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such, raise questions about optimum duration and cost-effectiveness. Remote monitoring draws on technology or telephone contacts to transfer information on patient status but raises the same questions about duration and cost-effectiveness. Patient self-management programs aim to motivate patients to collaborate in their care by teaching them self-management skills. If skills such as self-monitoring and environmental rearrangement can be learned, maintained, and used to implement medical advice, this is a potentially cost-effective approach to controlling heart failure costs.

Five trials of self-management among patients with heart failure have been published to date.9-13 All were limited by small sample sizes (range, 70-197 patients), short durations (typically 2-3 contacts), and inadequate evaluations of maintenance of treatment effects (typically 0-3 months). One trial showed benefit for a clinical end point (death or hospitalization),13 but baseline differences in prognostic factors limit interpretation. Thus, the value of self-management programs for patients with heart failure is questionable.

The Heart Failure Adherence and Retention Trial (HART) is the largest and most rigorous trial of self-management in heart failure to date. It was designed to assess the value of 1 year of self-management counseling on death or heart failure hospitalization in patients with mild to moderate heart failure and reduced or preserved systolic function.

METHODS

Design

The design and methods have been reported.14 HART was a single-center, multiple-hospital, partially blinded behavioral efficacy randomized controlled trial. We showed previously that self-management counseling plus heart failure education improved self-efficacy at self-management.15 We thus hypothesized that this benefit would extend to improvement in adherence to drug therapy, sodium restriction, and depression, which would in turn result in an improvement in the primary end point of death or heart failure hospitalization.

Patients were randomized in a 1:1 ratio into 2 trial groups and underwent follow-up for a minimum of 2 years (1 year of treatment and 1 year of follow-up) and a maximum of 3 years (1 year of treatment and 2 years of follow-up), depending on the timing of recruitment. Sample size was based on the assumption that the self-management intervention would produce a 25% reduction in the primary end point, based on the results of prior self-management trials.16,17 The base rate for the primary end point in the control group was assumed to be 15% per year, derived from rates in the treatment groups of positive drug trials with similar patients,18 because these drugs would likely be the standard of care when HART ended. Losses and withdrawals were estimated to be 15%, and sample size was adjusted by approximately 3% to allow for interim analyses. Assuming a 2-sided α of .05 and 80% power, this led to a sample size of 900 patients, evenly distributed between the 2 treatment groups.

Double-blinding in a behavioral trial is impossible, because patients are aware of the treatment they are receiving. However, HART was a partially blinded trial. All staff, except for the senior investigators, and all patients were blinded to trial hypotheses by providing neutral names for the treatment groups (ie, “skills training” for the self-management group and “enhanced education” for the education control group). All investigators and staff, except for the data management team, were blinded to the randomization status of the patient. Treatment teams within each group had no contact with patients in the other group.

The protocol was approved by the institutional committees on human research at the 10 recruiting hospitals. Patients provided written informed consent.

Trial Patients

Eligible patients had heart failure with reduced or preserved systolic function. All patients were receiving some form of active heart failure treatment, including diuretics, for the previous 3 months. Heart failure with reduced systolic function was defined as ejection fraction of 40% or less by echocardiography, radiographic ventriculography, or radionuclide ventriculography. Heart failure with preserved systolic function was defined as ejection fraction greater than 40% by 1 of the 3 methods and 1 or more previous hospitalizations for heart failure.

Exclusions were factors that would jeopardize the conduct or rigor of the trial. These included (1) New York Heart Association (NYHA) class IV, owing to low likelihood of benefiting from behavioral treatment; (2) NYHA class I, owing to low likelihood of having a primary end point; (3) heart failure symptoms that may be eliminated by surgery (eg, severe aortic stenosis); (4) uncertain 12-month prognosis (eg, likelihood of cardiac transplantation, symptomatic or sustained ventricular tachycardia); (5) severe medical or psychiatric comorbid condition (eg, cognitive dysfunction, substance abuse, psychotic disorder, or active suicidal ideation); (6) patient unwillingness to make lifestyle changes; (7) logistical barriers (eg, limited mobility, enrollment in a conflicting protocol, non–English-speaking); (8) physician refusal; and (9) patient refusal.

