



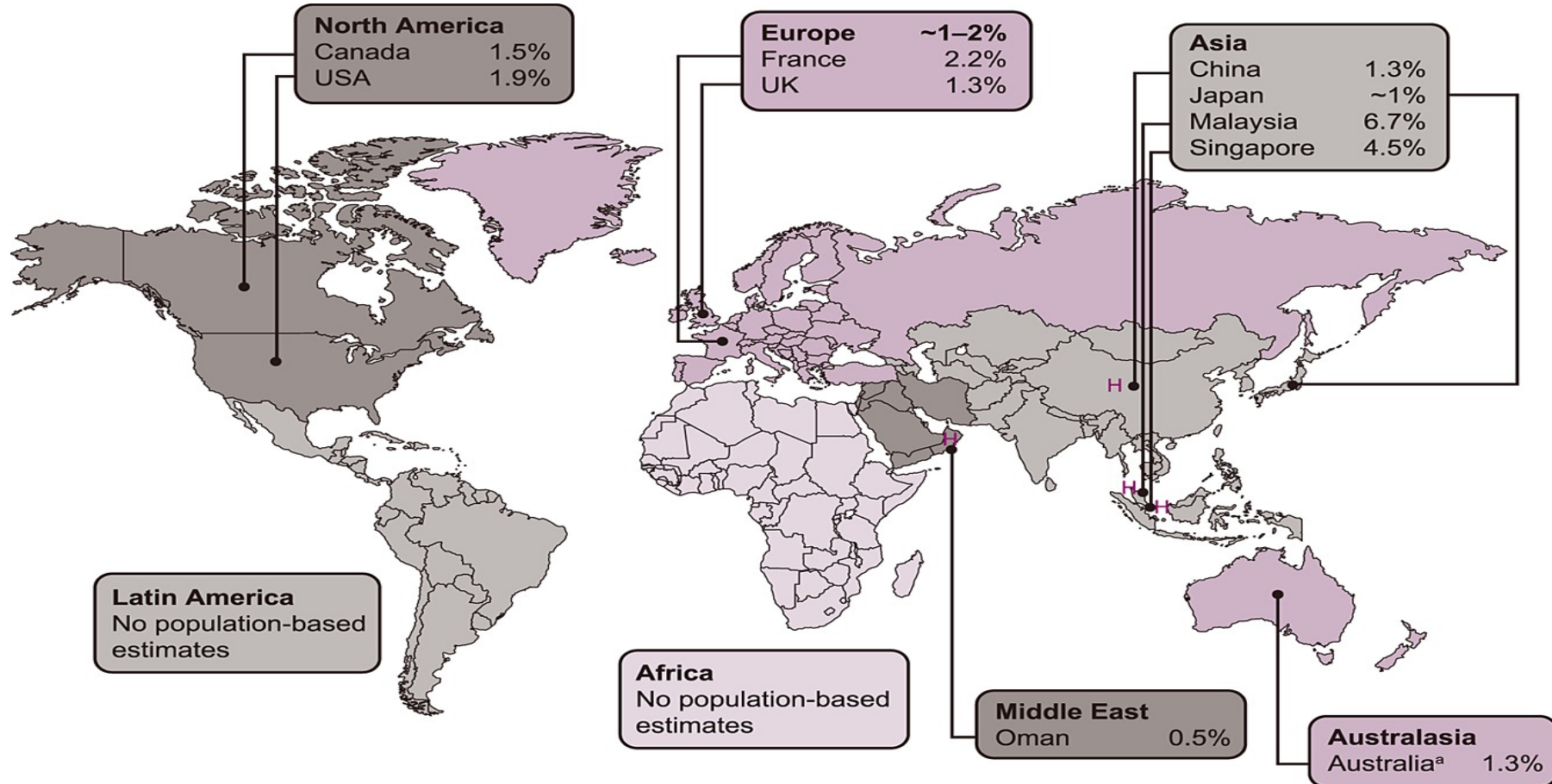
**XRONİK ÜRƏK ÇATIŞMAZLIĞI
ZAMANI MULTİDİSİPLİNAR
MÜDAXİLƏLƏR
KANSAS CİTY KMP ANKETİNİN
HƏDƏFLƏRİ**

**CHF - MULTIDISCIPLINARY
INTERVENTIONS, KCCQ GOALS**

M.D., Ph.D., ASSOCIATE PROFESSOR R. GABULOVA

**II ÜRƏK ÇATIŞMAZLIĞINDA YENİLİKLƏR KONQRESİ
10-11 İYUN, 2023
BAKI**

ÜÇ-nin DÜNYA ÖLKƏLƏRİ ÜZRƏ YAYILMA NİSBƏTİ



<https://doi.org/10.1002/ehf2.12005>

Ürək çatışmazlığı yüksək dərəcədə xəstələnmə və ölüm göstəricisi, yüksək səhiyyə xərcləri ilə xarakterizə olunan “çoxşaxəli” sindromdur. Dünyada 64 milyondan çox insan ÜÇ-dan əziyyət çəkir*.

Global burden of heart failure: a comprehensive and updated review of epidemiology

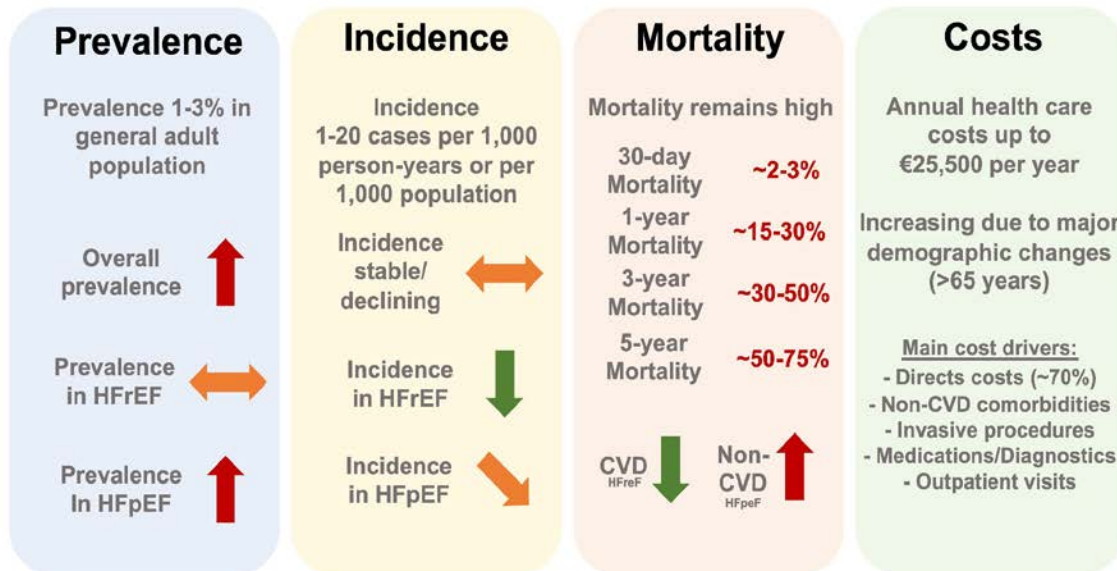
Gianluigi Savarese^{1,2†}, Peter Moritz Becher^{1,3†}, Lars H. Lund^{1,2}, Petar Seferovic^{4,5}, Giuseppe M.C. Rosano⁶, and Andrew J.S. Coats^{7*}

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Received 21 September 2021; editorial decision 10 January 2022; accepted 8 February 2022; online publication of print 12 February 2022

