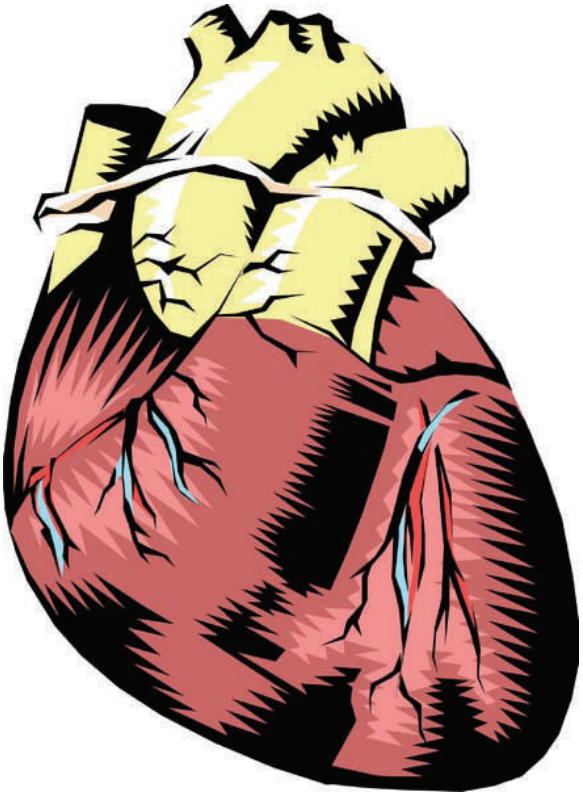
A HANDBOOK FOR CLINICIANS

PRIME HOME HEALTH SERVICES

QUALITY MANAGEMENT DEPARTMENT

CARING FOR PATIENTS WITH CONGESTIVE HEART FAILURE



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Introduction

Disease Management consists of multiple components and is an effective approach for the management of chronic diseases. According to the Disease Management Association of America **(**DMAA,) a disease management program must include six components:

1. Population identification processes including high risk for hospitalization.
2. Evidence-based practice guidelines implementation.
3. Collaborative practice models to include the physician and support services provided.
4. Patient self-management education.
5. Process and outcomes measurement, evaluation and management including acute hospitalization and any emergent care.
6. Reporting and feedback loop including communication with the physicians, health plans, patient and caregivers.

This Manual is developed to be used by Prime Home Health Services clinicians as a resource guide for the management of patients with Congestive Heart Failure (CHF).

Prime Home Health Services is dedicated to the training and development of a multidisciplinary team of professionals, and support staff that will work collaboratively during the provision of care, treatment and services to CHF patients.

Our multidisciplinary team of nurses, case coordinators, rehabilitation therapists, social workers and paraprofessional support staff is committed to addressing the challenges, and the implementation of disease management components to meet the needs of patients with Congestive Heart Failure.

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Mission

Prime Home Health Services will provide care to CHF patients that meet the highest standards of care. We will strive to meet the needs of adult CHF patients in the comfort of their homes in a safe manner.

We will provide holistic, patient-centered, quality care by a group of caring, compassionate and dedicated professionals.

Our professionalism, knowledge and skills, coupled with genuine warmth and concern for our patients' well-being and safety, is the foundation on which we have built Prime Home Health Services Disease Management Program.

Goals

To identify risk factors associated with Congestive Heart Failure and high risk for hospitalization.

Educate clinicians on best practices' strategies that utilize evidence based practice guidelines.

Encourage clinicians to utilize best practices that guide decision making with CHF patients.

Promote and educate patients on self management of CHF to empower patients living with the chronic illness.

Develop processes which include communication and integration of care across all disciplines.

Provide appropriate and safe care to patients with Congestive Heart Failure.

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Overview of CHF

There are currently 5 million cases of Heart Failure in America with an additional 500,000 new cases diagnosed annually. CHF is the number one diagnosis, primary or secondary, for hospitalization of people over the age of 65. (HH Quality Insights Organization Support Center for Home Health, 11/07).

Congestive Heart Failure accounts for 2 million hospitalizations annually and 300,000 deaths - 8% mortality rate. Patients with Congestive Heart Failure are a growing population in America.

Definition

Congestive Heart Failure (CHF) is an imbalance in pump function in which the heart is unable to adequately maintain the circulation of blood. As a result of this imbalance, there is an increase in lung fluid secondary to leakage from the pulmonary capillaries into the lungs. CHF can also be categorized as ventricular failure which is manifested by elevated systemic venous pressure and left ventricular failure secondary to reduced flow of blood into the aorta and systemic circulation. Patients with CHF often require timely medical intervention to treat the condition.