Race/ethnicity was self-reported using investigator-defined categories (white/caucasian, black/African American, Hispanic/Latino, Asian American/Pacific Islander, Native American/American Indian, or other [specify]).

Recruitment and Randomization

Recruitment of patients was conducted between October 2001 and October 2004 at 10 recruiting hospitals located throughout the Chicago metropolitan area. Each recruiting hospital had a cardiologist who served as the local principal investigator (see list at end of article). Patients were recruited through inpatient and outpatient screening and through referrals from cardiologists and internists.
At the conclusion of the baseline examination, the nurse coordinator called the automated randomization service (Moffitt Cancer Center, University of South Florida) and treatment assignment was sent to an unblinded staff member, who mailed a letter of notification to the patient. Follow-up by staff leading the relevant trial group commenced approximately 2 to 5 days after receipt of the letter.

To make group treatment logistically feasible, randomization was conducted using a stratified block design, with strata defined as 3 geographic locations and blocks of size 20. Once 20 patients from the same geographic area were recruited, randomization resulted in 10 patients assigned to a group held within their community.

Treatments
A detailed description of the 1-year treatments tested in HART has been reported. The self-management plus education treatment featured group-based heart failure education plus counseling to help patients develop mastery in problem-solving skills and in 5 self-management skills. Eighteen 2-hour group meetings of approximately 10 patients were spread over the course of 1 year. At each meeting, education in the form of 18 Heart Failure Tip Sheets from the American Heart Association (available at http://www.hearthub.org/heart-failure.htm) summarized basic elements of patient management, including medication adherence, sudden weight gain, sodium restriction, moderate physical activity, and stress management. Implementation of this advice was aided by training in 5 self-management skills: self-monitoring, environmental restructuring, elicitation of support from family and friends, cognitive restructuring, and the relaxation response. To foster proactiveness, a problem-solving format was used in which patients identified barriers to implementing the tips and used self-management skills to overcome them.

Groups were led by health professionals with advanced degrees, experience in conducting groups, willingness to follow a protocol, and demonstrated competency after a 2-day training session. Treatment fidelity was ensured by (1) audiotaping all sessions, randomly selecting 5% for review, and providing needed feedback; (2) monitoring data on patients and group leaders to identify and resolve problems; and (3) conducting mandatory monthly group leader meetings.

The education group was conceptualized as an attention control, representative of the standard of care in heart failure education that would be in place when HART ended. An attention control, rather than a usual-care control, minimizes such problems as a placebo effect in which any attention could promote benefit, the inability to mask patients to trial hypotheses, and an “underdog” effect that could promote differential dropout or treatment crossovers.

Patients randomized to receive education received the same 18 Heart Failure Tip Sheets, on the same schedule as the self-management group meetings but delivered by mail. To ensure receipt and check comprehension, a study coordinator contacted the patient by telephone within 2 to 3 days of each mailing. If the tip sheet had not been read, the call was rescheduled. All questions about the tip sheets were answered. For concerns unrelated to the tip sheets, the patient was referred to his or her primary care clinician.

Study coordinators were trained on purpose, structure, content, data reporting responsibilities, and quality control procedures. Training included role playing to simulate phone call interactions. Retraining occurred in response to special problems.

Outcome Measures
The primary end point was assessed in blinded fashion by a team of cardiologists (eAppendix, available at http://www.jama.com). All patients, or in the case of death, their family members, were contacted every 3 months by telephone to ascertain occurrence of a death or hospitalization. Reports of death were confirmed by medical record, death certificate, emergency medical services record, or queries from the Social Security Death Index. Heart failure admissions were adjudicated by the presence of shortness of breath, peripheral edema, or chest radiographic evidence of pulmonary edema without evidence of another disease process accounting for symptoms or signs. Heart failure admissions were confirmed if the patient responded to heart failure therapy or had a documented decrease in left ventricular function.