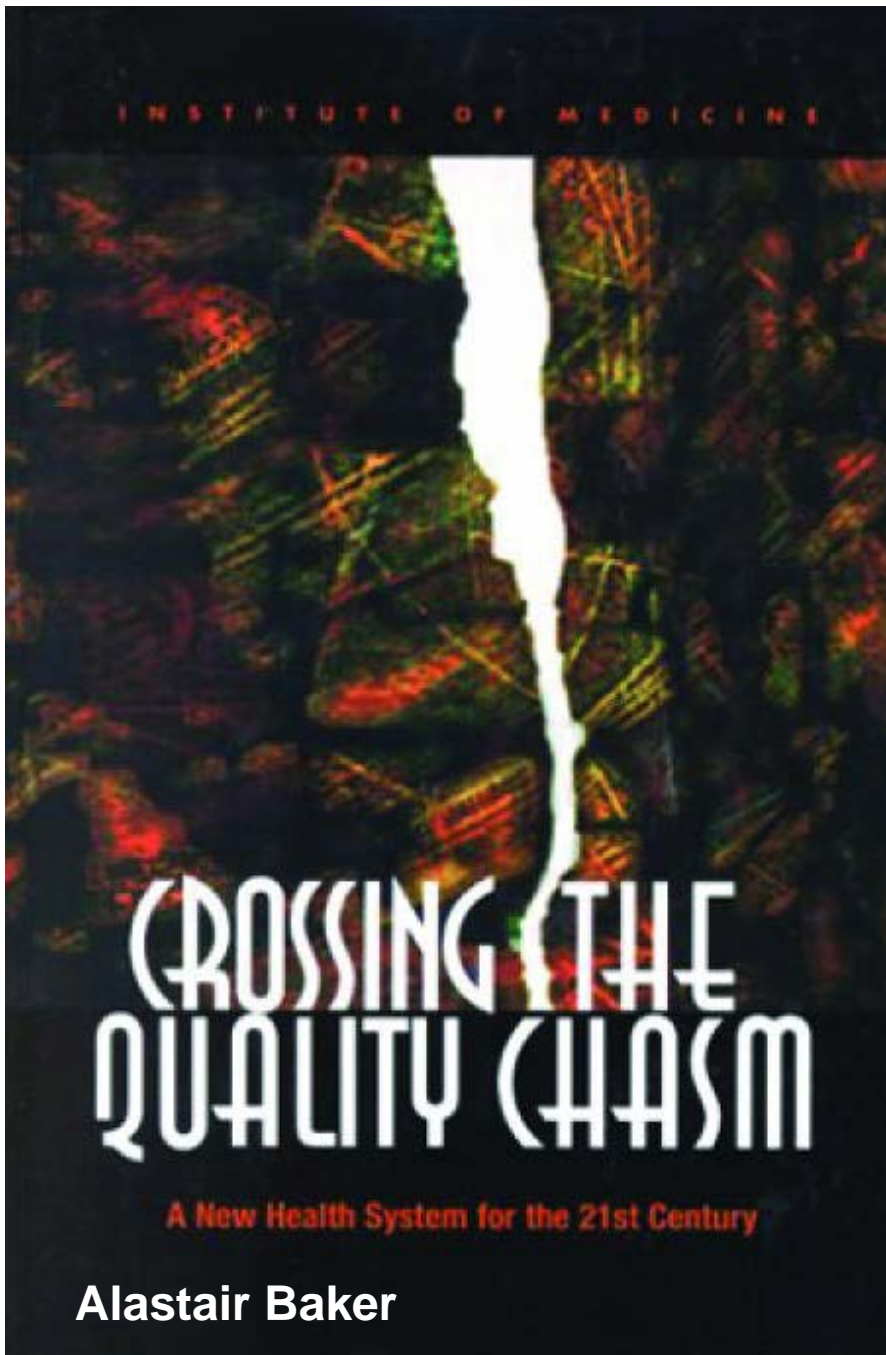
Abstract Heart Failure (HF) is a multi-faceted and life-threatening syndrome characterized by significant morbidity and mortality, poor functional capacity and quality of life, and high costs. HF affects more than 64 million people worldwide.

Global Burden of Heart Failure



ÜRƏK ÇATIŞMAZLIĞININ QLOBAL YÜKÜ

- ÜÇ-nin sosial və iqtisadi yükünü azaltmaq cəhdləri global ictimai sağlamlığın əsas prioritetlərindən biridir.
- İnkişaf etmiş ölkələrdə ÜÇ-nin meydana çıxma hallarının sayı sabitləşmiş/azalmışsa da,
- yayılması əhalinin qocalması, ÜİX müalicəsi və sağqalma faizinin artması və ÜÇ xəstələrinin ömrünü uzadan effektiv, sübuta əsaslanan müalicə nəticəsində artır.



Amerika Səhiyyə xidmətlərinin keyfiyyəti Komitəsinin XXI əsr səhiyyə sistemi üçün irəli sürdüyü 6 hədəf:

- Təhlükəsiz (safe)
- Effektiv (effective)
- Pasiyent mərkəzli/yönümlü (patient- centered)
- Vaxtında (timely)
- Səmərəli (efficient)
- Ədalətli (equitable)

Üç-nin idarəolunmasının keyfiyyətinin, əlçatanlığının, effektivliyinin yaxşılaşdırılması və ədalətli olması multidissiplinar müalicə yanaşması əsasında əldə edilə bilər.

2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)

Developed with the special contribution of the Heart Failure Association (HFA) of the ESC

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ESC entities having participated in the development of this document

Associations: Acute Cardiovascular Care Association (ACCA), European Association for Cardiovascular Prevention and Rehabilitation (EACPR), European Association of Cardiovascular Imaging (EACVI), European Heart Rhythm Association (EHRA), Heart Failure Association (HFA).

Councils: Council on Cardiovascular Nursing and Allied Professions, Council for Cardiology Practice, Council on Cardiovascular Primary Care, Council on Hypertension.

Working Groups: Cardiovascular Pharmacotherapy, Cardiovascular Surgery, Myocardial and Pericardial Diseases, Myocardial Function, Pulmonary Circulation and Right Ventricular Function, Valvular Heart Disease.

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Table 14.1 Characteristics and components of management programmes for patients with heart failure

Characteristics	
	Should employ a multidisciplinary approach (cardiologists, primary care physicians, nurses, pharmacists, physiotherapists, dieticians, social workers, surgeons, psychologists, etc.).
	Should target high-risk symptomatic patients.
	Should include competent and professionally educated staff. ⁶¹⁷
Components	
	Optimized medical and device management.
	Adequate patient education, with special emphasis on adherence and self-care.
	Patient involvement in symptom monitoring and flexible diuretic use.
	Follow-up after discharge (regular clinic and/or home-based visits; possibly telephone support or remote monitoring).
	Increased access to healthcare (through in-person follow-up and by telephone contact; possibly through remote monitoring).
	Facilitated access to care during episodes of decompensation.
	Assessment of (and appropriate intervention in response to) an unexplained change in weight, nutritional status, functional status, quality of life, or laboratory findings.
	Access to advanced treatment options.
	Provision of psychosocial support to patients and family and/or caregivers.

Recommendations for exercise, multidisciplinary management and monitoring of patients with heart failure

Recommendations	Class ^a	Level ^b	Ref ^c
It is recommended that regular aerobic exercise is encouraged in patients with HF to improve functional capacity and symptoms.	I	A	321, 618–621
It is recommended that regular aerobic exercise is encouraged in stable patients with HFrEF to reduce the risk of HF hospitalization.	I	A	618, 619
It is recommended that patients with HF are enrolled in a multidisciplinary care management programme to reduce the risk of HF hospitalization and mortality.	I	A	622–625
Referral to primary care for long-term follow-up may be considered for stable HF patients who are on optimal therapy to monitor for effectiveness of treatment, disease progression and patient adherence.	IIb	B	626, 627
Monitoring of pulmonary artery pressures using a wireless implantable haemodynamic monitoring system (CardioMEMS) may be considered in symptomatic patients with HF with previous HF hospitalization in order to reduce the risk of recurrent HF hospitalization.	IIb	B	628, 629
Multiparameter monitoring based on ICD (IN-TIME approach) may be considered in symptomatic patients with HFrEF (LVEF ≤35%) in order to improve clinical outcomes.	IIb	B	630

**ESC**European Society
of Cardiology

European Heart Journal (2021) 42, 3599–3726

doi:10.1093/eurheartj/ehab368

ESC GUIDELINES

2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

ÜÇ-nin idarə olunması proqramlarının xüsusiyyətləri

Xüsusiyyətlər

1. Pasiyentmərkəzli
2. Multidissiplinar
3. Proqramın istiqaməti şəraitə uyğun olmalıdır və bura daxildir:
 - xəstəliyin inkişafının profilaktikası
 - simptomlara nəzarət
 - ürək çatışmazlığının son mərhələsi ilə əlaqədar xəstələrin üstünlük verdikləri yerdə saxlanması
4. Səriştəli və peşəkar təhsil almış heyət
5. Xəstənin/qulluq edən şəxsi öz vəziyyətlərini anlamağa və onun idarə olunmasında iştirakını təşviq edilməsi

