Congestive Heart Failure Clinical Practice Guideline

Document Owner	Department	Intended Users
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Reference Number	Effective Date	Revised On	DHS Approval Date
1267	**11/15/2018**	**11/08/2019**	**N/A**

Purpose:

To provide a best practice approach to Inclusa Health & Wellness Coordinators (HWC) and Community Resource Coordinators (CRC) for managing care with members identified as having heart failure.

Overview:

Congestive heart failure (CHF) is a complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood. It is characterized by dyspnea and fatigue secondary to structural and functional changes in the heart.

The chief symptoms of congestive heart failure, dyspnea and fatigue, limit exercise tolerance and promote fluid retention, which may lead to pulmonary congestion and dependent edema, and significantly impact a member's ability to function. Members may have difficulty lying flat in bed, secondary to fluid overload in the lungs and dependent edema, especially swelling of the lower extremities. Occasionally, patients with CHF do not have obvious clinical signs or symptoms, or their signs and symptoms may be attributed to another cardiac or non-cardiac disorder.

I. Persistent signs and symptoms of congestive heart failure include:

- Difficulty concentrating
- Fatigue and weakness
- Lack of appetite and nausea
- Persistent cough or wheezing
- Rapid or irregular heartbeat
- Reduced ability to exercise
- Shortness of breath
- Sudden weight gain from fluid retention
- Swelling in abdomen
- Swelling in legs, ankles, and feet

II. Risk factors for developing congestive heart failure include:

- Alcohol use

- Congenital heart defects
- Coronary artery disease (CAD)
- Diabetes
- Heart attack
- High blood pressure
- Sleep apnea
- Viruses

Definitions:

Heart Failure (HF) or Congestive Heart Failure (CHF): A chronic disease in which the heart's pumping ability is impaired so much that it no longer meets the body's needs. This causes the fluid to build up in the lungs and throughout the body. Heart failure typically develops slowly, often developing after other conditions have damaged or weakened the heart. People with heart failure often struggle with cognitive impairment, functional disabilities, and have multiple co-morbidities.

Assessment:

Anticipating, recognizing, and responding to assessed needs.

- Utilize the Heart Failure Checklist (see Additional Resources section below) as a resource for education and planning for members with a diagnosis of CHF.
  - It is not required to be completed.
  - It does not need to be saved in the member record.
- Considerations for Assessment of Cardiac Function:
  - Review of past medical history.
  - Assess for signs and symptoms of heart failure.
  - Assess member's knowledge and understanding of congestive heart failure by asking:
    - "Can you explain what you know about congestive heart failure?"
    - "What are you doing in your daily life (i.e. monitoring daily weight, exercise routine, heart-healthy diet) to help your condition? What could you improve on?"
    - "What can we do to better assist you in managing your heart failure?"
- Assess member status regarding heart failure at least every six months. Document reassessment findings in the Cardiovascular field on the Systems Tab of the Member Center Plan (MCP) Health Review.

Plan:

Best Practice standards for prevention and management

Goals in caring for a member with congestive heart failure include:

- Prevent re-hospitalization. Data analysis of nationwide Medicare claims found that one out of five Medicare patients are re-hospitalized within 30 days and one-third are re-hospitalized within three months. Re-hospitalization is prevalent among the chronically ill and/or frail elderly.

The quality of life for members who have CHF can be greatly improved through increased knowledge about congestive heart failure and through developing an action plan for managing care, based off best practice guidelines.

- Improve care coordination. Effective care coordination between member, Inclusa Interdisciplinary Team (IDT), physician and other healthcare professionals involved in the member's care is essential. Heart failure is the leading admission diagnosis for all patients over age 65. It is critical for Inclusa HWCs to communicate regularly with nurses and physicians in the hospital setting and for all providers involved in member care to coordinate together to provide the best care possible.
- Self-management. Engage members and caregivers in effective self-management of heart failure by providing necessary teaching and linking members to specific resources.

Intervention:

Guideline/process for IDT to use regarding negotiating incorporation of prevention and management plan with member into the MCP.

- Provide "Self-Check Plan for HF Management" tool (links below in Additional Resources section) from the American Heart Association with initial assessment and teaching per assessed need. Review and reinforce as needed.
- Engage member and caregivers in care at each member visit. Use American Heart Association Heart Failure Tools & Resources, as applicable, in Additional Resources section below.
    - Provide education and have member successfully teach back key points. At a minimum, document education provided in the Congestive Heart Failure field on the Systems tab of the MCP Health Review at each six-month MCP review.
        - Medications – Examples: Do you understand what medications you are taking for your heart and why they are important? Do you take your medications as prescribed?
        - Preventing, Detecting, Treating Acute Complications – Examples: teach member the proper method to weigh themselves, reinforce weight gain parameters from healthcare provider, etc.
        - Self-Management of CHF – Examples: Discuss balanced activity/rest cycle, member should check with their health care provider before starting an exercise program, etc.
        - Nutritional Management (Heart Healthy Diet) – Examples: Following a heart healthy diet, reinforcing healthcare provider sodium recommendations, etc.
        - Risk Reduction (Tobacco Cessation, Avoiding Alcohol)
        - When to call Nurse/Medical Provider/Clinic – Examples: When weight goes up more than provider recommendation, increase in swelling in feet/ankles, etc.
        - Resources – Examples: Local support groups, nutritional workshops, etc.
    - Support member to develop and discuss specific goal(s) related to management of heart failure based on member priorities, preferences, and personalized outcomes.
    - Record and update as indicated outcomes, goals, and steps to achieve by member, medical providers, member's support systems, providers, and Inclusa IDT to meet these goals in the Physical Health Domain, Planning Tab of the MCP.

Evaluation:

Plan for monitoring of guideline effectiveness.

Member Plan Evaluation:

Evaluation techniques will vary from member to member based on individual outcomes and recommendations by their healthcare provider. Evaluation of outcomes and interventions need to be discussed and agreed upon by the member, the IDT, caregiver(s) as applicable, and other healthcare providers as indicated.

When a member describes or demonstrates a lack of understanding regarding their prevention and wellness needs related to the Congestive Heart Failure/Heart Failure, the HWC will assess member barriers and needs, plan to reduce risk as indicated by assessment, and document assessment and planning. Interventions will be put in place and documented as action steps in the appropriate domains in the MCP.

Ongoing education and evaluation of interventions are required to ensure achievement and maintenance of member-identified personal outcomes and to support effective member decision making. The MCP action steps will be modified to address the identified barriers in achieving the outcome.

Quality Improvement Evaluation:

Quality Improvement will monitor that the guideline is effective and is being utilized as recommended in this document through periodic file review process. Reviewers will audit records for documentation pertaining to implementation and ongoing utilization of this clinical practice guideline according to established criteria.

The Prevention & Wellness Workgroup will ensure regular review of this document along with tools and educational materials. This will ensure IDT, providers, and members are receiving the most current and accurate information.

Additional Resources:

American Heart Association – Heart Failure Tools & Resources

Heart Failure Checklist

Self-Check Plan for HF Management (English)

Self-Check Plan for HF Management (Spanish)

References:

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Centers for Disease Control and Prevention. (2016). Heart Failure Fact Sheet. Retrieved from https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_failure.htm

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Revision History #	Date	Description of Revision(s)	Requested By	Staff Training Date
1	09/05/2018	Merged for Inclusa	T.Mayek	11/15/2018
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