Baseline and annual outcome assessments have been described previously. Briefly, examinations consisted of (1) clinical assessment of height, weight, respiratory rate, blood pressure, 6-minute walk, and a blood draw; (2) medical history including medical conditions, medications, sociodemographic status, and risk factors; and (3) questionnaires completed via interview and self-report. The patient was asked to place a month’s supply of an angiotensin-converting enzyme (ACE) inhibitor (or β-blocker if the patient was not taking an ACE inhibitor) into a Medication Event Monitoring System electronic pill cap container (MEMS V Trackcap; AARDEX, Zug, Switzerland) and was taught to use it for the ensuing month. Adherence to drug therapy was defined as the percentage of pills taken, relative to pills prescribed, with a cutpoint of 80% or greater.

Sodium intake was assessed as milligrams per day based on the CALS Food Frequency Questionnaire, which was developed to include the main sources of sodium in the diet. Clinically significant sodium intake is 2400 mg/d or less for patients with hypertension and 2000 mg/d or less for those with heart failure. A cutoff of 2400 mg/d or less was used because too few patients had an intake of 2000 mg/d or less to make statistical analyses feasible.

The Self-Efficacy at Self-Management Scale, developed specifically for HART, included 5 items targeting each of the 5 self-management skills taught in the intervention. Each item had a 10-
SELF-MANAGEMENT IN PATIENTS WITH HEART FAILURE

![Figure 1. Study Flow](image)

NYHA indicates New York Heart Association.

**a** Patients who refused intervention were continued in follow-up until they completed, died, fully withdrew, or were lost to follow-up.

**b** Includes patients who died before start of intervention.

**c** All withdrawals were voluntary and patient-initiated.

The primary outcome was used. Categorical variables were compared using χ² tests. Continuous variables were compared using t tests, except when skewed distributions warranted use of the Wilcoxon rank-sum test.

The effect of the 2 treatment groups on the primary end point and secondary clinical end points was compared using Kaplan-Meier time-to-event curves and analyzed using the Wilcoxon test. The Wilcoxon test was used because the curves clearly indicated that the hazards were nonproportional. Patients who were lost to follow-up or who withdrew consent were included until the time of censoring. Rates during the entire trial period were calculated as events divided by the number of patients at risk minus those censored. Annualized rates were calculated as events divided by person-years. χ² Statistics produced P values. Odds ratios (ORs) were the proportion of at-risk patients with an event in the self-management group relative to those in the education group and were accompanied by 95% confidence intervals (CIs).

The effect of treatment on secondary end points was analyzed as a comparison of change between baseline and 1 year posttreatment, adjusting for baseline values. The effect of treatment on behavioral treatment targets was analyzed using repeated-measures mixed-effects regression analyses, with treatment group as the between-subject factor and time (before and after the 1-year treatment) as the repeated within-subject factor. A significant time effect indicated that both groups changed, and a significant time × treatment group interaction indicated that one group changed more than the other.

The effect of treatment in prespecified subgroups was analyzed by stratifying on the relevant subgroup and comparing treatment group within strata using ORs and 95% CIs. Because of the compromised power in this approach, subgroups were also evaluated by testing for interactions between subgroup and treatment, adjusting...
ing for covariates, using a parametric log-logistic accelerated failure time multivariate model, which is appropriate for use with nonproportional hazard data.27,28 This model assumes that explanatory variables act multiplicatively on the speed with which a patient proceeds to an event. Acceleration factors greater than 1 indicate faster time to event. A multivariate base model considered all prespecified subgroup variables (ie, age, sex, education, income, race/ethnicity, functional capacity, comorbid conditions, preserved vs reduced systolic function, and baseline drug adherence)14 and other predictors associated with the primary outcome from the literature (ie, NYHA class, depression, use of ACE inhibitors or angiotensin receptor blockers, and use of β-blockers) and retained only those reaching \(P \leq .15\) at each iteration using backward elimination. All prespecified subgroup variables remaining in the base model were tested for their interaction with treatment group.