Komponentlər

1. Optimallaşdırılmış yanaşma; həyat tərzinin dəyişdirilməsi, farmakoloji, və cihazla müalicə
2. Xəstələrin təhsili (özünəqulluq və simptomların idarə olunmasına xüsusi diqqət verməklə)
3. Pasiyentlər və ailə üzvlərinə psixososial dəstək
4. Evə yazıldıqdan sonra xəstələrin təqibi (klinik; evdə vizit; telefonla əlaqə saxlanması və ya telemonitorinq)
5. Səhiyyə xidmətlərinin əlçatanlığı, xüsusilə dekompensasiyanın profilaktikası və idarə olunmasında
6. Bədən çəkisinin səbəbi aydın olmayan dəyişməsi, qidalanma və funksional vəziyyət, həyat keyfiyyəti, yuxu problemləri, psixososial problemlər və ya digər aşkar olunmuş (məsələn, laborator nəticələr) dəyişikliyin qiymətləndirilməsi (və buna uyğun müdaxilənin olunması)
7. Qabaqcıl müalicələrin əlçatan olması; dəstəkləyici və palliativ qayğı

XÜÇ-ün idarə olunması üçün multidissiplinar yanaşma

Təvsiyələr	Sınıf ^a	Səviyyə ^b
ÜÇ xəstələrinin ÜÇ-dən hospitalizasiya və ölüm riskini azaltmaq məqsədilə onların multidissiplinar ÜÇ müalicə proqramına daxil edilməsi təvsiyə olunur.	I	A
ÜÇ ilə xəstəxanaya yerləşdirmə və ölüm riskini azaltmaq üçün özünə nəzarət strategiyaları təvsiyə olunur.	I	A
Evdə və/ya klinikada aparılan proqramlar nəticələri yaxşılaşdırır və ÜÇ-dən ölüm ilə hospitalizasiya riskini azaltmaq üçün təvsiyə olunur.	I	A
ÜÇ ilə hospitalizasiyanın profilaktikası üçün qrip və pnevmokok peyvəndi nəzərdən keçirilməlidir.	IIa	B

ESC GUIDELINES

Multidissiplinar yanaşmanın xüsusiyyətləri

• ÜÇ MP (multidissiplinar proqramının) optimal tətbiq olunması multidissiplinar komandadan ÜÇ-nin bütün gedişi boyunca

- Xəstəliyin manifestasiyası
- Kəskinləşmə mərhələsində
- Stabilləşmə mərhələsində və həmçinin
- Terminal mərhələdə fəal olmağı tələb edir.

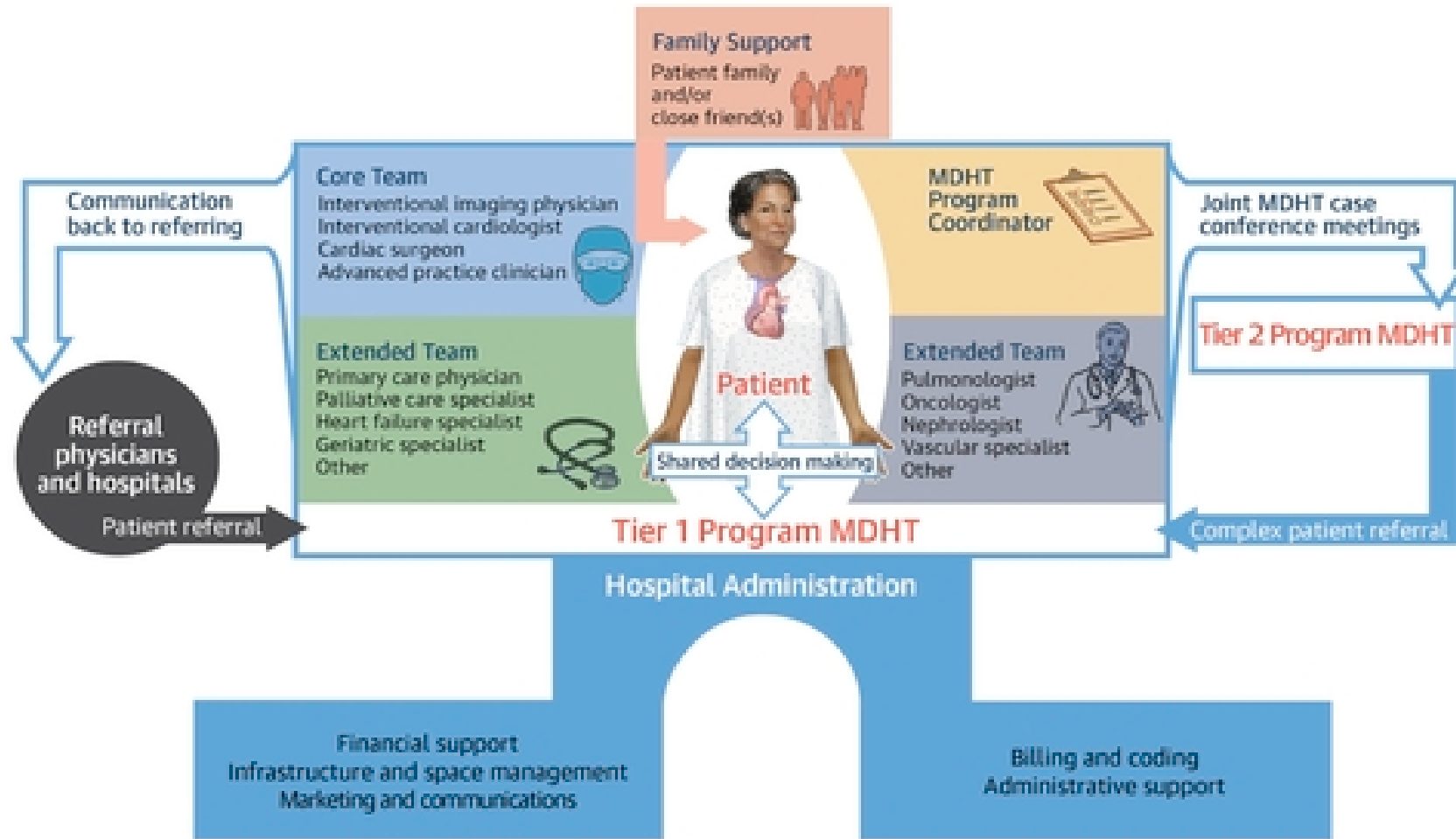
ÜRƏK ÇATIŞMAZLIĞI MULTİDİSSİPLİNAR PROQRAMLARI XİDMƏT MODELLƏRİNƏ VƏ KOMPONENTLƏRİNƏ GÖRƏ FƏRQLƏNİR

ÜÇ-MP-lər səhiyyə sistemində, mövcud mənbələrə (infrastruktur, imkanlar, işçi heyəti və maliyyə), inzibati siyasətə və xəstənin ehtiyaclarına uyğunlaşdırılmalıdır

- Klinik şəraitdə (birincil, ikincil və ya üçüncü dərəcəli tibbi yardımda)
- ev şəraitində və
- hibrid proqramlar tətbiq edə bilər.
- Servis modellərinin bir-birindən üstünlüyü göstərilməyib.
- ÜÇ-li xəstələrə palliativ və dəstəkləyici yanaşmanın erkən tətbiqi tövsiyə olunur.