Pathophysiology of CHF

The heart is a pear shaped organ about the size of a large fist. It weighs less than a pound and is located in the thoracic cavity. It is responsible for pumping oxygenated blood to all parts of the body. The left side of the heart pumps oxygenated blood through the atrium and ventricles to the rest of the body. The left ventricle is capable of pumping with a force that moves the blood circulating through the arteries. If the left ventricle loses its ability to pump effectively, the oxygenated blood returning from the lungs to the left ventricle becomes diminished and causes leakage into the lungs.

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Pathophysiology of CHF cont'd

Failure of the left side of the heart affects the right side which attempts to compensate for the left-sided function. As the right side fails from extra work load, fluid (edema) builds up in the tissues of the body, especially the lower extremities.

This sequence of events leads to the chronic condition of Congestive Heart Failure.

Identification of Risk Factors

CHF is more common among elderly people and is caused by damage to the heart muscle and valves. Heart failure is a complex condition that is usually associated with risk factors and several co-morbidities. High risk factors associated with CHF include but are not limited to:

- Smoking
- Alcohol
- Excessive salt in diet
- Elevated cholesterol levels
- Stress
- Sedentary life style and lack of exercise
- Weight

Co-morbidities associated with CHF

Patients with CHF may have one or more of the following diseases which contributes significantly to the chronic nature of the illness. Treatment of the condition will improve the quality of life for the CHF patient.

- High Blood Pressure
- Diabetes
- Coronary artery disease

Co-morbidities associated with CHF cont'd

- High Cholesterol levels (above 200)
- Previous heart attack (MI)
- Lung diseases such as COPD
- Congenital heart defects such as valve problems
- Obesity

Signs and Symptoms of CHF

The clinician needs to understand and recognize the signs and symptoms of CHF. Patients with CHF may experience symptoms suddenly, or they may occur gradually over a period of time. The most common symptoms of progressive CHF are:

- Shortness of breath
- Paroxysmal nocturnal dyspnea
- Anxiety
- Coughing
- Weakness and fatigue
- Edema of the feet, ankles, hands, abdomen or sacrum.
- Sudden weight gain of 2-3 lbs in 24 hrs or 3-5 lbs/wk
- Chest pain or heaviness
- Memory loss and confusion

Medical Management/Treatment of CHF

The medical management of the CHF must occur timely to ensure better outcomes and enhance the quality of life for patients. There is a variety of treatment protocols. The goal of the medical treatment of CHF is to improve the pumping function of the heart, and to encourage the patient to make lifestyle changes to enhance the quality of life.

- Medical evaluation
- Decreasing fluid overload
- Medications including Oxygen treatment

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Medical Management/Treatment of CHF cont'd

- Lifestyle changes (stop smoking and limit alcohol consumption)
- Diagnostic tests
- Treatment orders: Diet (low salt, fat and calories)
- Surgical procedures may include; pacemaker implant, valve replacement and coronary artery bypass graft (CABG)
- Tele -monitoring
- Palliative treatment or hospice care

Medications

1. **Diuretics:** lasix, aldactone to increase urinary output and decrease fluid overload
2. **Inotropics:** Digoxin
3. **ACE inhibitors:** Lisinopril and Catopril to lower the patient's blood pressure and improve the pumping ability of the heart.
4. **Vasodilators:** Isordil or Apresoline to increase elasticity of arteries
5. **Beta Blockers:** Coreg
6. **Other: Other:** Calcium Channel blockers - Diltiazem;

   Anticoagulant - Coumadin

Diagnostic tests

The physician may prescribe one or more of the following tests as part of the treatment protocol for CHF patients:

- Serum labs: electrolytes, ABG'S, liver enzymes, etc
- Chest X-ray
- Electrocardiogram (EKG)
- Echocardiogram
- Cardiac catheterization if patient has chest pain.
- Oxygen Saturation

The nurse has a responsibility to follow up with the MD and laboratory on any test that was ordered for the patient.

Lifestyle changes and risk reduction strategies

Smoking

Smoking tobacco is a major cause of CHF. Reducing or stopping cigarette smoking can decrease the risk of heart failure.

Diet

Consumption of excessive saturated fat can result in obesity and high cholesterol levels. Decreasing daily calories can reduce weight, control cholesterol levels and improve the function of the heart. Consumption of too much salt in the daily diet can also cause retention of fluid in patients with CHF and weight gain.