HART featured a cluster design within the self-management group only, in which patients were treated in 42 groups of approximately 10 patients each. Because the effect of group assignment and group leader on the primary outcome was found to be nonsignificant, clustering was not considered further.

RESULTS

Figure 1 presents the trial profile. Of 3154 patients screened during 3 years, 902 were enrolled, resulting in a screening-enrollment ratio of 3.5 patients screened for every patient enrolled. The median (interquartile range) follow-up time was 935 (439-1095) days—918 (464-1095) days in the self-management group and 963 (389-1095) days in the education group. Of the 18 treatment contacts during 1 year, 14 or more (>80%) were received by 46.4% of patients in the self-management group and 53.1% of those in the education group.

Table 1. Baseline Characteristics in the Total Cohort and by Treatment Group

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall (N = 902)</th>
<th>Self-management (n = 451)</th>
<th>Education (n = 451)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>63.6 (13.5)</td>
<td>63.8 (13.7)</td>
<td>63.4 (13.3)</td>
</tr>
<tr>
<td>Women</td>
<td>427 (47.3)</td>
<td>209 (46.3)</td>
<td>218 (48.3)</td>
</tr>
<tr>
<td>Minority race/ethnicity</td>
<td>362 (40.1)</td>
<td>177 (39.2)</td>
<td>185 (41.0)</td>
</tr>
<tr>
<td>High school education</td>
<td>394 (43.7)</td>
<td>197 (43.7)</td>
<td>197 (43.7)</td>
</tr>
<tr>
<td>Annual family income &lt;$30 000</td>
<td>428 (51.6)</td>
<td>215 (51.9)</td>
<td>213 (51.3)</td>
</tr>
<tr>
<td>Unmarried</td>
<td>503 (56.3)</td>
<td>251 (56.3)</td>
<td>252 (56.4)</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preserved systolic function</td>
<td>208 (23.1)</td>
<td>107 (23.8)</td>
<td>101 (22.4)</td>
</tr>
<tr>
<td>NYHA class III</td>
<td>285 (31.6)</td>
<td>144 (31.9)</td>
<td>141 (31.3)</td>
</tr>
<tr>
<td>6-min walk, median (IQR), m</td>
<td>252.9 (149.4-339.0)</td>
<td>264.0 (150.0-349.5)</td>
<td>248.1 (147.0-330.0)</td>
</tr>
<tr>
<td>Heart rate, mean (SD)/min</td>
<td>69.7 (14.8)</td>
<td>69.7 (13.9)</td>
<td>69.7 (15.7)</td>
</tr>
<tr>
<td>Respiratory rate, mean (SD)/min</td>
<td>15.7 (8.2)</td>
<td>16.0 (7.9)</td>
<td>15.4 (8.5)</td>
</tr>
<tr>
<td>Blood pressure, mean (SD), mm Hg</td>
<td>120.7 (20.7)</td>
<td>120.5 (20.1)</td>
<td>120.8 (21.3)</td>
</tr>
<tr>
<td>Systolic</td>
<td>70.2 (11.5)</td>
<td>70.2 (11.1)</td>
<td>70.3 (11.9)</td>
</tr>
<tr>
<td>Diastolic</td>
<td>71.1 (11.0)</td>
<td>71.0 (11.1)</td>
<td>71.2 (11.9)</td>
</tr>
<tr>
<td>Acute physiology score, mean (SD)</td>
<td>2.6 (2.1)</td>
<td>2.6 (2.0)</td>
<td>2.6 (2.1)</td>
</tr>
<tr>
<td>History of hypertension</td>
<td>676 (75.2)</td>
<td>345 (76.8)</td>
<td>331 (73.6)</td>
</tr>
<tr>
<td>History of diabetes</td>
<td>362 (40.2)</td>
<td>178 (39.6)</td>
<td>184 (40.9)</td>
</tr>
<tr>