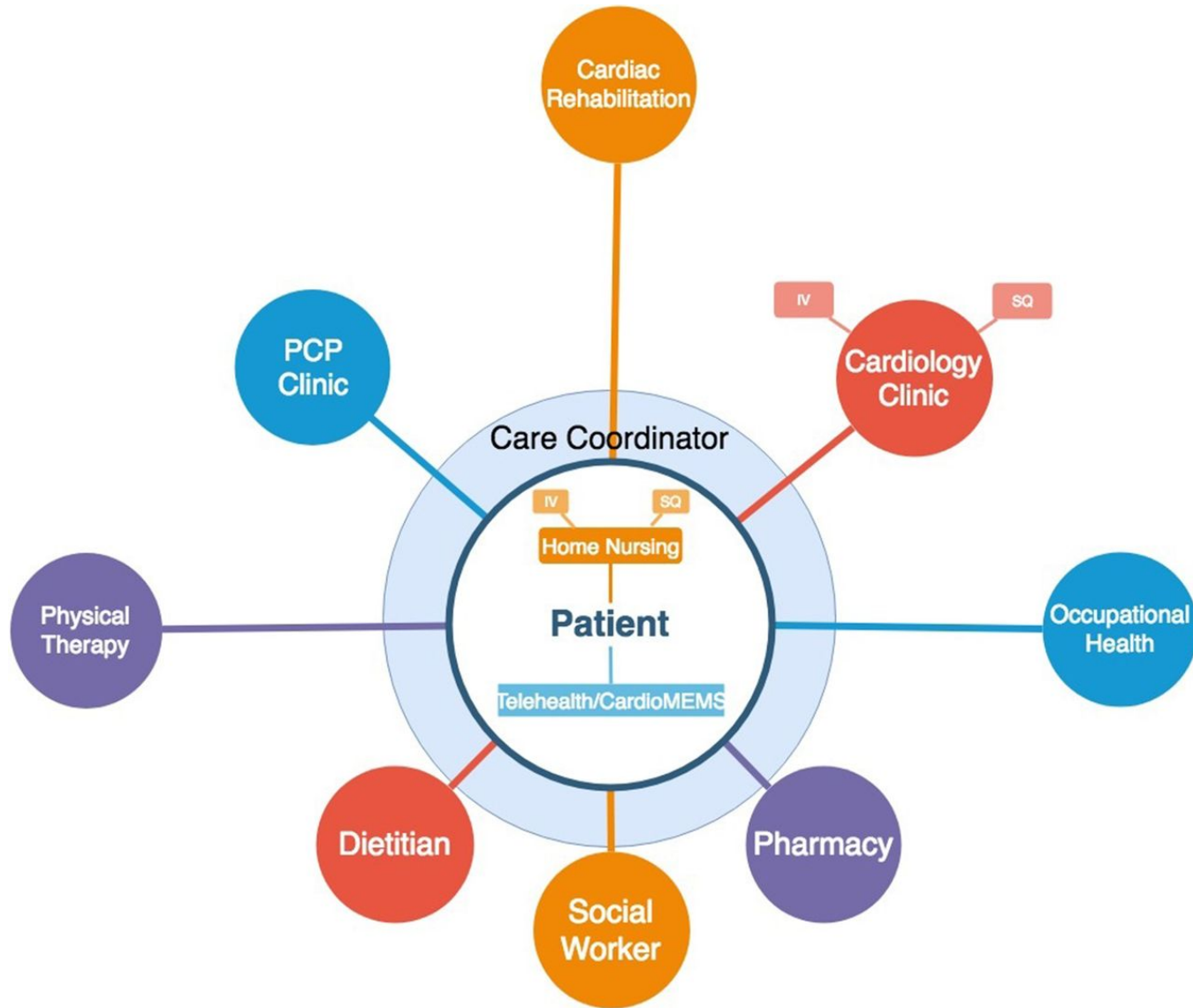


CENTRAL ILLUSTRATION: Conceptual Framework for the MDHT



Batchelor WB, et al. JACC Adv. 2023;2(1):100160.

360o heart failure centre: a patient-centred comprehensive model for the care for congestive heart failure



ÜÇ-li xəstəyə fərdi müalicə modeli - xəstə mərkəzli ÜÇ-proqramı

Müalicə xəstənin ətrafında mərkəzləşir və müxtəlif xidmətlər arasındakı məsafə dəstəyin tezliyinə və səviyyəsinə görə dəyişir.

Comparative effectiveness of transitional care services in patients discharged from the hospital with heart failure: a systematic review and network meta-analysis

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Michiel Coppens⁵, R. Brian Haynes², and Stuart Connolly¹

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Received 4 July 2016; revised 15 December 2016; accepted 30 December 2016; online publish-ahead-of-print 24 February 2017

Aims To compare the effectiveness of transitional care services in decreasing all-cause death and all-cause readmissions following hospitalization for heart failure (HF).

Methods and results We searched PubMed, Embase, CINAHL, and Cochrane Clinical Trials Register for randomized controlled trials (RCTs) published in 2000–2015 that tested the efficacy of transitional care services in patients hospitalized for HF, provided ≥ 1 month of follow-up, and reported all-cause mortality or all-cause readmissions. Our network meta-analysis included 53 RCTs (12 356 patients). Among services that significantly decreased all-cause mortality compared with usual care, nurse home visits were most effective [ranking *P*-score 0.6794; relative risk (RR) 0.78, 95% confidence intervals (CI) 0.62–0.98], followed by disease management clinics (DMCs) (ranking *P*-score 0.6368; RR 0.80, 95% CI 0.67–0.97). Among services that significantly decreased all-cause readmission, nurse home visits were most effective [ranking *P*-score 0.8365; incident rate ratio (IRR) 0.65, 95% CI 0.49–0.86], followed by nurse case management (NCM) (ranking *P*-score 0.6168; IRR 0.77, 95% CI 0.63–0.95), and DMCs (ranking *P*-score 0.5691; IRR 0.80, 95% CI 0.66–0.97). There was no significant difference in the comparative effectiveness of services that improved each outcome. Nurse home visits had the greatest pooled cost-savings (3810 USD, 95% CI 3682–3937), followed by NCM (3435 USD, 95% CI 3224–3645), and DMCs (245 USD, 95% CI –70 to 559). Telephone, telemonitoring, pharmacist, and education interventions did not significantly improve clinical outcomes.

Conclusion Nurse home visits and DMCs decrease all-cause mortality after hospitalization for HF. Along with NCM, they also reduce all-cause readmissions, with no significant difference in comparative effectiveness. These services reduce healthcare system costs to varying degrees.

Keywords Transitional care • Comparative effectiveness • Heart failure

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- 53 randomizə olunan tədqiqat və **12 356 pasiyent** daxil olan meta-analiz, **2000–2015** illərdə ÜÇ olan xəstələrin hospitalizasiyadan sonra 1 aydan çox təqibi
- tibb bacılarının ev ziyarətlərinin adi müalicə ilə müqayisədə bütün səbəblərdən ölümü azaltdığı qənaətinə gəlmişdir.

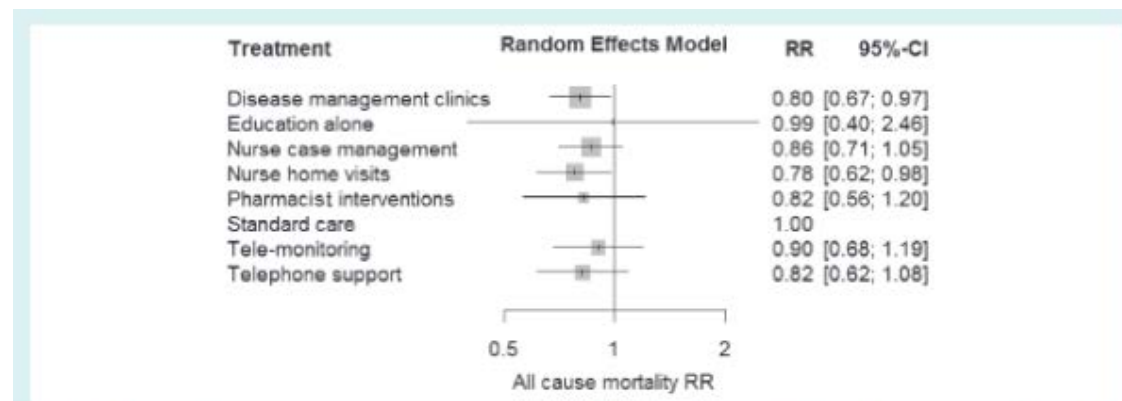


Figure 2 Comparative effectiveness of transitional care services in reducing all-cause mortality after hospitalization for heart failure. Results of the network meta-analysis are depicted in the forest plot. CI, confidence interval; RR, relative risk.