Excessive fluid intake

Patients with CHF should limit the intake of fluid in order to decrease the incidence of edema.

Sedentary life style

Patients with CHF need to include exercise in their daily activities with MD approval . Failure to engage in exercise activities can lead to a deterioration of the patient's clinical condition.

Obesity

Patients who are overweight can decrease the stress on the heart by losing a few pounds and controlling the intake of calories.

Alcohol and drug abuse

Excessive use of alcohol or recreational drugs can place additional stress on the liver which is already affected by CHF, and can lead to liver damage.

Stress

Patients with CHF should try to avoid stressful situations. Stress can increase blood pressure levels which can create more strain on the heart and lead to heart failure.

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Depression

Patients who are depressed appear to have a higher risk for developing high blood pressure and heart disease. Since depression is becoming more prevalent amongst the elderly population, screening for depression would be a good indicator of the patient's ability or inability to learn self-management of the disease.

Clinician Assessment Strategies

The clinician should assess the patient, obtain and document baseline information for the following parameters: weight, blood pressure, pulse, respirations, abdominal circumference and lower extremities measurements and identify changes from the baseline data. Early identification and reporting of changes in symptoms by the clinician will result in early medical intervention, and a decrease in the acute care hospital rate.

On the initial visit to the patient, the clinician will conduct a comprehensive assessment and at each revisit will:

1. Assess for heart sounds, lung sounds, increase in orthopnea
2. Assess mental status
3. Assess current dietary knowledge, cultural preferences, patterns and compliance
4. Assess for abdominal pain, changes in abdominal girth
5. Assess for edema
6. Assess patient activity level, sleep patterns, perceived dyspnea
7. Assess urinary output
8. Assess for pain, focus on chest pain
9. Assess for weight gain of 2- 3 lbs. a day or 3-5lbs. a week
10. Assess psychosocial coping skills and for the presence of depression

Clinician Intervention Strategies

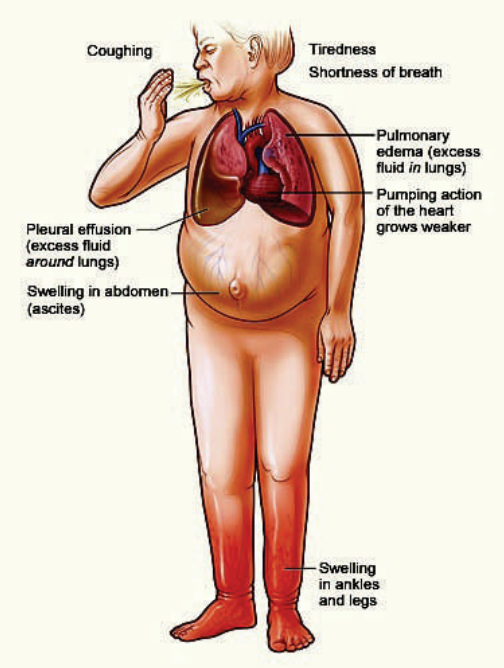
Patients with Congestive Heart Failure (CHF) need your assistance in changing their lifestyle. Our job is to motivate the patient into taking an active role in reducing the risk posed to them from CHF and other illnesses.

Clinician Intervention Strategies cont'd

The most common co-morbidities are hypertension, coronary heart disease, arrhythmias, and diabetes. If edema is identified and treated early, changes in diuretic therapy only may be adequate and the patient can be treated safely at home. The primary supportive treatment for CHF begins with decreasing fluid overload.

After the assessment of the patient, the clinician will discuss the treatment plan with the MD, patient/caregiver and the case coordinator. Together they will develop a patient specific plan of care to address the patient's needs.

Is this your patient? Assess the patient, understand the specific signs and symptoms your patient is exhibiting. Plan the interventions that will help the patient optimize their wellness.



The assigned disciplines will develop individualized care plans with the patient and family/caregivers. Clinicians should encourage the patient's family/caregivers to participate and cooperate with the treatment plan.

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Patient Education: Self Management Strategies

Patient/family/caregiver education by the nurses will require the use of more visual aids, since some elderly patients may have difficulty with communication.

The nurse will promote self management of Congestive Heart Failure and work with the patient to develop daily goals.

