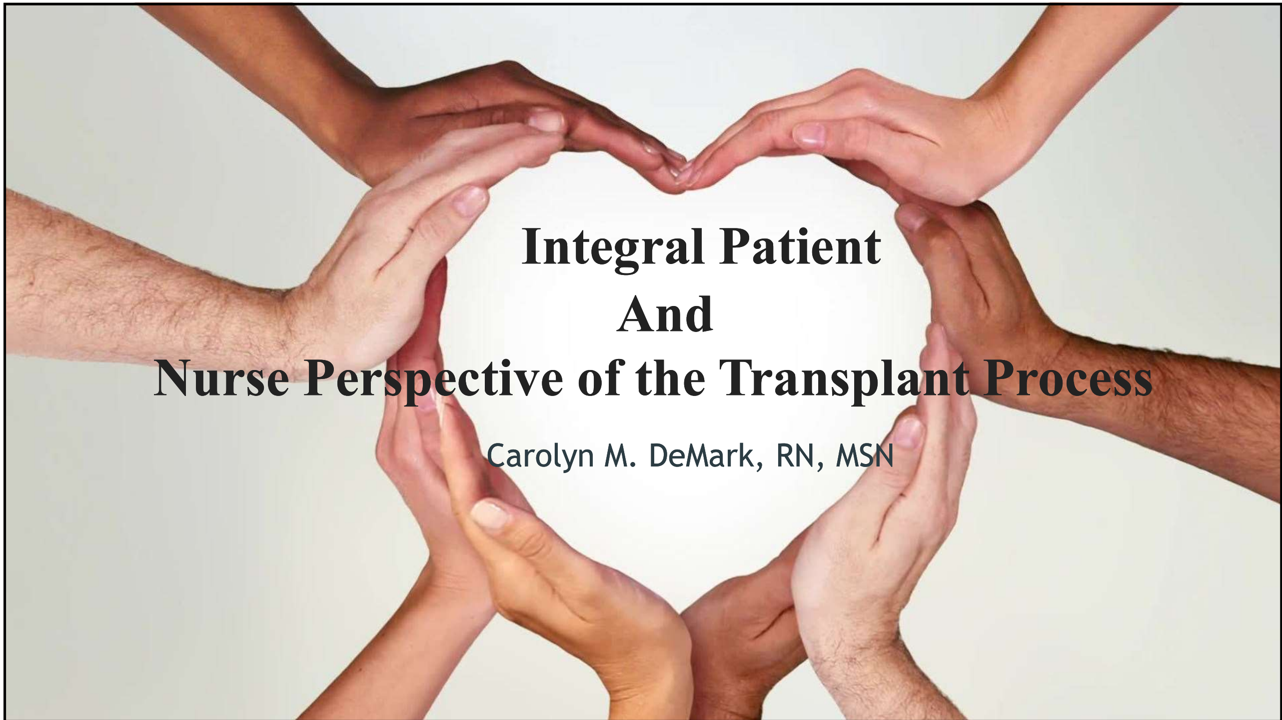

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2

How this will flow

- Heart Failure
- Nursing and Care Management
  - Assessment
  - Communication, Collaboration, Coordination
- Patient Experience

3

Learning Objectives

1. Explain how Nursing Collaborative Care promotes quality care for Heart Failure Patients.
2. Identify how Care Management support high-intensity interventions and information for individualized patient care.
3. Describe understanding for how to support the patient experience with their medical care.