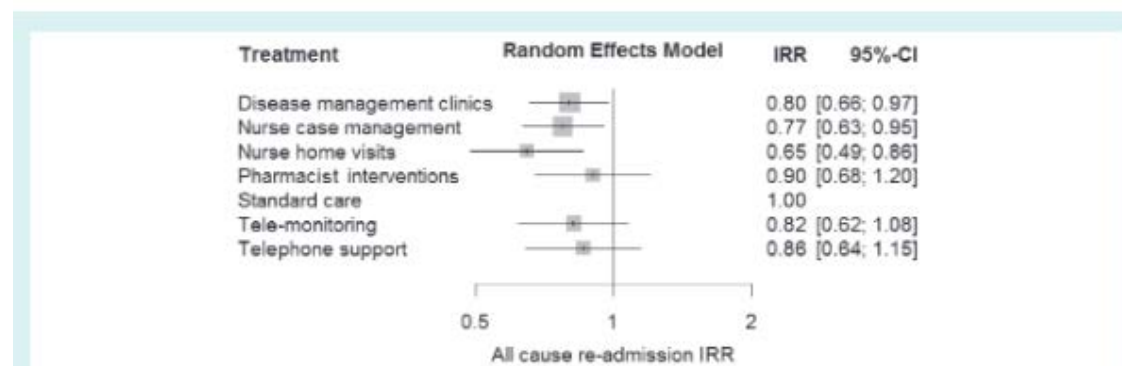
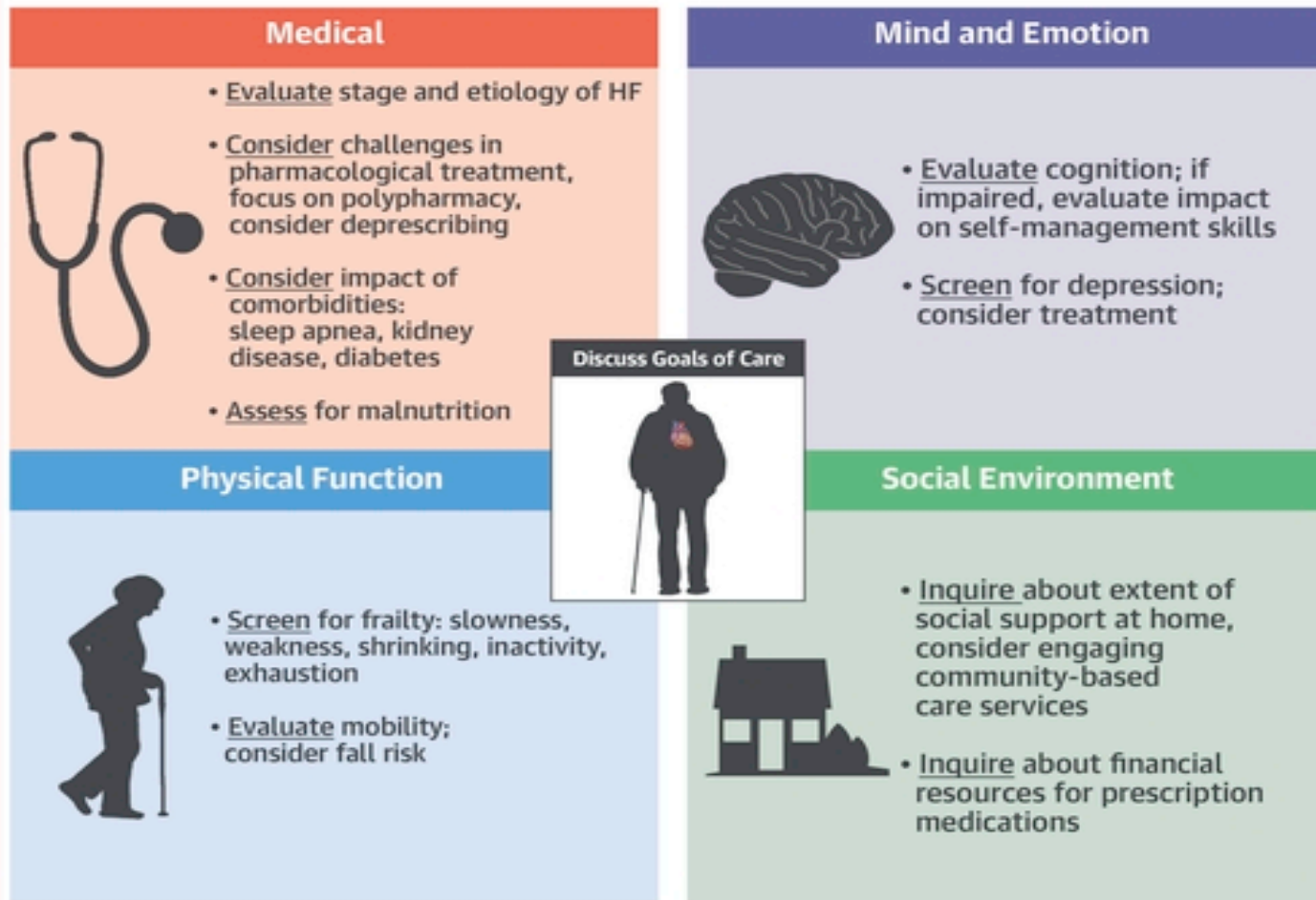


Figure 3 Comparative effectiveness of transitional care services in reducing all-cause readmissions after hospitalization for heart failure. Results of the network meta-analysis are depicted in the forest plot. CI, confidence interval; IRR, incident rate ratio.

CENTRAL ILLUSTRATION: Domain Management Approach to HF in the Geriatric Patient



Gorodeski, E.Z. et al. J Am Coll Cardiol. 2018;71(17):1921-36.

ÜÇ əsasən yaşlanma ilə əlaqədardır, xəstələrin orta yaşı 70 dən artıqdır.

UÇ-nin yayılması 60 -79 yaşlarda 6%, ≥80 yaşda 14% təşkil edir.

Multidissiplinar proqram tərtib olunarkən

- Komorbidlik
- Polipraqmaziya
- Fiziki funksiyalar (zəiflik, yıxılma riski)
- Koqnitiv funksiya, depressiyanın olub-olmaması
- Sosial mühit (evdə sosial dəstək, s.)
- Dərman müalicəsi üçün maliyyə dəstəyinin olması

openheart Multispecialty multidisciplinary input into comorbidities along with treatment optimisation in heart failure reduces hospitalisation and clinic attendance

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Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/openhrt-2022-001979>).

To cite: Essa H, Walker L, Mohee K, et al. Multispecialty multidisciplinary input into comorbidities along with treatment optimisation in heart failure reduces hospitalisation and clinic attendance. *Open Heart* 2022;9:e001979. doi:10.1136/openhrt-2022-001979

Received 1 February 2022
Accepted 20 June 2022



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ABSTRACT

Aims Heart failure (HF) is associated with comorbidities which independently influence treatment response and outcomes. This retrospective observational study (January 2020–June 2021) analysed the impact of monthly HF multispecialty multidisciplinary team (MDT) meetings to address management of HF comorbidities and therapy on provision, cost of care and HF outcomes.

Methods Patients acted as their own controls, with outcomes compared for equal periods (for each patient) pre (HF-MDT) versus post-MDT (multispecialty) meeting. The multispecialty MDT comprised HF cardiologists (primary, secondary, tertiary care), HF nurses, nephrologist, endocrinologist, palliative care, chest physician, pharmacist, clinical pharmacologist and geriatrician. Outcome measures were (1) all-cause hospitalisations, (2) outpatient clinic attendances and (3) cost.

Results 334 patients (mean age 72.5±11 years) were discussed virtually through MDT meetings and follow-up duration was 13.9±4 months. Mean age-adjusted Charlson Comorbidity Index was 7.6±2.1 and Rockwood Frailty Score 5.5±1.6. Multispecialty interventions included optimising diabetes therapy (haemoglobin A1c-HbA1c pre-MDT 68±11 mmol/mol vs post-MDT 61±9 mmol/mol; $p<0.001$), deprescribing to reduce anticholinergic burden (pre-MDT 1.85±0.4 vs 1.5±0.3 post-MDT; $p<0.001$), initiation of renin-angiotensin aldosterone system inhibitors in HF with reduced ejection fraction (HFrEF) with advanced chronic kidney disease (9% pre vs 71% post-MDT; $p<0.001$). Other interventions included potassium binders, treatment of anaemia, falls assessment, management of chest conditions, day-case ascitic, pleural drains and palliative support. Total cost of funding monthly multispecialty meetings was £32 400 and resultant 64 clinic appointments cost £9600. The post-MDT study period was associated with reduction in 481 clinic appointments (cost saving £72150) and reduced all-cause hospitalisations (pre-MDT 1.1±0.4 vs 0.6±0.1 post-MDT; $p<0.001$), reduction of 1586 hospital bed-days and cost savings of £634 400. Total cost saving to the healthcare system was £664 550.