The nurse will teach the patient to:

- Weigh self daily and keep a log.
- Notify the MD and the nurse of any increase in weight of 2-3 or more pounds in a day or 5lbs in a week.
- Elevate legs to decrease edema.
- Measure legs, and abdominal girth with a tape measure daily.
- Discuss increasing physical activities with MD first, and then start an exercise program slowly.
- Action and side effects of medication.
- Read labels carefully for the correct dosage and to take medications as prescribed by the MD.
- Limit alcohol intake and to reduce smoking if patient smokes. Adhere to a low sodium diet, and to read food labels carefully for salt content. Advise patient that salt causes fluid retention and increased weight gain.
- Manage signs and symptoms of fatigue by incorporating rest and relaxation techniques into the plan of care.
- Get immunized for Flu and Pneumonia, if appropriate in order to stay healthy.
- Report persistent cough, chest congestion, dizziness or lightheadedness.

The nurse will also utilize other appropriate teaching tools such as; CHF Care Pathway; CHF Patient Self Management Plan; CHF Self-Management Zone Plan to educate the patients on self-management of CHF disease.

- Obtain standing order for a PRN medication based on symptoms of exacerbation and teach patient when to take the ordered medication.

Emergency Management

Patients with Congestive Heart Failure will require extra support and assistance during an emergency situation, if there is a need to evacuate the building. The nurse should encourage the patient living alone to plan for an emergency and encourage them to have a prepared "Go Bag" that should include copies of all important documents in a waterproof bag, extra set of house keys, bottled water and energy snacks, flashlight and extra batteries, a list of any or all medications patient is taking and name of physician, portable radio, toiletries, phone numbers of friends and family.

Case Coordination

The Case Coordinator's role is very important in the management of patients with CHF. The Case Coordinator is responsible for ensuring that the information from the multidisciplinary team of nurses, therapists, social workers and paraprofessional worker (if applicable) is integrated and addresses the needs of the patients.
The Coordinator will need to follow up with the MD/family/caregiver to ensure that the patient is obtaining the appropriate medical services, and additional follow up when appropriate to ensure that terminal patients receive information on palliative care and end of life counseling .

Education Tools

- CHF Care Pathway
- CHF Patient Self Management Plan
- CHF Self Management Zone Plan
- CHF Patient Goals

Patient/Caregiver Education Booklet

- Weight Log
- Edema Measurement Log
- Medication Schedule Log
- Rehabilitation Therapy Guide
- CHF Medication list

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CONGESTIVE HEART FAILURE (CHF) CARE PATHWAY
Visit By Visit Plan Of Care

Visit 1

Assessment – OASIS

- Comprehensive physical assessment
- Psychosocial assessment
- Environmental assessment
- Pain assessment
- Nutritional assessment
- Fall assessment
- Assess for signs of Depression
- Assess Immunizations
- Activity level
- Use of medications, med changes, Comprehensive drug regimen review
- Evaluate patient's knowledge of and ability to weigh self
- Assess patient's knowledge of measuring abdomen and legs
- Evaluate patient's response to therapeutic medical regimen

Interventions

- Develop urgent plan/emergency plan
- Locate scale at home and calibrate , obtain base line weight
- Initiate patient's weight log
- Initiate referrals as needed
- Develop POC with patient/family
- Provide patient with Booklet "Self Management Guide for Congestive Heart Failure" and review appropriate information
- Discuss Immunizations – Flu and Pneumonia
- Obtain a standing order for PRN medication/dosage change and parameters

Teaching

- Signs/systems to report to MD/Call 911
- Oxygen use and safety
- Weight and weight log
- Body measurement - abdomen, legs
- High risk medications
- Pain Management
- Fall Reduction Strategies

CONGESTIVE HEART FAILURE (CHF) CARE PATHWAY
Visit By Visit Plan Of Care

Visits 2 and 3

Assessment

- Head to toe physical, psychosocial, environmental assessment
- Vital Signs
- Abdominal girth, peripheral edema
- Weight

Interventions

- Discharge planning with patient /family
- Monitor weight log
- Contact MD for any abnormal findings, obtain order for POC changes
- Continue medication teaching

Teaching

- Complete any teaching from above not done at previous visit
- Evaluate patient's knowledge of teaching from previous visit and instruct as needed on:
- Disease process
- Elevate legs when seated
- Change position slowly
- Energy conservation
- Gradual activity increase to promote strength and endurance
- Instruct on diet /fluid restrictions
- Review appropriate information from "Patient Self Management Guide for Congestive Heart Failure".