4

Heart Failure

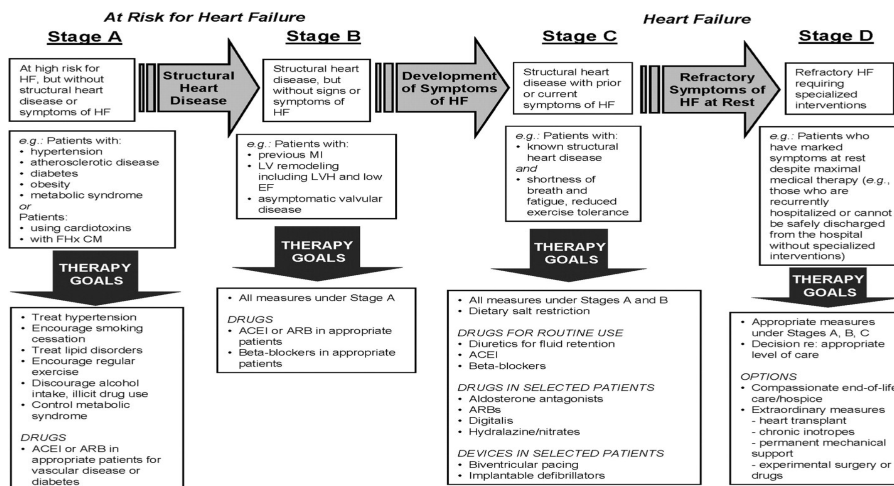
- Definition: HF is a complex clinical syndrome with symptoms and signs that result from any structural or functional impairment of ventricular filling or ejection of blood. [EF <35… now the new <40]
- NYHA classification is used to characterize symptoms and functional capacity of patients with symptomatic.
- Independent predictor of mortality

New Onset/De Novo HF:	Resolution of Symptoms:	Persistent HF:	Worsening HF:
• Newly diagnosed HF • No previous history of HF	• Resolution of symptoms/ signs of HF Stage C with previous symptoms of HF with persistent LV dysfunction | HF in remission with resolution of previous structural and/or functional heart disease*	• Persistent HF with ongoing symptoms/signs and/or limited functional capacity	• Worsening symptoms/ signs/functional capacity

ACA Guidelines, 2022

5

Stages of Heart Failure



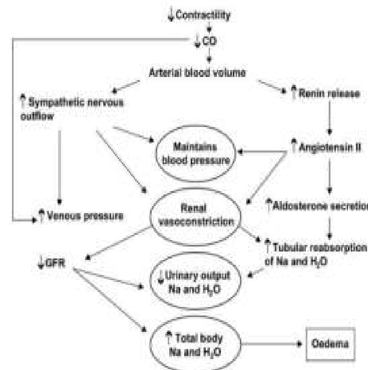
ACC/AHA guidelines for the evaluation and management of chronic HF

6

Golden Standard

Guideline Directed Medical Therapy

- Beta-blockers
  - Metoprolol succinate
  - Carvedilol
  - Bisoprolol
- RASi
  - ACEi
  - ARB
  - ARNI
- MRA
  - Spiro
  - Eplernone
- SGLT2i
  - Dapagliflozin
  - Empagliflozin



Lauren Gilstrap, 2022 & Heidenreich, et al, 2022

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Nursing & Care Management

- Care Managing the more Advanced in their Heart Failure progression
- **Quality Patient Care** Increase desired health outcomes, based on evidence-based professional knowledge.
  - Defined as: Safe, Effective, Efficient & Timely, Equitable, Effective.
- **Case Management Practice**: Coordinate Services between settings – Hospital, Clinic, Home
- **Vital Decision-** Makers and a Key-Stakeholder when collaborating on a patient's behalf, sharing assessments
- **Support** and help guide the Care needed
- **IHI** recommends focus on System and Clinical issues, effective education
- **Evidence-Based Care**: Instructions activity level, diet, discharge medications, follow-up appointments, weight monitoring, and what to do if symptoms worsen
- **The Key** to timing and follow-up at discharge, to reduce 30-day Re-Admission

(Krishna, P. (2023) Assuring a Continuum of Care for Heart Failure Patients Through Post Acute Care Collaboration: p 3-10 & WHO, 2023 Quality Patient Care & ACA 2022

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Assessment

- Alert to new Symptoms or Changes
- Observe and Assess Subtle Changes from Baseline
- Be specific to the Physical and Emotional Details
- Confirm the Trends
- Confirm the Medications
- Activity Level: is a change in breathing and/or endurance that might hallmark a change in heart function
- Assess and Management Transitions from Hospital to Ambulatory Care
- F/U appointment with in 10 days of discharge
- Telephone call within 1 day of Discharge and regularly till Follow-up

