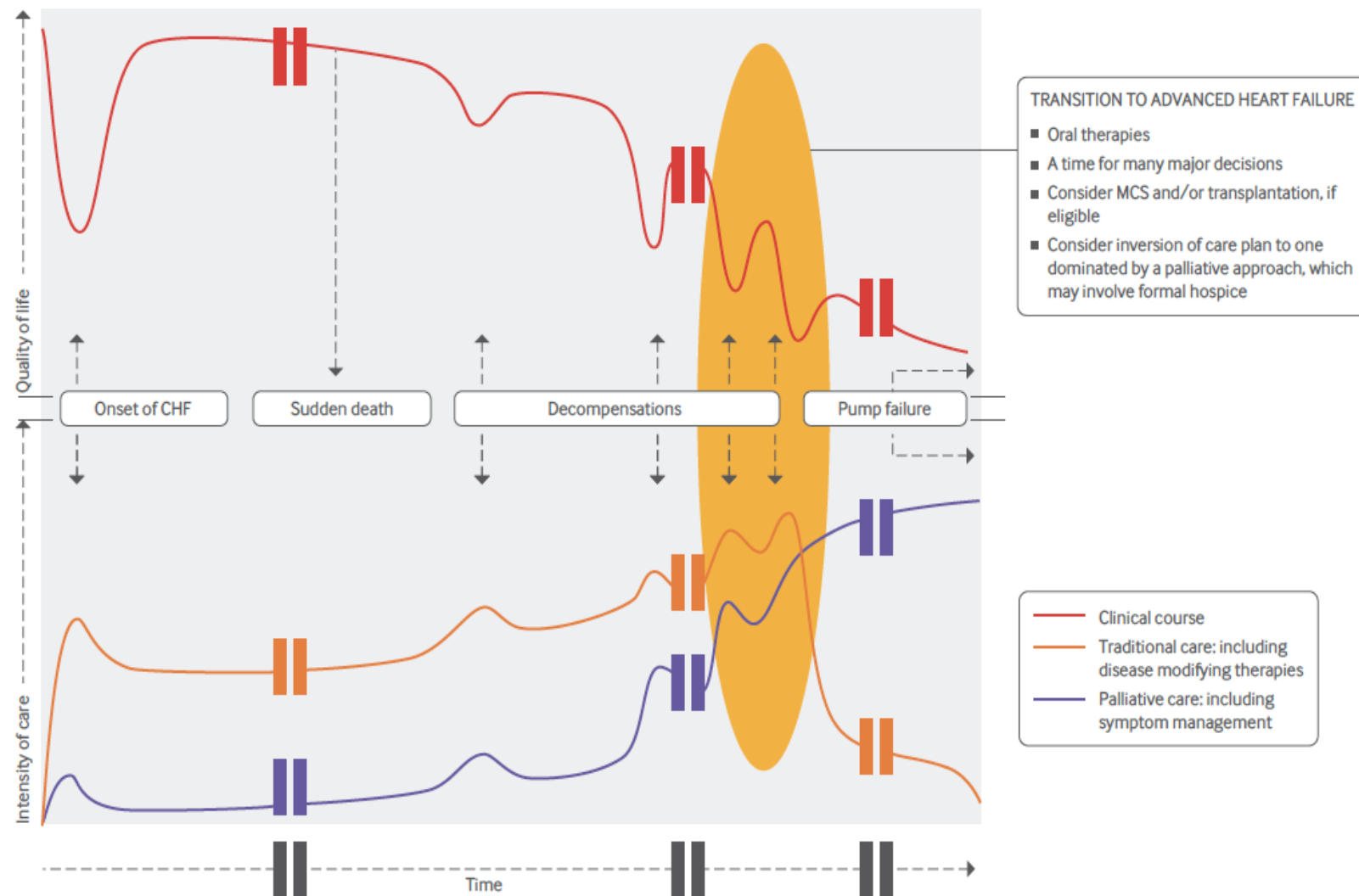
# Promoting Heart Failure Awareness

- Heart failure is poorly recognized by the public and healthcare professionals
  - Not a disease as such
  - Clinical syndrome – so find the cause
- National Heart Failure Awareness/ Network needed – co-ordinated effort to make heart failure and its therapies a national priority