Visit 4 and 5

Assessment

- See visit 2 and 3
- Patient self-management /readiness for discharge

Intervention

- Same as visit 2 and 3
- Contact MD for any abnormal findings, obtain order for POC changes
- Continue medication teaching

CONGESTIVE HEART FAILURE (CHF) CARE PATHWAY
Visit By Visit Plan Of Care

Teaching

- Evaluate patients knowledge of teaching from previous visit and instruct as needed
- Continue medication teaching
- Instruct on lifestyles changes
- Instruct on stress, anxiety, and relaxation
- Instruct on importance of MD follow-up
- Instruct on obtaining supplies as needed
- Instruct on community resources
- Medicare Notice of Provider Non-Coverage if applicable
- Review appropriate information from "Patient Self Management Guide for Congestive Heart Failure" after discharge

Visit 6 final visit

Assessment

- See visit 2 and 3 same as previous visit
- Patient self-management/readiness for discharge

Intervention

- Evaluate patients knowledge of teaching from previous visit and instruct as needed
- Continue medication teaching
- Monitor weight log for patient compliance
- Elaborate on discharge planning
- Monitor patient self management activities, re-instruct as needed
- Discuss Medicare Notice of Provider Non-Coverage if applicable
- Instruct on fall reduction strategies after discharge
- Instruct emergency measures and when to call **911** after discharge
- Instruct medical follow up after discharge

Nursing considerations prior to discharge of patient

- **Ensure Notice of Provider Non-Coverage was issued and signed by patient at least 2 days prior to discharge (if applicable)**
- **Patient is competent with self management activities and/or caregiver is knowledge-able, available, willing and able to assist patient.**
- **Patient/Caregiver understands the emergency protocol.**

CONGESTIVE HEART FAILURE PATIENT SELF MANAGEMENT PLAN

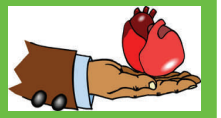
Risk Factors	Signs & Symptoms	Medication Management	Life Style Changes	Daily Weights & Measurement	Medical Follow-up
High blood pressure Diabetes Coronary artery disease Cholesterol	Shortness of breath Coughing Weakness and fatigue Swelling of abdomen, hands, feet and ankles.	Medications your doctor may order: Digoxin Lasix Potassium Lisinopril or Captopril Isordil	Smoking will increase your risk of a cardiac event 2-5 fold **Smoking** your physician can assist you with methods to Reduce tobacco use.	Weigh yourself every morning after urinating and before you eat breakfast. Record your weight in the weight log	**Keep all follow up appointments with your doctor.**
High blood pressure and diabetes control will decrease the risk of kidney failure heart attacks and stroke	Chest pain or heaviness	Take your medications as ordered by your doctor.	**Low Salt Diet** Low salt diet is very important. It will decrease the retention of fluid and ease the work of the heart.	Check your legs, feet and abdomen for swelling daily. Measure your legs and abdomen every day and record.	If you do not keep your scheduled doctor's appointment, please inform your nurse, and reschedule.
Control of your cholesterol levels will decrease the risk of coronary artery disease.	By monitoring and reporting your symptoms early you can decrease re-hospitalizations.	Medications are very important in the treatment of your heart condition.	**Fat and sugar** Limit your intake of foods high in saturated fat and sugar to control weight.	Report sudden increase in your weight to the doctor immediately.	If you experience sudden chest pain, call **911** immediately

CONGESTIVE HEART FAILURE PATIENT SELF MANAGEMENT PLAN

Risk Factors	Signs & Symptoms	Medication Management	Life Style Changes	Daily Weights & Measurement	Medical Follow-up
Smoking Alcohol Stress Sedentary lifestyle Obesity		Do not stop taking your medications unless your doctor advised you to stop. Ask your nurse or doctor if you have questions about your medications.	**Alcohol** Reduce your intake of alcohol. **Stress** Talk to the nurse about things that make you upset And strategies to address it. **Exercise** Include exercise in your daily activities based on your doctor's orders. **Eat healthy foods** Try to include more fruit, vegetables and whole grain foods with your daily meals.	Weight gain of 2-3 lbs in a day or 3 -5 lbs in a week may be a sign of worsening heart failure.	

