

HF: Education, Phone Follow-Up Top Usual Care

BY DOUG BRUNK

FROM THE ANNUAL MEETING OF
THE HEART FAILURE SOCIETY OF AMERICA

SAN DIEGO – Patients with heart failure on optimal medical therapy who received a multidisciplinary, non-pharmacologic intervention for follow-up care and observation had a 38% reduction in death and rehospitalization for heart failure at 1 year, compared with patients who received usual care.

They also had significant improvements in depression scores from baseline, compared with their counterparts, Dr. Viacheslav Mareev reported at the meeting.

“It’s well known that many patients with congestive heart failure have depression,” said Dr. Mareev of the Russian Society of Heart Failure Specialists, Moscow. A meta-analysis of trials studying the association found that the prevalence ranges from 19% to 34%, and that the prevalence of depression worsens as heart failure (HF) worsens (*J. Am. Coll. Cardiol.* 2006;48:1527-37).

For the current trial, known as CHANCE (Congestive Heart Failure: A Multidisciplinary Nonpharmacological Approach for Changing in Rehospitalization and Prognosis), Dr. Mareev and his associates at 38 sites in 24 cities in Russia randomized 385 patients with New York Heart Association class III or IV heart failure to receive optimal medical treatment plus usual care, and 360 patients to receive optimal medical treatment plus education and observation by a multidisciplinary team of clinicians.

Patients in the intervention group attended four 30-minute, in-hospital educational sessions about how to live optimally with heart failure. After discharge, bilat-

eral phone contact was made once weekly during the first month, twice a month until month 6, and then monthly until month 12. To date, none of the patients has been lost to follow-up, Dr. Mareev said.

Both groups of patients completed the HADS (Hospital Anxiety and Depression Scale) at baseline and at 12 months. In this scale, a score of less than 7 suggests the absence of anxiety and/or depression, a score of 7-10 suggests sub-clinical or minor anxiety and/or depression, and a score greater than 10 suggests clinically relevant, severe anxiety and/or depression.

The mean age of the study participants was 63 years, 60% were male, and 72% had NYHA class III heart failure.

Dr. Mareev reported that patients in the intervention group had a 38% reduction in death and rehospitalization for heart failure, compared with patients in the usual care group.

Baseline HADS scores in the intervention group fell significantly (from 9.7 at baseline to 7.1 at 1 year), whereas scores in the usual care group dropped slightly but not significantly (from 9.3 to 8.7). Dr. Mareev said that the number of patients who scored greater than 10 on the HADS dropped slightly between baseline and 1 year for patients in the usual care group (from 31% to 30%), but dropped markedly for patients in the intervention group (from 37% to 18%).

The relative risk of death among all patients who

scored greater than 10 on the HADS was 50% higher than for patients who scored 7-10 or less than 7.

Patients in the intervention group who scored less than 10 on the HADS had a 25% relative risk reduction of death, compared with their counterparts in the usual care group, whereas patients in the intervention group who scored greater than 10 on the HADS had a 17% relative risk reduction of death, compared with their counterparts in the usual care group.

The multidisciplinary intervention improved the prognosis of heart failure, “even in the group of patients with clinically relevant depression,” Dr. Mareev concluded.

The results support the recent findings of the SADHART-CHF (Sertraline Against Depression and Heart Disease in

Chronic Heart Failure) trial, which found that a non-medical intervention by a specially trained nurse improved prognosis and matched the efficacy of sertraline (*J. Am. Coll. Cardiol.* 2010;56:692-9). At the meeting, one of the investigators in that trial, Dr. Christopher M. O’Connor of Duke University in Durham, N.C., said the CHANCE study “confirms that depression is an important risk factor and confers an increased risk in morbidity and mortality” in heart failure. “This is an important advance in the field. We need more long-term studies like this.”

Dr. Mareev said that he had no relevant financial conflicts to disclose. ■

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Barbershop Intervention Improved Hypertension Control

BY MARY ANN MOON

FROM THE ARCHIVES OF
INTERNAL MEDICINE

An outreach program in which barbers served as health educators – monitoring their black male clients’ hypertension and referring them for medical treatment when necessary

– improved the rate of blood pressure control by about 9% over 10 months, according to a report published online in the Archives of Internal Medicine

The intervention, which was tested in 17 black-owned barbershops in a single Texas county, motivated about half the hypertensive patrons at participating barbershops to see a physician, and reduced their systolic blood pressure by a mean of 2.5 mm Hg, said Dr. Ronald G. Victor of the University of Texas Southwest Medical Center, Dallas, and his associates.

