Disease Management Guidelines

A working tool intended to assist with the development
of an individualized comprehensive plan of care

Congestive Heart Failure

Goal: Optimize Management of Congestive Heart Failure and Minimize Risk of Debilitating Complications

Action Steps:

✓ **CM will:**

- ❑ Explore and provide MEMBER/caregivers with information on Congestive Heart Failure (CHF) resources such as the American Heart Association, local support groups, and area CHF management programs.
- ❑ Facilitate an IDT with RN, PT, Dietitian, Diabetes Educator, Member, PCA, Informal Caregivers, and/or other providers as deemed appropriate and available to assess disease status, safety/supervision needs, program and community appropriateness, and to develop an individualized program of CHF management
- ❑ Provide ____home visits (frequency to be determined by MEMBER need) to:

_ Assess medical, psychosocial, and economic needs and explore needed resources

_ Monitor and evaluate MEMBER adherence and outcomes to include, but not limited to review of:

- Medications
- Functional abilities
- Daily weight logs
- Exercise logs/PT Plan
- Food diary
- Vital signs (wt, BP, and pulse) log
- Mental Health
- Caregiver stability
- Life Transition Planning
- Immunizations
- Regular medical visits

_ Evaluate effectiveness of plan

- _ Observe and verify MEMBER and caregiver skills and knowledge levels
  - ❑ Provide information on obtaining Medic Alert identifier
  - ❑ Provide referrals as required by plan, to include but not limited to:

❖ Physical Therapist:

- _ Assess MEMBER ability for physical activity
- _ Contact Member's physician to obtain exercise recommendations
- _ Assess MEMBER need for mobility and safety assistive devices
- _ Develop an exercise plan adapted to the specific needs and abilities of the MEMBER
- _ Provide CM with written report documenting assessments, interventions, activity plan, outcomes, and recommendations

❖ Dietitian:

- _ Assess MEMBER nutritional status
- _ Assess MEMBER, PCA, and informal caregiver knowledge of diet requirements
- _ Provide nutrition education (relevant to MEMBER need) including, but not limited to:
  - Weight management
  - Dietary guidelines to manage:
    - salt intake
    - lipids
    - fluids
    - protein/caloric needs
    - alcohol consumption
- _ Provide CM with written reports documenting assessments, education, diet plan, outcomes, and recommendations
  - ❑ Obtain needed equipment and supplies as recommended by the IDT and approved by MEMBER's physician
  - ❑ Obtain and review reports of each visit by all providers, including RN, PT, and Dietitian
  - ❑ Collaborate with MEMBER, caregivers, and all providers and amend the plan as needed to meet changing MEMBER needs, including referrals for specialty care

✓ **Skilled Nurse will:**

- ❑ Provide _____ home visits (frequency to be determined by MEMBER need) for assessment, disease management planning, and monitoring to include:

_ Thorough history, including all health conditions impacting CHF (diabetes, CAD, kidney disease, etc.)

_ Physical examination including: standing and resting blood pressure changes, heart rate and regularity, peripheral edema, lung function, weight and height, and calculation of body mass index.

_ Review of medical records

_ Assure medical regimen is consistent with practice guidelines

_ Medication review and evaluation
- Using ACE Inhibitor
- Using Beta Blocker
- Using Warfarin if has Atrial Fibrilation
- Using other medications as appropriate such as diuretics, anti-hypertensives, anti-arrythmics

_ Signs and symptoms of hypoxia

_ Monitor and evaluate physician ordered laboratory tests including
- Last routine blood test for clotting time (if taking blood thinner such as coumadin, warfarin)
- Last routine blood test for electrolytes (if using diuretics with or without potassium supplements)

_ Urinary output/frequency

_ Physical tolerance of activity

_ Risk for falls

_ Signs and symptoms of digitalis toxicity (if Member using Digitalis)

_ Signs and symptoms of sleep apnea

_ Signs and symptoms of depression and/or anxiety

_ Pain assessment

_ Comprehension and ability to adhere to medical regimen

_ Comprehension and ability to perform self-care activities

❑ Contact Member's physician office to discuss CHF clinical management strategies and obtain physician recommendations for plan of care

❑ Assess MEMBER, PCA, and informal caregiver knowledge and skills

❑ Provide CHF management education (relevant to Member need) to include, but not limited to:

_ Disease process

_ Self–monitoring of daily weights

_ Medication purpose, administration, side effects, and adverse reactions

_ Signs, symptoms, and management of complications

_ Assess and provide strategies for reducing risk for and managing complications:
  - Salt/Fluid restrictions
  - Exercise
  - Stroke prevention
  - Blood pressure control target level: ≤ 139/89
  - Lipid management: target levels: LDL <100, triglycerides <150, HDL > 40; if 75 years of age or older: LDL 130
  - Immunizations (pneumonia and flu)
  - Smoking cessation
  - Mental Health

❑ Monitor and evaluate MEMBER adherence to CHF management program

❑ Monitor and evaluate MEMBER, caregivers, and PCA for proper use of equipment and supplies

❑ Provide CM with written reports of all visits, documenting assessments, education and clinical interventions, outcomes and recommendations

✓ **MEMBER, informal caregivers, and/or providers will:**

❑ Keep logs of daily weights

❑ Prepare meals using diet plan as prescribed by dietician, RN, and/or physician

❑ Maintain food diary

❑ Take medications as prescribed by the physician

❑ Participate in an activity program as prescribed by the physical therapist and/or physician

❑ Make and keep all medical appointments including, but not limited to:

_ Routine check-ups to monitor health status

_ Annual flu vaccination

_ One-time pneumococcal vaccination with revaccination as recommended by physican

❑ Immediately call the doctor if you experience signs and symptoms of illness:

_ Weight gain of 3-5 lbs. or more within a week

_ Increased difficulty breathing

_ Cough that won't go away, especially at night

_ Dizziness or fainting

_ Sudden vision changes, including seeing greenish/yellow circles around objects

- _ Nausea/Vomiting
- _ Tightness or pain in chest, neck or arm
- _ Urinating less frequently
- _ Pulse under 50 or over 100 and/or irregular
- _ Adverse effects from medications

❑ Verbalize understanding of when and how to seek emergency care

❑ Verbalize understanding of risks and benefits of adherence/non-adherence to plan

❑ Report difficulties with plan adherence, changes in health status, or service plan needs to CM

Expected Outcomes:

- PCA, caregivers, and/or MEMBER can verbalize CHF disease process management plan
- PCA, caregivers, and/or MEMBER recognize symptoms of disease progression or complications and can verbalize when to call the RN or physician
- PCA, caregivers, and/or MEMBER can demonstrate proper use of equipment and supplies
- MEMBER and caregivers have adequate information to make informed decisions, including the risks and benefits of adherence/non-adherence to plan