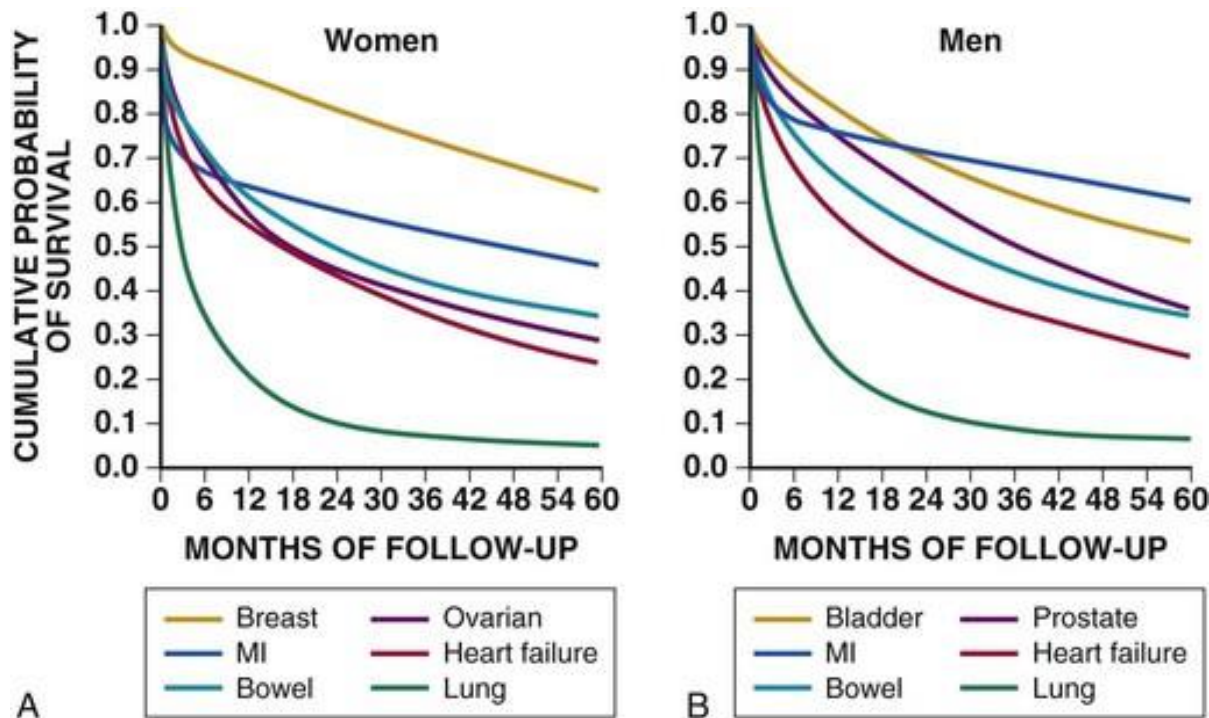
# 10 core messages that require action

1. Heart failure destroys life
2. Heart failure is common
3. Heart failure is becoming more prevalent
4. Heart failure affects the elderly disproportionately
5. Poor recognition leads to preventable deaths

6. Heart failure leads to poor quality of life
7. Heart failure is costly to health resources
8. Heart failure care can be improved
9. Heart failure is preventable
10. Co-ordinated care is needed



