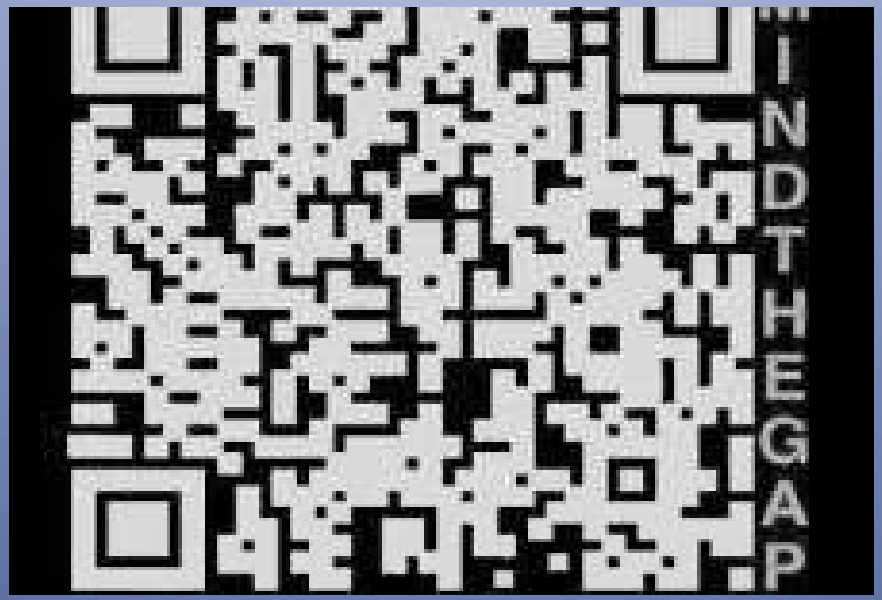


# Using (G)uidelines, (A)ccess to care and (P)atient –centered care for Self Care Management

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# Closing the GAP in CHF care

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# Why does close follow up matter in clinical practice?

- Improved EF% (Wilcox 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 (Ftizgerald 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-Calo 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!!!

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