<td>Comorbid conditions, mean (SD), No.</td>
<td>3.2 (1.7)</td>
<td>3.2 (1.7)</td>
<td>3.3 (1.7)</td>
</tr>
<tr>
<td>Medications, mean (SD), No.</td>
<td>6.8 (3.0)</td>
<td>6.8 (3.0)</td>
<td>6.8 (3.0)</td>
</tr>
<tr>
<td>Current medication use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE inhibitor or angiotensin receptor blocker</td>
<td>773 (85.7)</td>
<td>383 (84.9)</td>
<td>390 (86.5)</td>
</tr>
<tr>
<td>β-Blocker</td>
<td>636 (70.5)</td>
<td>320 (71.0)</td>
<td>316 (70.1)</td>
</tr>
<tr>
<td><strong>Quality of life, mean (SD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SF-36 Physical functionb</td>
<td>48.1 (25.0)</td>
<td>48.1 (24.9)</td>
<td>48.1 (25.1)</td>
</tr>
<tr>
<td>Vitalityb</td>
<td>46.5 (23.7)</td>
<td>45.9 (23.7)</td>
<td>47.1 (23.6)</td>
</tr>
<tr>
<td>Quality of Life Index–Cardiac Satisfaction with health and functionc</td>
<td>4.3 (1.0)</td>
<td>4.3 (1.1)</td>
<td>4.2 (1.0)</td>
</tr>
<tr>
<td>Satisfaction with psychological/spiritual functionc</td>
<td>4.7 (1.1)</td>
<td>4.7 (1.1)</td>
<td>4.8 (1.0)</td>
</tr>
<tr>
<td><strong>Adherence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonadherence to drug therapyd</td>
<td>274 (36.5)</td>
<td>142 (38.4)</td>
<td>131 (34.6)</td>
</tr>
<tr>
<td>Sodium, median (IQR), mg/d</td>
<td>3338 (2654-4275)</td>
<td>3309 (2665-4255)</td>
<td>3342 (2669-4290)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>85 (9.4)</td>
<td>39 (8.6)</td>
<td>46 (10.2)</td>
</tr>
<tr>
<td>Body mass index, mean (SD)</td>
<td>31.0 (7.7)</td>
<td>31.1 (7.3)</td>
<td>30.9 (8.0)</td>
</tr>
<tr>
<td>Self-efficacy at self-management, mean (SD)d</td>
<td>7.6 (1.7)</td>
<td>7.6 (1.8)</td>
<td>7.6 (1.6)</td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depressive symptomsd</td>
<td>265 (29.4)</td>
<td>136 (30.2)</td>
<td>129 (28.7)</td>
</tr>
<tr>
<td>Social support–emotional, mean (SD)b,bb</td>
<td>75.0 (22.2)</td>
<td>74.2 (22.5)</td>
<td>76.1 (21.9)</td>
</tr>
<tr>
<td>Purpose in life, mean (SD)bb,ci</td>
<td>4.5 (0.8)</td>
<td>4.5 (0.8)</td>
<td>4.5 (0.8)</td>
</tr>
</tbody>
</table>

Abbreviations: ACE, angiotensin-converting enzyme; IQR, interquartile range; NYHA, New York Heart Association; SF-36, RAND 36-Item Short-Form Health Survey.

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women, 40% self-reported racial/ethnic minority, and 23% with preserved systolic function, making it representative of typical clinical populations. Patients were taking an average of 6.8 medications, and 37% did not adhere to at least 80% of the prescribed dosage of either an ACE inhibitor or β-blocker. Median sodium intake was 3338 mg/d, well more than the recommended 2000 mg/d for patients with heart failure21 or 2400 mg/d for those with hypertension.20 Major depressive symptoms were evident in 29%. There were no statistically significant differences between treatment groups for any of the baseline variables.