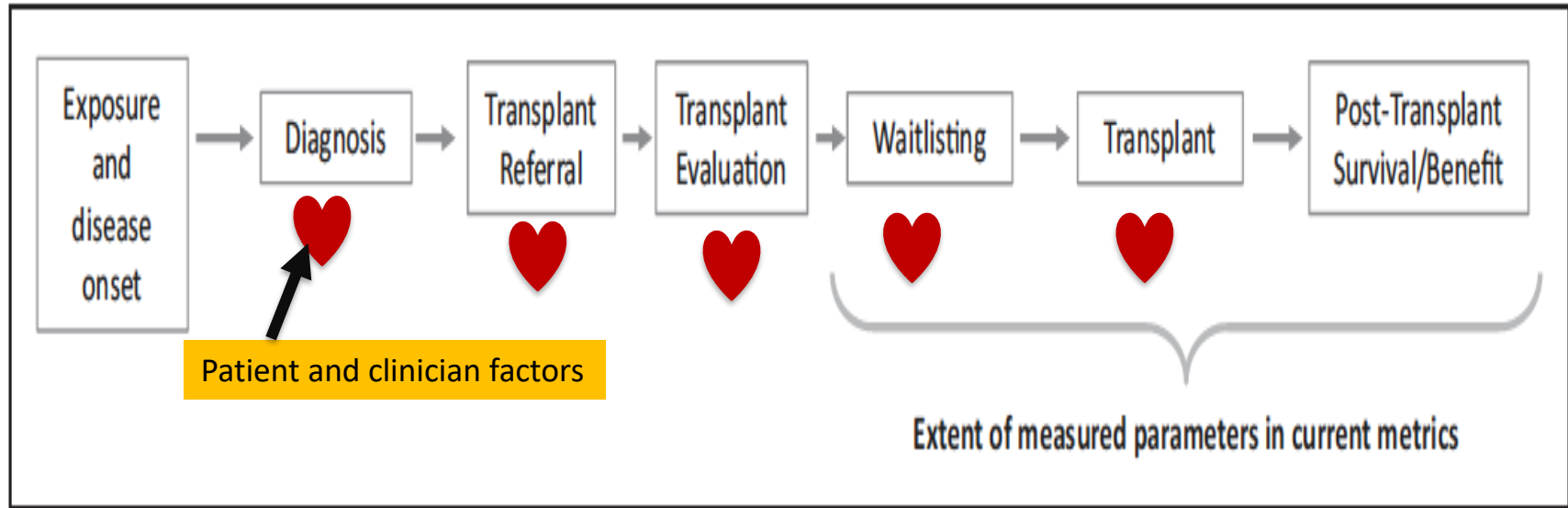
# 'More malignant than a cancer'



## Outcomes for people with heart failure:

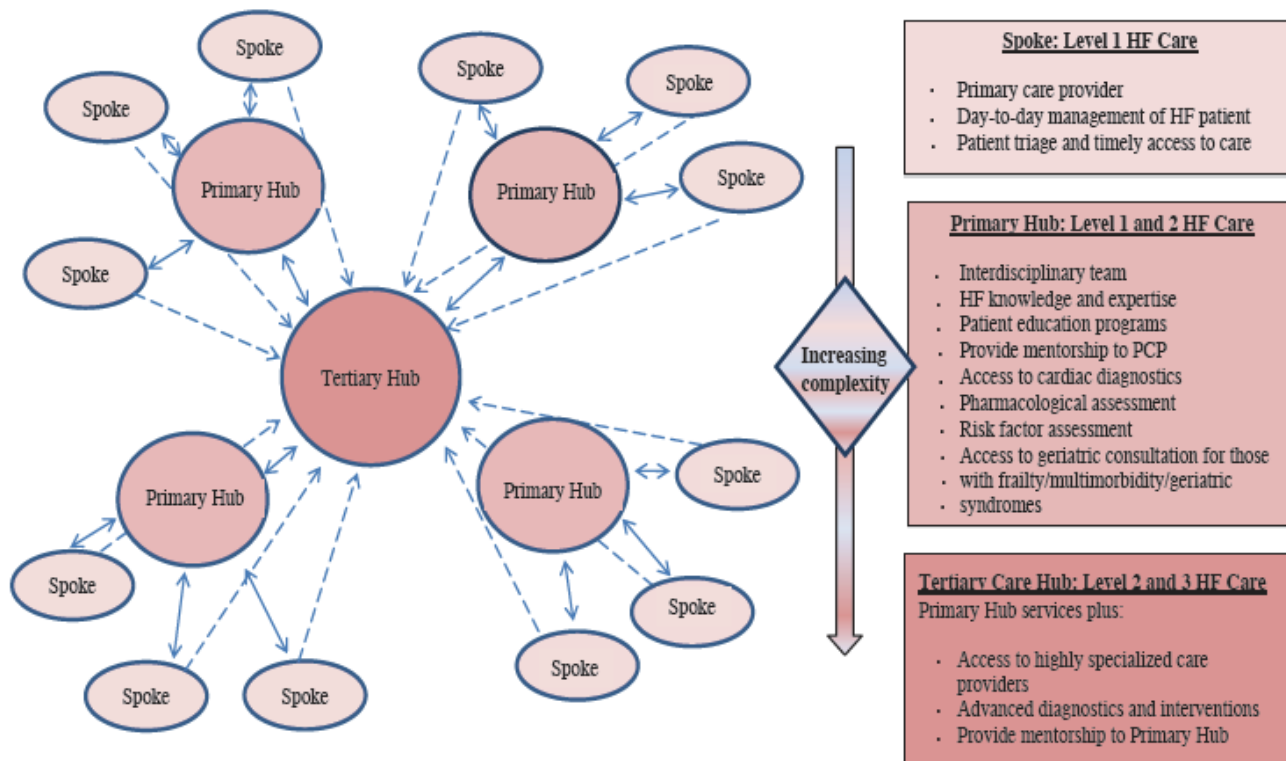
- Approximately 1 in 10 patients hospitalised with HF will die in hospital
- An estimated 1 in 4 will be readmitted to hospital within one month
- Around 1 in 3 will die within 1 year
- Approximately 1 in 2 will die within 5 years