Conclusion HF multispecialty virtual MDT model provides integrated, holistic care across all healthcare tiers for

WHAT IS ALREADY KNOWN ON THIS TOPIC

Heart failure is associated with several comorbid health conditions (multimorbidity) which independently influence outcomes as well as response to treatment.

WHAT THIS STUDY ADDS

This study assesses the impact of multispecialty multimorbidity input into the management of comorbidities and therapy the effect on all-cause outcomes.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

Results of this study illustrate that multispecialty management of comorbidities associated with heart failure, may not only improve all-cause outcomes but could also prove to be cost beneficial.

management of HF and associated comorbidities. This approach is associated with reduced clinic attendances and all-cause hospitalisations, leading to significant cost savings.

INTRODUCTION

Heart failure (HF) is a complex clinical syndrome, representing the final common pathway of many different pathological processes and associated with high mortality and frequent hospital admissions.¹ There are an estimated 64.5 million cases of HF worldwide.² This global burden is expected to increase due to an ageing population, with 80% of hospitalisations occurring in those aged >65 years.³ Significantly, hospitalisation in people with HF confers a poor prognosis with a 1-year mortality of 31%, 5-year mortality of 69% and 10-year mortality of 82% and these outcomes are worse in comparison to those who do not require hospitalisation.⁴



Figure 4 Integrated multispecialty MDT model illustrating the team members involved in the MDT meetings. HF, heart failure; MDT, multidisciplinary team.

Essa H, et al. *Open Heart* 2022;9:e001979. doi:10.1136/openhrt-2022-001979

- İnteqrasiya olunmuş **virtual çoxixtisaslı multidisiplinar yaşama** bütün səbəblərdən hospitalizasiya və klinik vizitlərin azalması ilə ÜÇ nəticələrinin yaxşılaşdırılmasına səbəb olmuşdur.
- Bu, **həm xəstə mərkəzli, həm də iqtisadi cəhətdən sərfəlidir**
- Bu modelin tətbiqi ÜÇ olan xəstələrdə **multimorbidlik probleminin həllində qızıl standart yaşama** ola bilər.

XƏSTƏ MƏRKƏZLİ (PAİYENTƏ YÖNƏLİMİŞ) YANAŞMA: ÖZÜNÜ QIYMƏTLƏNDİRMƏ, ÖZÜNÜ İDARƏETMƏ, BİRGƏ QƏRAR VERMƏ

Özünü idarəetmə, insanın xroniki xəstəliklərə xas olan simptomlar, müalicə, fiziki və psixososial nəticələr ilə mübarizə və həyat tərzini dəyişdirmək qabiliyyətinə aiddir.

Effektiv özünü idarəetmə, öz vəziyyətini idarə etmək və qənaətbəxş həyat keyfiyyətini saxlamaq üçün lazım olan idrak, davranış və emosional reaksiyaları həyata keçirmək qabiliyyətini əhatə edir (J.Barlow, 2002).



Clinical Investigation

What Are Effective Program Characteristics of Self-Management Interventions in Patients With Heart Failure? An Individual Patient Data Meta-analysis

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Utrecht, Deventer and Maastricht, The Netherlands; Linköping and Jönköping, Sweden; Córdoba, A Coruña and Madrid, Spain; Glasgow, UK; Chapel Hill, North Carolina; Seattle, Washington; Ann Arbor, Michigan; Basel, Switzerland; Aomori, Japan; Heidelberg, Germany; St. Louis, Missouri; Philadelphia, Pennsylvania; and Edmonton, Alberta, Canada

ABSTRACT

Background: To identify those characteristics of self-management interventions in patients with heart failure (HF) that are effective in influencing health-related quality of life, mortality, and hospitalizations.

Methods and Results: Randomized trials on self-management interventions conducted between January 1985 and June 2013 were identified and individual patient data were requested for meta-analysis. Generalized mixed effects models and Cox proportional hazard models including frailty terms were used to assess the relation between characteristics of interventions and health-related outcomes. Twenty randomized trials (5624 patients) were included. Longer intervention duration reduced mortality risk (hazard ratio 0.99, 95%

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Manuscript received March 16, 2016; revised manuscript received May 22, 2016; revised manuscript accepted June 28, 2016.

Dr. Stephen Gottlieb served as Guest Editor for this paper.

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Funding: This work was supported by the Dutch Ministry of Health, Welfare and Sport, ZonMw [grant number 520001002]. The funding source had no involvement in study design; in the collection, analysis and interpretation of data; in the writing of the report; nor in the decision to submit the article for publication.

Contributions: NHJ, HW, RHHG, TJ, JCAT, MJS, and AWH participated in the design of the study. SA, MA, LB, PWFBA, DAD, PLH, MH, TJ, GHMK, MEL, DJAL, JMårtensson, JMuniz, HO, FPK, MWR, BR, AS, and RTT contributed data to this study. NHJ and HW collected and merged the data. NHJ, HW, RHHG, JCAT, AWH, and MJS wrote the statistical analysis plan. NHJ and RHHG carried out the statistical analysis. All authors reviewed the statistical plan and the statistical analysis. NHJ wrote the draft of the manuscript. All authors contributed to critical revision of the manuscript. All authors approved the final version of the manuscript.

See page 869 for disclosure information.

1071-9164/\$ - see front matter

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5624 xəstəni əhatə edən 20 tədqiqatın meta-analizi:
Üç olan xəstələrdə özünü idarəetmə müdaxilələri intensivliyi, məzmunu və heterogenliyinə baxmayaraq nəticələri yaxşılaşdırır.

Özünü idarəetmə müdaxilələri

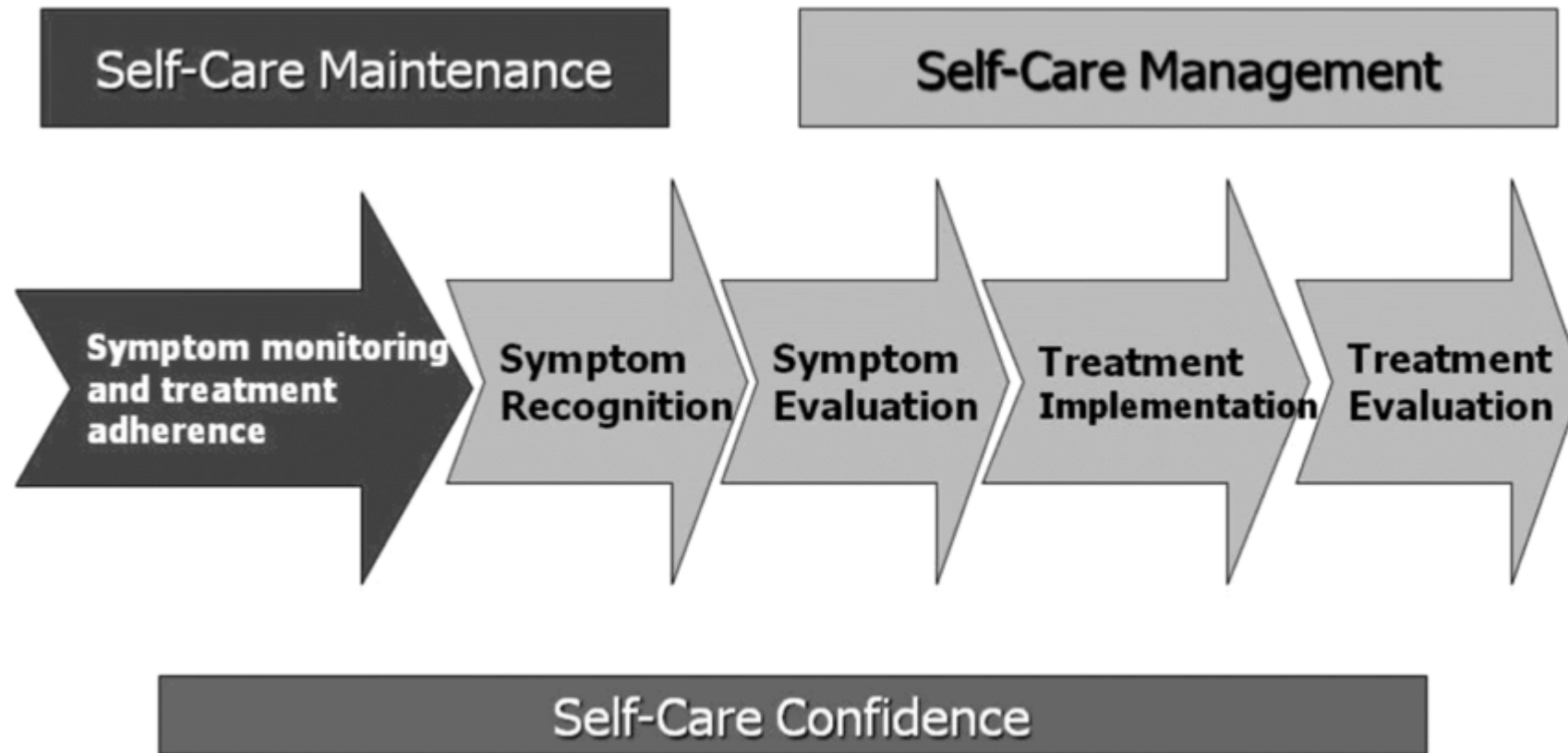
- Əlamətlərin/simptomların monitorinqini
- problem həll etmə bacarıqlarını öyrənmək (məsələn, özünə qulluq, stres/simptomları idarə etmək)
- tibbi müalicəyə riayətkarlıq
- fiziki aktivlik
- pəhrizə riayət etmək
- tütünçəkməni dayandırmaq.

