

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: $\leq 139/89$
- 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

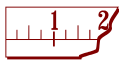
— Increased difficulty breathing

— 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