## Individual continuum of care in organ failure and transplantation



- An integrated, patient centered system of care
- Identifies different levels of care (esp in SA with few clinicians) as determined by patient's complexity and risk of poor outcome
- NB of accessing care at an appropriate time
- Navigating the selection process successfully (esp applicable to disadvantaged communities)

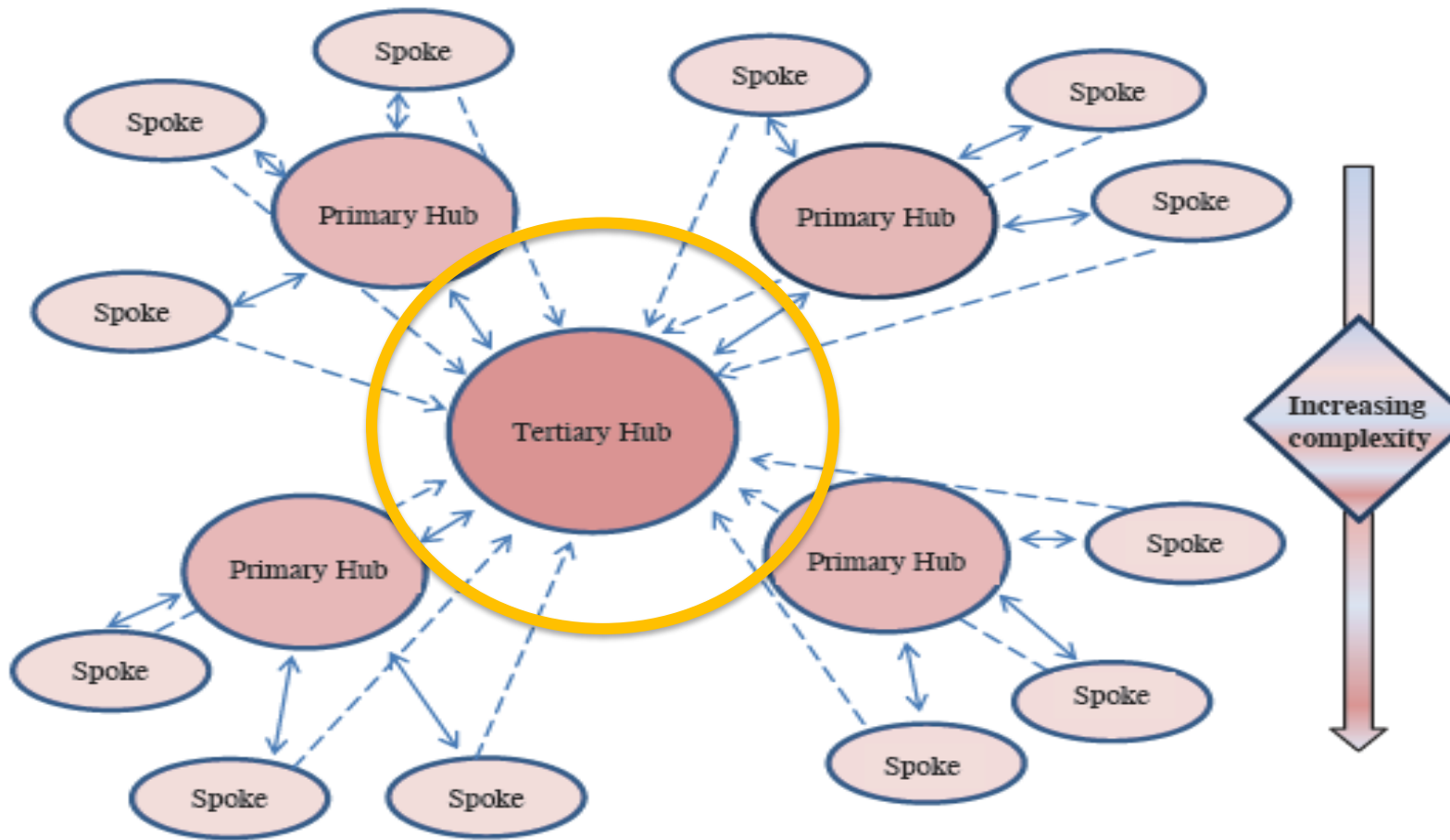
# Hub and spoke model



HF- Heart failure; PCP- Primary care provider

Patients are to be stratified according to clinical risk and complexity with the intensity of intervention adjusted accordingly