ÜRƏK ÇATIŞMAZLIĞININ FƏRDİ, XƏSTƏ MƏRKƏZLİ İDARƏ OLUNMASI: “MƏNSİZ MƏNİM HAQQIMDA HEÇ NƏ ...” PRİNSİPİ



- ÜÇ- MP fərdi xüsusiyyətlər nəzərə alınmaqla hazırlanır
- pasiyentlərin ehtiyac və üstünlüklərinə diqqət yetirir və onlara hörmət edir
- ailəni və digər maraqlı tərəfləri cəlb edir
- birgə qərar vermə və
- hədəfi müəyyənləşdirməni əhatə edir.

Model illustrating the process of heart failure self-care



•January 2021 [Heart Failure Reviews](#) 26(1)
DOI:[10.1007/s10741-019-09907-w](https://doi.org/10.1007/s10741-019-09907-w)

AHA/ACC/HFSA CLINICAL PRACTICE GUIDELINE

2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

7.1. Nonpharmacological Interventions

7.1.1. Self-Care Support in HF

Recommendations for Nonpharmacological Interventions: Self-Care Support in HF		
Referenced studies that support the recommendations are summarized in the Online Data Supplements.		
COR	LOE	Recommendations
1	A	1. Patients with HF should receive care from multidisciplinary teams to facilitate the implementation of GDMT, address potential barriers to self-care, reduce the risk of subsequent rehospitalization for HF, and improve survival. ¹⁻⁴
1	B-R	2. Patients with HF should receive specific education and support to facilitate HF self-care in a multidisciplinary manner. ^{2,5-9}
2a	B-NR	3. In patients with HF, vaccinating against respiratory illnesses is reasonable to reduce mortality. ¹⁰⁻¹⁶
2a	B-NR	4. In adults with HF, screening for depression, ^{17,18} social isolation, ¹⁹⁻²² frailty, ^{23,24} and low health literacy ^{25,26} as risk factors for poor self-care is reasonable to improve management.

14. RECOMMENDATION FOR PATIENT-REPORTED OUTCOMES AND EVIDENCE GAPS AND FUTURE RESEARCH DIRECTIONS

14.1. Patient-Reported Outcomes

Recommendation for Patient-Reported Outcomes		
COR	LOE	Recommendation
2a	C-LD	1. In patients with HF, standardized assessment of patient-reported health status using a validated questionnaire can be useful to provide incremental information for patient functional status, symptom burden, and prognosis. ¹⁻¹⁹

PASIYENTLƏRİN MAARİFLƏNDİRİLMƏSİ VƏ ÖZÜNÜ QIYMƏTLƏNDİRMƏ VASİTƏLƏRİ

Updated & improved

COVID-19 Virus and Heart Failure: Information and Practical Tips [Learn more](#)

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SCROLL DOWN



ESC Clinical Practice Guidelines on **The Management of Chronic and Acute Heart Failure: What Patients Need to Know**

ESC European Society of Cardiology

ARCHIVE

ers.org

New



HEART FAILURE MATTERS:

PRACTICAL INFORMATION FOR PATIENTS, FAMILIES AND CAREGIVERS.



<https://www.heartfailurematters.org/>

Self-Check Plan for HF Management

American Heart Association

- Excellent - Keep Up the Good Work!**
 - No new or worsening shortness of breath
 - Physical activity level is normal for you
 - No new swelling, feet, ankles and legs look normal for you
 - Weight check stable
 - No chest pain

GREAT! CONTINUE: Daily Weight Check, Meds as Directed, Low-Sodium Eating, Follow-up Visits
- Pay Attention - Use Caution!**
 - Dry, hacking cough
 - Worsening shortness of breath with activity
 - Increased swelling of legs, ankles and feet
 - Sudden weight gain of more than 2-3 lbs in a 24-hour period (or 5 lbs in a week)
 - Discomfort or swelling in the abdomen
 - Trouble sleeping

CHECK IN! Your symptoms may indicate: A need to contact your doctor or health care team, A need for a change in medications
- Medical Alert - Warning!**
 - Frequent dry, hacking cough
 - Shortness of breath at rest
 - Increased discomfort or swelling in the lower body
 - Sudden weight gain of more than 2-3 lbs in a 24-hour period (or 5 lbs in a week)
 - New or worsening dizziness, confusion, sadness or depression
 - Loss of appetite
 - Increased trouble sleeping; cannot lie flat

WARNING! You need to be evaluated right away. Call your physician or call 911

XƏSTƏ TƏRƏFİNDƏN BİLDİRDİRİLƏN SAĞLAMLIQ VƏZİYYƏTİ

Patient-reported health status

Patient reported outcomes

- xəstə mərkəzli tibb xidmətini inkişaf etdirilməsi məqsədilə **xəstələr tərəfindən bildirdirilən nəticələr** simptomlar, funksiyalar və həyat keyfiyyətini ölçmək üçün istifadə olunur.
- *The US Food and Drug Administration (FDA) defines a patient-reported outcome as “any report of the status of a patient’s health condition that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else.”*

KANSAS CITY CARDIOMYOPATHY QUESTIONNAIRE (KCCQ)

APPENDIX

THE KANSAS CITY CARDIOMYOPATHY QUESTIONNAIRE:

The following questions refer to your heart failure and how it may affect your life. Please read and complete the following questions. There are no right or wrong answers. Please mark the answer that best applies to you.

1. Heart failure affects different people in different ways. Some feel shortness of breath while others feel fatigue. Please indicate how much you are limited by heart failure (shortness of breath or fatigue) in your ability to do the following activities over the past 2 weeks.

Place an X in one box on each line

Activity	Extremely Limited	Quite a bit Limited	Moderately Limited	Slightly Limited	Not at all Limited	Limited for other reasons or did not do the activity
Dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Showers/Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 1 block on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing yardwork, housework or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing a flight of stairs without stopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hurrying or jogging (as if to catch a bus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Compared with 2 weeks ago, how your symptoms of heart failure (shortness of breath, fatigue or ankle swelling) change? My symptoms of heart failure have become ...

Much worse	Slightly worse	Not changed	Slightly better	Much better	I've had no symptoms over the last 2 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Over the past 2 weeks, how many times did you have swelling in your feet, ankles or legs when you wake up in the morning?

Every morning	3 or more times a week, but not every day	1-2 times a week	Less than once a week	Never over the past 2 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Over the past 2 weeks, how much has swelling in your feet, ankles or legs bothered you? It has been ...