Figure 2 presents the Kaplan-Meier estimates of the time to death or heart failure hospitalization by treatment group. There was no benefit of self-management compared with education (Wilcoxon P = .46). During approximately 2.56 years of follow-up, there were 163 events (40.1%) in the self-management group and 171 (41.2%) in the education group (OR, 0.95 [95% CI, 0.72-1.26]). The annual event rate was 18.4%, based on 883.84 person-years in the self-management group and 19.2% based on 889.11 person-years in the education group. eTable 1 presents ORs and 95% CIs for the secondary clinical end points (death: OR, 0.87 [95% CI, 0.63-1.21]; heart failure hospitalization: OR, 1.00 [95% CI, 0.72-1.38]; all-cause hospitalization: OR, 0.85 [95% CI, 0.62-1.17]). Both groups had a mean of 0.7 heart failure hospitalizations (P = .39). eTable 2 presents change from baseline to the 1-year conclusion of treatment in secondary end points. There were no differences between groups on change in NYHA class, 6-minute walk, heart rate, respiratory rate, blood pressure, body mass index, quality of life, emotional support, or purpose in life. There were no adverse or serious adverse events in either group.

The treatments produced variable changes on risk factor targets. Self-efficacy scores improved by 0.2 points in both groups (P = .008 for time effect). Major depressive symptoms decreased to 90 (20%) in the self-management group and 99 (22%) in the education group (P = .008 for time effect). Restricting sodium to 2400 mg/d or less occurred in 126 (28%) patients in the self-management group and 81 (18%) in the education group (P = .01 for time effect), but there was more improvement in the self-management group (P = .02 for treatment × time interaction). However, even in the self-management group, sodium intake remained high, with 325 (72%) having an intake greater than 2400 mg/d.

### Table 2. Prespecified Independent Predictors of Death or Heart Failure Hospitalization

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Acceleration Factor</th>
<th>Parameter Estimates</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥65 y</td>
<td>1.57</td>
<td>−0.45</td>
<td>.002</td>
</tr>
<tr>
<td>New York Heart Association class III</td>
<td>1.92</td>
<td>−0.65</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Major depressive symptoms</td>
<td>1.32</td>
<td>−0.28</td>
<td>.07</td>
</tr>
<tr>
<td>≥3 Comorbid conditions</td>
<td>1.84</td>
<td>−0.61</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Minority race/ethnicity</td>
<td>1.34</td>
<td>−0.29</td>
<td>.057</td>
</tr>
<tr>
<td>Income ≥$30 000</td>
<td>−0.21</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>Education treatment</td>
<td>−0.39</td>
<td>.056</td>
<td></td>
</tr>
<tr>
<td>Treatment × income interaction</td>
<td>0.64</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>Self-management Income &lt;$30 000</td>
<td>Reference</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td>Income ≥$30 000</td>
<td>1.23</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>Education Income &lt;$30 000</td>
<td>1.44</td>
<td>.056</td>
<td></td>
</tr>
<tr>
<td>Income ≥$30 000</td>
<td>0.93</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: NA, not available.

aStatistics reported are derived from log-logistic accelerated failure time models.

bComputationally unobtainable from the accelerated failure time model.

### Figure 3. Time to Death or Heart Failure Hospitalization by Treatment Group in Low- and High-Income Subgroups

Accelerated failure time model that included age, New York Heart Association class, depression, comorbid conditions, race/ethnicity, income, treatment, and the income × treatment interaction resulted in a significant interaction (P = .02). Time indicates time since randomization.
adherence to the prescribed dosage of ACE inhibitor or β-blocker increased in both groups by 7 percentage points (P = .01 for time effect).

The effect of treatment on 9 prespecified subgroups is presented in the eFigure and eTable 3. There were no statistically significant differences between the self-management and education groups within any subgroup. Table 2 presents the results of multivariate accelerated failure time modeling. Adjusting for covariates and main effects, the only significant interaction between treatment and a subgroup was for income (parameter estimate, 0.64; P = .02). In patients with income less than $30 000, those randomized to receive education alone had a statistically nonsignificant 44% faster time to event than those randomized to receive self-management (acceleration factor, 1.44; P = .056); in patients with income of $30 000 or greater, there was no difference between treatment groups (Figure 3).