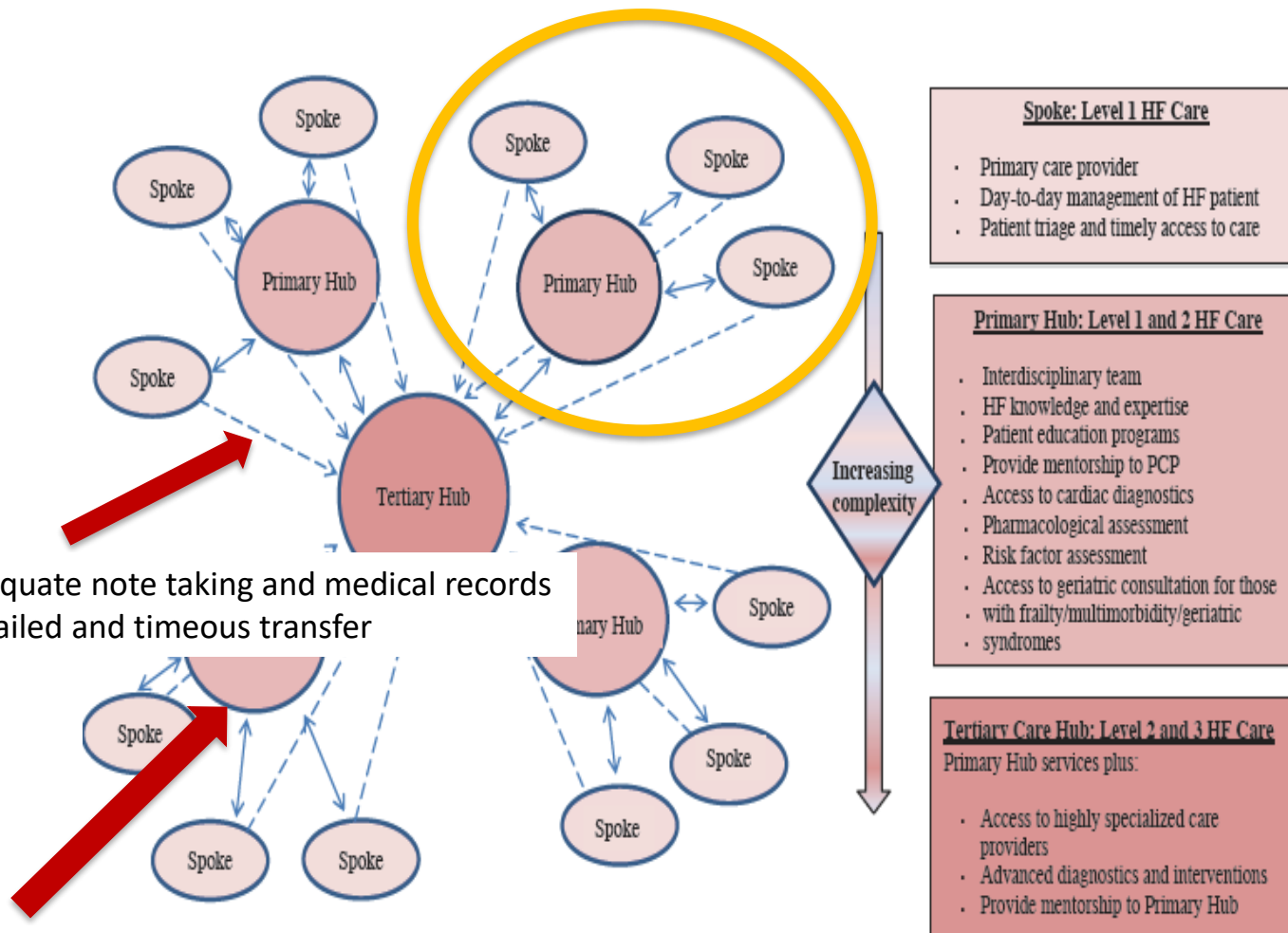




HF- Heart failure; PCP- Primary care provider

# Tertiary center goals

- Transplant referral center
- Inotropic support in a HCU/ICU setting (increasing bed capacity)
- Improving the donor pool – dealing with issues of scarcity, donor supply equality
- Correcting ‘Accidents of Geography’
- Cardiac catheterisation and endomyocardial biopsy
- Mechanical circulatory support
- Transplantation
- Immunosuppression
- Heart Team
- Advance care planning
- Palliation



- Adequate note taking and medical records
- Detailed and timeous transfer

- Training and education
- Establish relationships with tertiary center
- Regular training refreshers

# Diagnosis and Risk stratification

Level of Care	Patient Status	Care Provision
1	Low complexity NYHA I-II	Optimal prescription of pharmacological and non-pharmacological therapy, patient and caregiver self-care education and support.
2	Intermediate complexity NYHA II-III Unable to stabilize at Level 1	Consultation by Level 2 HF team. Patient stabilization, review of therapies and recommendations for changes. Discharge back to Level 1 when stable.
3	High complexity NYHA III-IV Unable to stabilize at Level 2	Consultation with and involvement of Level 3 specialized HF team until patient stabilizes sufficiently for transfer to Level 2 care.



- Levels 2 and 3 are largely merged as there are no secondary level cardiologists
- We could however utilize physicians to fulfil this role

# Rate limiting steps in SA



- Less than adequate primary and secondary level care
- Few cardiologists – less than optimal referral for transplant
- Only 4 centers that offer cardiac transplantation:
  - 3 private (Cape Town, Johannesburg, Durban, 1 state (GSH) )
  - Few surgeons equipped to do transplantation
- Sociodemographic factors in SA
- Sustainable after-care

# What can we do now?

- Clinical guidelines and knowledge translation
- Patient partners
- Define eligibility criteria
- Streamline referral patterns
- Templates for referral with appropriate work-up

