**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 Fibrillation
- Using other medications as appropriate such as diuretics, anti-hypertensives, anti-arrhythmics

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 physician
    - 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