**COMMENT**

Past trials have failed to support the efficacy of motivating patients to manage their heart failure by learning self-management skills.9,11 but these trials have been limited by weak designs. The size, duration, methodological rigor, and representativeness of HART position it well to provide more conclusive results.

We hypothesized that heart failure education, the standard of care, was necessary but not sufficient to affect clinical outcomes. Like any chronic illness, heart failure should be managed collaboratively, such that the clinician prescribes evidence-based therapy and an informed, proactive patient implements it.29,30 To enable patients to be proactive, we reasoned that heart failure education should be augmented by training in self-management skills to help patients implement the education. This hypothesis was not supported. Consistent with past trials, self-management training plus education had no benefit compared with education alone in reducing death or heart failure hospitalization in patients with mild to moderate heart failure.

We believe, however, that the results of HART provide some direction for future trials. In post hoc analyses of prespecified subgroups, we observed a significant interaction between treatment group and income, suggesting that self-management counseling may be beneficial for low-income patients. Others have suggested that low-income patients may need special attention to help them manage chronic illnesses, possibly owing to poor health habits, poor health literacy, and/or limited health insurance.13,31 Were future trials to support the value of self-management counseling for low-income patients with heart failure, this would encourage a tailored approach that goes beyond the current standard of care.

Technology-assisted remote monitoring was not evaluated in this trial. However, a recent meta-analysis showed that both telephone monitoring and technology-assisted monitoring achieved a 30% reduction in risk of heart failure hospitalization compared with usual care.8 Long-term cost-effectiveness, however, remains to be demonstrated.8 It is possible that remote telephone monitoring, such as that used in the HART education group, may enhance patient self-monitoring and thus be an effective way to teach patient self-management skills. Long-term cost-effectiveness of such a joint approach should be studied.

Two limitations of this trial must be considered. First, the education control appeared to have been more active treatment than expected. Patients in the education group received education tip sheets by mail, and follow-up telephone calls ensured that they were read and comprehended. This enhanced standard of care improved sodium intake, depression, and self-efficacy at self-management.

Second, the assumption that self-management counseling would produce a 25% reduction in the primary endpoint compared with education may have been overly optimistic. Although the results from early self-management trials, available when HART was designed, produced an effect greater than 25%, current heart failure trials seek smaller effects (eg, HF-ACTION [Heart Failure: A Controlled Trial Investigating Outcomes of Exercise Training]: 11% reduction compared with usual care,32 CHARM [Candesartan in Heart Failure]: 18% reduction compared with placebo33). Taking these 2 limitations together, one possible explanation for the HART results is that a type II error attributable to small sample size precluded the observation of a treatment benefit.

In summary, the results of HART are consistent with those of past trials. There appears to be no benefit from self-management counseling on important clinical end points in patients with heart failure. However, given the epidemic of heart failure burdening the health care system, identification of innovative and cost-effective approaches to outpatient management is urgently needed. Future trials might evaluate the benefit of self-management counseling in low-income patients.

**Author Contributions:** Dr Powell had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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Analysis and interpretation of data: Powell, Calvin, Richardson, Janssen, Mendes de Leon, Avery.

Drafting of the manuscript: Powell, Calvin, Richardson, Rucker-Whitaker, Eaton, Avery.

Critical revision of the manuscript for important intellectual content: Powell, Calvin, Richardson, Janssen, Mendes de Leon, Flynn, Grady, Avery.

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Obtained funding: Powell, Calvin, Richardson, Mendes de Leon, Flynn, Grady.

Administrative, technical, or material support: Powell, Richardson, Flynn, Grady, Rucker-Whitaker, Eaton, Avery.

Study supervision: Powell, Calvin, Richardson, Mendes de Leon, Flynn, Eaton.

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Online-Only Material: eTables 1 through 3 and the eFigures are available at http://www.jama.com.

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REFERENCES