# Does this model work?

## Importance of a Partnered Heart Failure Network to Increase Access to Advanced Heart Failure Therapies

*S. Rodriguez, E. Melrose, S. George, M. Duke and D.A.*

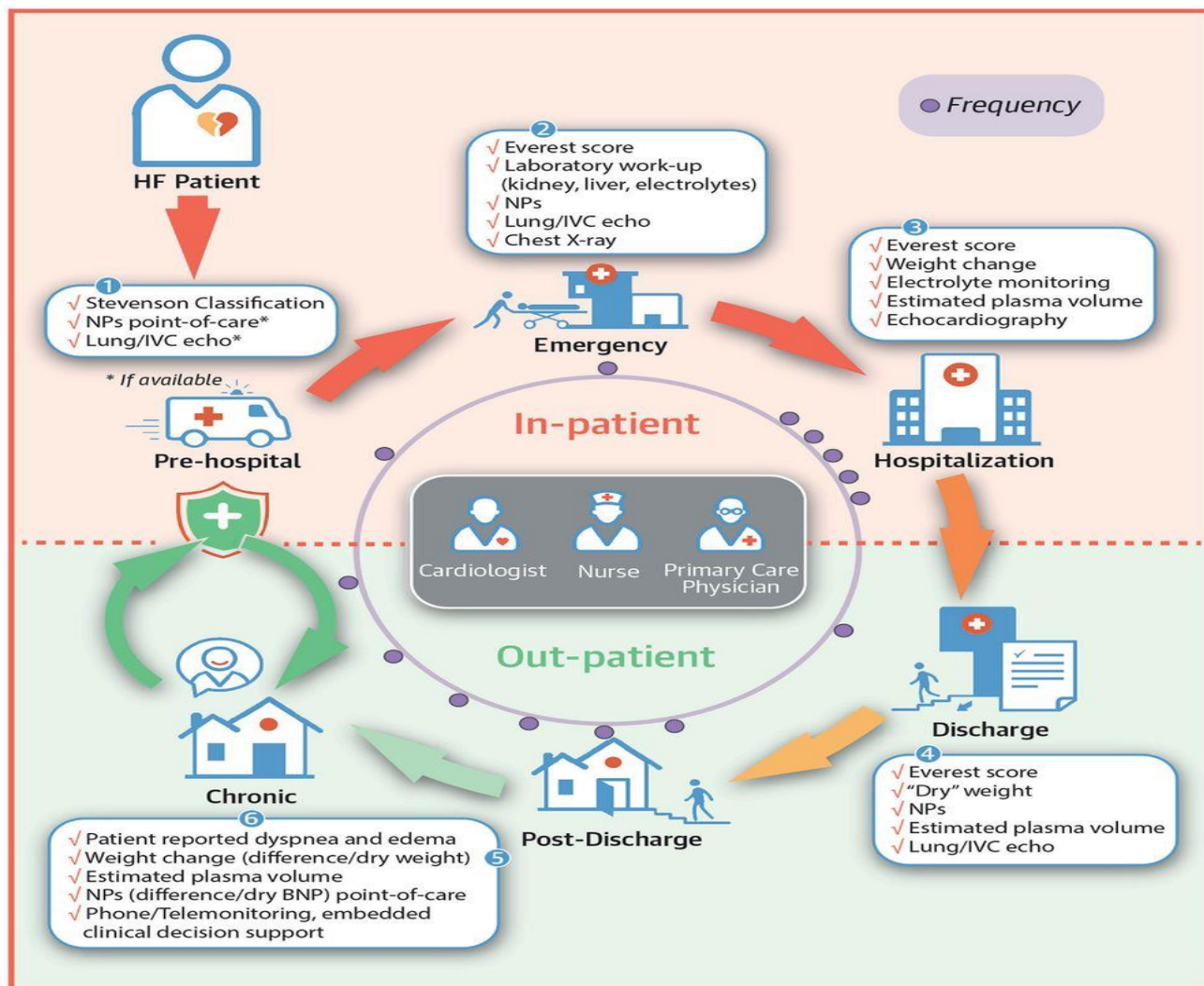
*Horstmanshof INTEGRIS Baptist Medical Center, Oklahoma City, OK.*

Clinic	Referral Volume: Phase 1	Referral Volume: Phase 2	Referral Growth (%)	MCS Volume: Phase 1	MCS Volume: Phase 2	MCS Growth (%)	HTX Volume Phase 1	HTX Volume: Phase 2	HTX Growth (%)
1	71	54	-24%	2	2	0%	0	0	0
2	26	57	119%	4	6	50%	0	1	100%
3	62	101	63%	7	8	14%	4	6	50%
4	1	37	3600%	0	1	100%	0	0	0
5	3	33	1000%	3	7	133%	0	0	0
6	136	157	15.40%	19	28	47%	6	4	-33%
7	1	39	3800%	0	0	0%	0	0	0
Total	300	478	59%	35	52	48%	8	11	38%

- Overall increase in heart failure referrals – 59%
- 48% increase in mechanical circulatory support implantation
- 38% increase in transplantation



## CENTRAL ILLUSTRATION: Congestion Assessment in HF Patient Journey



Girerd, N. et al. J Am Coll Cardiol HF. 2018;6(4):273-85.

