Using (G)uidelines, (A)ccess to care and (P)atient –centered care for Self Care Management

Susan Quaglietti RN, MSN, ANP
Cardiology Comprehensive Care
Cardiology, PAVAHCS
Closing the GAP in CHF care
Why does close follow up matter in clinical practice?

- Improved EF% (Wilcoxon et al, 2012)
- Reduction in deaths with optimal therapies (Fonarow, Yancy et al, 2011)
- Hospitalization and mortality rates for Veterans have increased (Heidenreich, Sahay et al, 2010)
What is close follow up?

• Using guidelines for CHF management
• Timely access to care, ability to access care
• Patient adherence to treatment plan
• Coordinated communication with providers and patient
Close follow up using Cardiology clinics

• Outpatient Cardiology clinics improve use of CHF guideline recommended therapies (Fonarow, Albert et al, 2010)

• Nurse lead CHF clinics are effective but specific components for a successful program needs to be determined (Lambrinou et al, 2011)
Using Telemedicine for close follow up

- Collaboration with GMC and CHF clinics improves outcomes (Dendale et al, 2011)
- Need to complete the circle between home and HF management care (Desai et al, 2010)
- Patient satisfaction with telemedicine is not well documented (Kraai et al, 2011)
Multidisciplinary Teams for CHF care

• Specialized multidisciplinary heart failure teams are cost effective and improve outcomes (Ahmed, 2002)
• Team approach helps deal with complex care towards end of life (Ryder et al, 2011)
• Research being conducted on impact of home versus clinic based management (Stewart et al, 2011)
Mind the GAP: Guidelines

- Poorer outcomes with non-adherence to medical therapy (Fitzgerald et al, 2011)
- Dietary adherence with low sodium intake and fluid restriction
- Treat all cardiac disease such as CAD, AF and HTN to improve overall outcomes
Summary: Guidelines

1. Medications
   ---beta blockers, ACE/ARB, aldactone for neurohormonal effects/improved survival
   ---diuretics for symptoms
   ---anticoagulation for AF, BP control, ASA/statin for CAD

2. Dietary recommendations-
   less than 2000mg sodium per day, less than 2000cc per day
Mind the GAP: Access to Care

- Follow up sooner rather than later decreases readmission rates (Hernandez et al, 2010)
- Type of care-phone, clinic (GMC vs. Cardiology), home, combination of all types
- Timing of care-patient contact 7-10 days after hospital discharge
Summary of access to care

- Coordinate care with other providers
- A team approach works and includes the patient
- Contact with the patient is most important to manage symptoms and adjust medications
- Discuss barriers to attending clinic appointments, be creative on how to provide care
Mind the GAP: Patient-centered care

• Use motivational interviewing to assess patient values regarding goals (Paradis et al, 2010)

• Incorporate assessment of mood and illness beliefs to guide care-improved symptoms help mood and QOL (Mulligan et al, 2011)
Self care and QOL

• Determinants of self care in heart failure (Oosterom-Calò et al, 2011)
  ---self care management
  ---self care maintenance
  ---sodium, fluid and ETOH restriction
  ---physical activity
  ---smoking cessation
  ---monitoring signs and symptoms
  ---attending follow up appointments

• Self care does not always improve QOL (Grady, 2008)
Advanced CHF care

• Using scores to guide care/assess mortality can help plan goals that involve palliative care (Lee et al, 2003)

• Conduct honest discussions about long term care goals and advanced directives

• Coordination of care and communication between patients, families and providers is critical (Low et al, 2011)
Quality of Care in Heart Failure in 2011

- Telephone support/telemonitoring
- Quality of care
- Heart Failure specialists/general Cardiology
- Patient Adherence
- Health literacy
- Performance measures

(Rich, 2011)
Conclusions

• Guidelines—medications, dietary recommendations, treat other cardiac diseases
• Access to care—use all methods of contact, coordinate with all members of the team
• Patient center care—promote self care, self directed care
Work with the patient to close the GAP and gain a new perspective!!!