“If the intervention could be implemented in the approximately 18,000 black-owned barbershops in the United States to reduce blood pressure by 2.5 mm Hg in the approximately 50% of hypertensive U.S. black men who patronize these barbershops (2.2 million persons), we project that about 800 fewer myocardial infarctions, 550 fewer strokes, and 900 fewer deaths would occur in the first year alone,” the investigators noted.

Black-owned barbershops “are rapidly gaining traction as potential community partners for health promotion programs targeting hypertension as well as diabetes, prostate cancer, and other diseases that disproportionately affect black men,” the researchers said.

Such barbershops “are a cultural insti-

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Major Finding: The rate of blood pressure control was a significant 8% higher in black men attending barbershops that participated in an active intervention than in those attending a comparison group of barbershops in Texas.

Data Source: BARBER-1, a cluster-randomized controlled trial assessing a barbershop-based health promotion program aimed at identifying hypertension in black men and referring them to a physician for treatment.

Disclosures: The National Heart, Lung, and Blood Institute, the Donald W. Reynolds Foundation, the Aetna Foundation Regional Health Disparity Program, Pfizer, Biovail, Cedars-Sinai Heart Institute, the Lincy Foundation, and the Robert Wood Johnson Foundation supported the trial. Dr. Victor reported ties to Pfizer and Biovail.

tion that draws a large and loyal male clientele and provides an open forum for discussion of numerous topics, including health, with influential peers.”

Dr. Victor and his colleagues conducted their study by offering free blood pressure screening to patrons of 17 barbershops representing four geographic sectors with sizeable black populations in the Barber-Assisted Reduction in Blood

Pressure in Ethnic Residents (BARBER-1). Nine barbershops with 695 patrons who were found to have hypertension then were randomly allocated to the intervention, and eight barbershops with 602 patrons who had hypertension were randomly allocated to a comparison group.

Most of the barbershop clients were middle income.

The comparison group was not strictly a control group; patrons there underwent two BP screenings at baseline and received standard written explanations and recommendations for physician follow-up, because failing to advise them would have been unethical. The comparison barbershops also made available American Heart Association pamphlets entitled “High Blood Pressure in African Americans.”

For the intervention, barbers continually offered all male clients blood pressure checks along with their haircuts. They displayed large posters depicting authentic stories of other male hypertensive patrons of the same shop modeling treatment-seeking behavior, using the model’s own words to tell the story. Barbers and other male patrons also discussed the issue conversationally.

The barbers were trained, equipped, and paid to conduct BP testing and interpret the results, with the main focus on encouraging clients who had positive results to consult a physician. They referred clients who had no physician to a nursing staff that then referred them to local physicians or safety-net clinics. Barbers also gave patrons found to be hypertensive a wallet-sized card for the

physician to sign, documenting an office visit concerning hypertension.

The barbers were paid \$3 for every recorded blood pressure they took, \$10 for every referral they made to the nursing staff, and \$50 for every BP card that clients returned to them with physicians’ signatures. Patrons received free haircuts (a \$12 value) for every BP card they returned with a physician’s signature.

Overall, nearly half of the patrons who were screened had high blood pressure; 78% of them were already aware that they were hypertensive, and 69% said they were taking treatment for HT, yet only 38% had their blood pressure under control.

Barbers were able to measure blood pressure in three of every four patrons who had hypertension, and each hypertensive client averaged eight blood pressure checks during the 10-month study. “The barbers motivated 50% of their patrons with elevated BP readings to visit a physician,” the researchers said.

The rate of blood pressure control – the number of men who achieved blood pressure control during BARBER-1 – improved by about 10% in the comparison group, but improved by an additional and significant 8% in the intervention group. The intervention group also showed an absolute decrease of 2.5 mm Hg in systolic blood pressure compared with the control group, a secondary outcome of borderline significance, the investigators said (*Arch. Intern. Med.* 2010 Oct. 25 [doi:10.1001/archinternmed.2010.390]). ■