Extremely bothersome	Quite a bit bothersome	Moderately bothersome	Slightly bothersome	Not at all bothersome	I've had no swelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Over the past 2 weeks, on average, how many times has fatigue limited your ability to do what you want?

All of the time	Several times per day	At least once a day	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 2 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Over the past 2 weeks, how much has your fatigue bothered you? It has been ...

Extremely bothersome	Quite a bit bothersome	Moderately bothersome	Slightly bothersome	Not at all bothersome	I've had no fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Over the past 2 weeks, on average, how many times has shortness of breath limited your ability to do what you want?

8. Over the past 2 weeks, how much has your shortness of breath bothered you? It has been ...

Extremely bothersome	Quite a bit bothersome	Moderately bothersome	Slightly bothersome	Not at all bothersome	I've had no shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Over the past 2 weeks, on average, how many times have you been forced to sleep sitting up in a chair or with at least 3 pillows to prop you up because of shortness of breath?

10. Heart failure symptoms can worsen for a number of reasons. How sure are you that you know what to do, or whom to call, if your heart failure gets worse?

11. How well do you understand what things you are able to do to keep your heart failure symptoms from getting worse? (for example, weighing yourself, eating a low salt diet, etc.)

12. Over the past 2 weeks, how much has your heart failure limited your enjoyment of life?

13. If you had to spend the rest of your life with your heart failure, the way it is right now, how would you feel about this?

14. Over the past 2 weeks, how often have you felt discouraged or down in the dumps because of your heart failure?

15. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

16. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

17. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

18. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

19. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

20. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

21. How much does your heart failure affect your lifestyle? Please indicate how your heart failure may have limited your participation in the following activities over the past 2 weeks.

Please place an X in one box on each line

KANSAS CITY KARDIOMIOPATIYA ANKETI

ürək çatışmazlığı olan pasiyentlərin xəstəliklə əlaqəli sağlamlıq vəziyyətini qiymətləndirmək (ölçmək) üçün psixometrik xüsusiyyətlərə əsaslanan beynəlxalq standartdır.

23 maddədən ibarət olub, ÜÇ -lü xəstələrin sağlamlıq vəziyyətinin 7 sahəsini müəyyənləşdirir:

JACC STATE-OF-THE-ART REVIEW

Interpreting the Kansas City Cardiomyopathy Questionnaire in Clinical Trials and Clinical Care

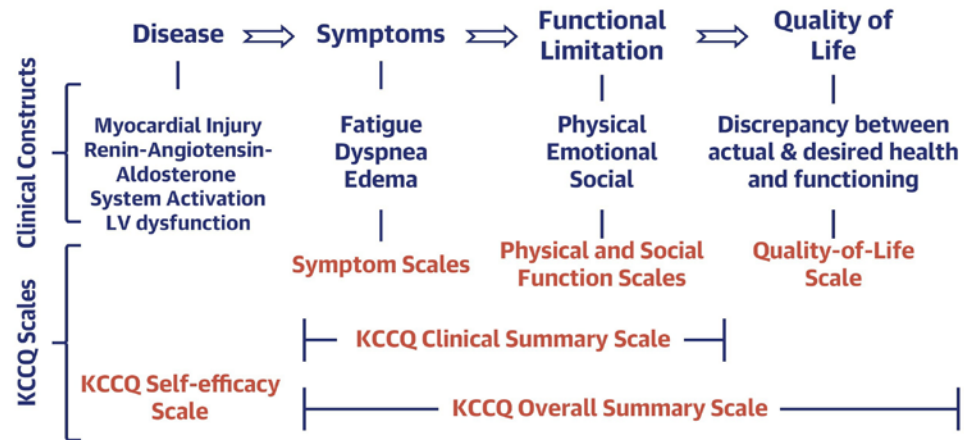
JACC State-of-the-Art Review

John A. Spertus, MD, MPH,^a Philip G. Jones, MS,^a Alexander T. Sandhu, MD, MS,^b Suzanne V. Arnold, MD, MHA^a



CENTRAL ILLUSTRATION: Conceptual Mapping of the Kansas City Cardiomyopathy Questionnaire to Different Manifestations of Heart Failure

Mapping the Kansas City Cardiomyopathy Questionnaire (KCCQ) Scales



Spertus, J.A. et al. J Am Coll Cardiol. 2020;76(20):2379-90.

Physical Limitation - fiziki məhdudiyət (6 bənd),
Symptom Stability - simptomun sabitliyi (1 bənd),
Symptom Frequency - simptomun tezliyi (4 bənd),
Symptom Burden – Simptom yükü (3 bənd),
Self-Efficacy - şəxsi effektivlik (2 bənd),
Quality of Life - həyat keyfiyyəti (3 bənd)
Social Limitations - sosial məhdudiyətlər (4 bənd).
Qiymətləndirmələr 0 - dan 100-ə qədər aparılır.

Bundan əlavə, bir neçə ümumi bal hesablanır:

Total Symptom score - Ümumi Simptom Balı (simptomların tezliyi və simptomların yükünün ortalaması),
Clinical Summary score - Ümumi Klinik Bal (fiziki məhdudiyətlərin ortalaması və simptomların ümumi sayı)
Overall Summary score - Ümumi Cəmi Bal (fiziki məhdudiyətlərin ortalaması, simptomların ümumi sayı, həyat keyfiyyəti və sosial məhdudiyətlər).

THE KANSAS CITY CARDIOMYOPATHY QUESTIONNAIRE (KCCQ)

- XÜÇ-ün klinik gedişinin etibarlı göstəricisidir (condition-specific)
- təkrarlana bilən və klinik dəyişikliklərə həssasdır
- HFrEF, HFpEF, və ürək qapaq qüsurları olan xəstələrdə effektivliyi yoxlanılmışdır.
- KCCQ göstəriciləri bir-birindən asılı olmayaraq sağqalma, hospitalizasiya və səhiyyə xərcləri üçün proqnozlaşdırıcı xüsusiyyətə malikdir
- alt şkalalar NYHA təsnifatı, SF-36, 6 dəqiqəlik yeriş testi ilə korrelyasiya edir (JACC 2000)
- 1 il ərzində ürək-damar ölümü və hospitalizasiyanı proqnozlaşdırır (Circulation 2004)

NƏTİCƏ

- ÜÇ–nin klinik, psixoloji, sosial, iqtisadi yükünü nəzərə alaraq onun idarə olunmasına multidissiplinar yanaşma (proqram və komanda daxil olmaqla) tətbiq olunmalıdır
- Xəstə mərkəzli ÜÇ proqramının, pasiyentlərin fərdi xüsusiyyətləri, ehtiyac və üstünlükləri nəzərə alınmaqla MD ÜÇ komandası tərəfindən səhiyyə xidmətlərinin hər 3 səviyyəsində tətbiq olunması məqsədəuyğundur
- ÜÇ üzrə ixtisaslaşdırılmış mütəxəssislərin hazırlanması yerli şəraitdə uyğunlaşdırmış kurikulum əsasında aparılmalıdır
- Evdə və klinika şəraitində ÜÇ-li xəstələrə ixtisaslaşmış xidmət göstərə biləcək tibb bacılarının hazırlanmasına xüsusi diqqət verilməlidir
- Xəstələrin özünəqulluq və özünü idarəetməsini yaxşılaşdırmaq məqsədilə pasiyentlərin və onlara qulluq edən şəxslərin maarifləndirilməsi proqramları tətbiq edilməlidir
- Xəstələr tərəfindən həyat keyfiyyətinin qiymətləndirilməsi klinik təcrübədə və tədqiqatlarda daha geniş istifadə olunmalıdır (ölüm və təkrari hospitalizasiyaya olan təsirini nəzərə alaraq)
- Tətbiq olunan kompleks müalicənin nəticələrinin qiymətləndirilməsi üçün tədqiqatlarla təsdiqlənmiş standart şkalalar istifadə olunmalıdır
- KCCQ pasiyent məlumatlarına əsaslanan, klinik cəhətdən əhəmiyyətli, ürək çatışmazlığına xas olan şkala olaraq klinik nəticələrin obyektiv proqnozlaşdırılmasına imkan verir.



Knowing is not enough; we must
apply. Willing is not enough; we
must do.

~ Johann Wolfgang von Goethe