SELF MANAGEMENT ZONE PLAN FOR CONGESTIVE HEART CARE

Green Zone = "All Clear "



- No shortness of breath
- No swelling
- No weight gain
- No decrease in your ability to maintain normal activity level

Green Zone Means:

- Your symptoms are under control
- Continue taking your medications
- Follow low salt diet
- Keep physician appointments

Yellow Zone = "Caution"

If you have any of the following signs or symptoms:

- Increased weight (2-3 lbs. in one day or 3-5 lbs. in past 7 days)
- Increased cough
- Increased swelling of legs, ankles and /or feet
- Increased shortness of breath with activity
- Chest pain
- Increased number of pillows needed to sleep or need to sleep in a chair
- Anything else unusual that bothers you

Call your Nurse and/or physician if you are in the YELLOW ZONE

Yellow Zone Means:

- Your symptoms may indicate that you need an adjustment in your medications
- **Call your physician**

Primary Dr.:_____

Number:_____

Prime Home Health Services (718) 646-1900

(Please notify the Nurse if you contact or go to your doctor)

Red Zone = "Medical Alert"

- **Unrelieved shortness of breath**
- **Unrelieved chest pain**
- **Wheezing or chest tightness at rest**
- **Chest pain not relieved or reoccurs after taking Nitro tablets twice 3 minutes apart**
- **Mental Changes**

Call your physician and/or Nurse if you are in the RED ZONE

Red Zone Means:

- **This indicates that you need to be evaluated by a physician right away**
- Primary Dr.:_____
- Number:_____

Prime Home Health Services (718) 646-1900

(Please have your family notify the Nurse if you go to the emergency room or are hospitalized)

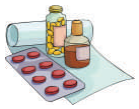
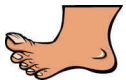
Source: http:/www.improvingchroniccare.org/improvement/docs/rygdm.doc

CHF SELF MANAGEMENT GOALS

Congestive Heart Failure is a very serious condition in which the heart is unable to adequately pump oxygenated blood to meet the demands of the body. You may experience difficulty breathing, sudden weight gain and swelling of the hands, ankles, feet or abdomen.

You, the patient, are the most important person to manage your CHF.

We will guide you and offer support as you manage your heart failure. The following goals will help you gain and maintain control to reduce additional damage to your heart and lungs. Select two (2) goals to work on with the help of the nurse.

Please choose goals you are willing to work on to better manage your CHF		Yes	No
	**Goal 1**: I will work to monitor my signs and symptoms of CHF		
	**Goal 2:** I will take my medications daily as ordered by my Doctor		
	**Goal 3:** I will measure my hands, ankles, feet and abdomen daily with a tape measure and record the results in a log		
	**Goal 4:** I will weigh myself every day in the morning and keep a log of my weight. I will call my doctor if I gain more than 2-3 lbs in one day.		
	**Goal 5:** I will try to achieve my ideal body weight. I will lose ____ pounds by my next office visit.		
	**Goal 6:** I will prepare my meals using the low sodium diet as ordered by my doctor.		
	**Goal 7:** I will exercise (walk) 30 minutes ____ days per week. If I notice chest pain, shortness of breath or chest tightness, I will seek medical attention.		
	**Goal 8:** I will decrease my smoking activity and alcohol intake		
	**Goal 9:** I will keep all of my MD follow up appointments and seek emergency care when necessary.		
	**Goal 10:** I will report any difficulty in keeping my goals, making lifestyle changes or following my treatment plan to the nurse.		

MY GOALS

The goal I choose to work on between now and my next visit:

_____

The change I am willing to make:

_____

_____

Name_____ Date_____

The goal I choose to work on between now and my next visit:

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The change I am willing to make:

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Name_____ Date_____

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Helpful Resources

- **American Heart Assosiation**

www. heaer.org/heart.org
1-800-242-8721 1-800-AHA-USA1

- **ACC/AHA Guideline for the Evaluation and Management of Heart Failure in the Adult**

http://circ.ahajournals.org/cgi/content/full/112/12/1825

- **Heart Care Medication Information:**

www.**cardiology**inoregon.org/GAPproject/HFMedInformation14Fontbw.pdf

- **Heart Failure**

www.webenhanced.lbcc.edu/vncb/vn230cb/downloads/Heartfailure.ppt

- **Helping Patients Manage Their Chronic Conditions**

www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf

- **How to Care for Your Heart if You Have Heart Failure**
  American College of Cardiology

http://www.acc.org/gap or http://www.oregangap.htm

- **Motivate Healthy Habits**

http:/www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/tools/DecisionBalanceWorksheet.htm

- **My Shared Care Plan**

www.sharedcareplan.org

- **Patient Self Management Best Practice Intervention Packages**

http://www.homehealthquality.org/

- **Symptoms of Heart Failure**

http://www.clivir.com/lessons/show/symptoms-congestive-heart-failure-is-worsening.html

- **Zones for Chronic Disease Management CHF**

http://www.improvingchroniccare.org/improvement/docs/rvgchf.doc

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