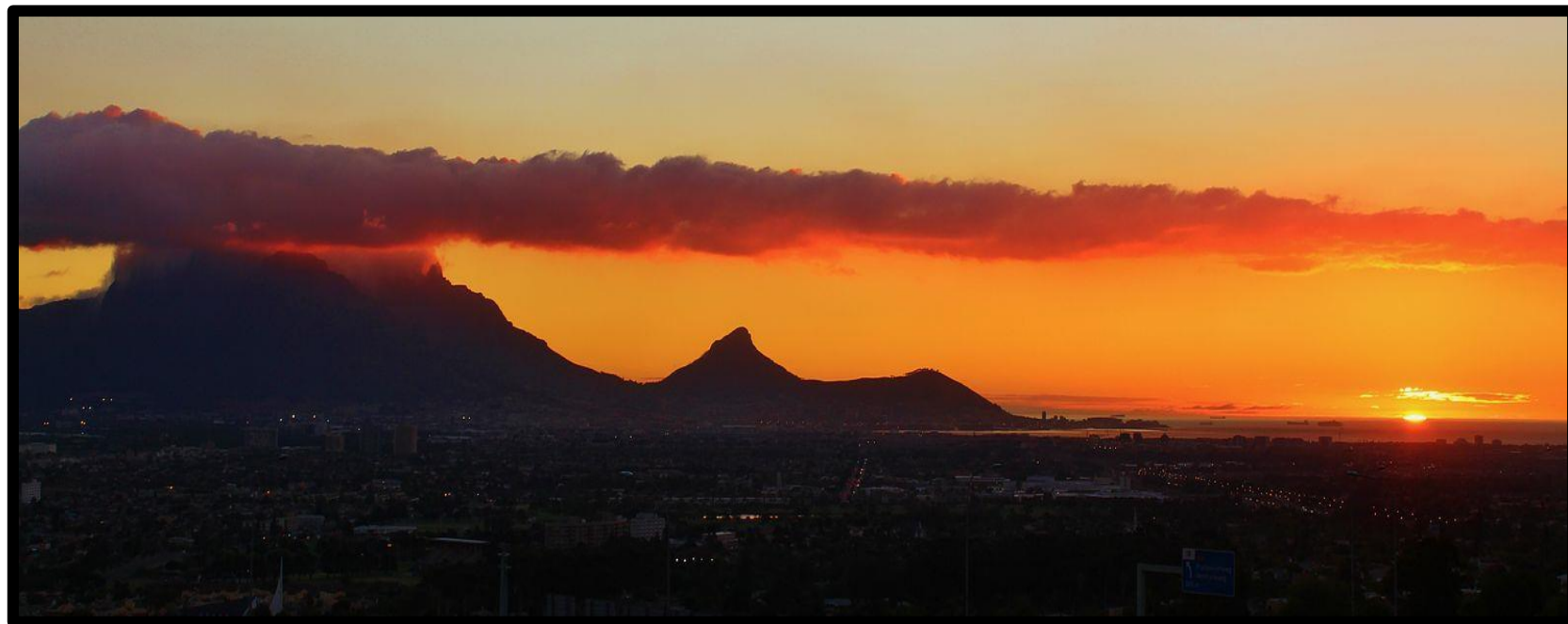


# A priority in SA



1. Create visibility for heart failure
2. Expose gaps in care
3. Hold the system to account
4. Support evidence based objectives with sufficient resources (financial and human)
5. Improve diagnosis at primary and secondary level
6. Quality education and support to patients and families
7. Patient centered approaches to care
8. Invest in professional capacity
9. Seamless transition of care
10. Equitable provision of medicine, devices and care





**Thank you**

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