Prasun M, et al., 2012

9

Communication/ Collaboration/ Coordination

- The Power is really in the LISTENING
- Pausing and Reiterating, Clarifying
- Time – TIME. the Pressures of Time. MULTI TASKING!!
- Within the Facility
- Between Facilities
- Within the Team
- Clarify
- Verbally, Telephone
- Emails
- Interdepartmental

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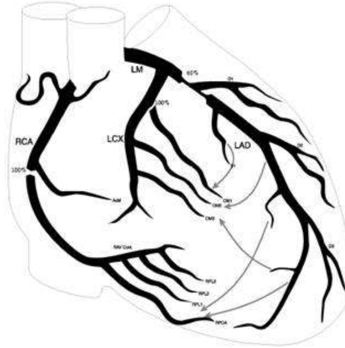
Introductions of Special Guest

- As a Person, a Patient : WE DO THIS WELL!
- Not by Results
- No by Numbers



Hemodynamics:

Right Heart Pressures

Resting:

	Systolic	Diastolic	EDP	a	v	m̄
RA				2	3	4
RV	20		4			
PA	20	2				10
PCW				5	8	4

Hemodynamic Profile:

	Profile 1
CO	6.48
CI	2.95
TPR	123
PVR	74
Technique	Estimated Fick

LHC 4/7/2020 & RHC 3/4/2022 after GDMT

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Patient and Family Perspective

April 2020 to February 2023 [***Nurse Care Manager***]

April 5, 2020 VT/VF Cardiac Arrest. Resuscitated at home by his wife

History of Cardiomyopathy, HTN, smoker (quit)
Cooled and recovered!
Dual Chamber ICD placement (Boston Sci) and CABG x3

April 2020 Discharged EF 18%

May 2020 Meet On phone: COVID time !!

October 2020 Advanced Heart Disease Clinic Cardiologist EF 28%
Medications: Metoprolol, Torsemide, Warfarin, Mg., Spiro, Atorvastatin …. Started Lisinopril

[Shannon tends to run low BP's and some symptoms –medication adjustments]

March 2021 Appointment Cardiologist: Prognosis discussion.
Consideration for advanced therapies EF 30%

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Medical Care Continues ….

[Working on Denial of coverage for CT scans,
Work release paperwork,
Scheduling and Coordinating,
Assessing & Managing Symptoms]

April 2021 Increasing feelings of Anxiety and Depression felt manageable and working full time.

[Calls weekly to assess Cardiac status and how managing]

Aug 2021 Passed out at work. Thought low BP to ER, sent home.
BUT - I had them do a Download
VT and ICD shock

8/18-22/2021 **Admitted:** Amio load due to VF. LHC for PCI to RCA

Sept 2021 Paperwork for Part Time work

[We are talking a couple times/week. Sometimes each day]

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Patient Experience continues…

Oct 2021 CPET. Consider Referral for OP Elective Tufts Transplant Eval

Nov 2021 Cardiac Rehab at Mt Ascutney

Dec 2021 Tufts Referral, started BB (Metoprolol) and ARB (Losartan)

[Jan-Mar/2022 Tufts Evaluation needs: Coordinating and planning CT, CXR, PFT's, Colo, Abdominal US]

March 2022 RHC. Hemodynamically therapeutic with current GDMT

March 2022 Transplant Eval. Distal 5cm AAA - Vascular studies/appts

[Care Management continued with Coordination of anticoagulation DC to ASA
Continues GDMT on Captopril, Metop Succ, Eplerenone, Torsemide prn, Amio for VT/VF]

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Autumn 2021 to Spring 2022

Oct 2021 CPET. Consider Referral for OP Elective Tufts Transplant Eval

Nov 2021 Cardiac Rehab at Mt Ascutney

Dec 2021 Tufts Referral, started BB (Metoprolol) and ARB (Losartan)

[Jan-Mar/2022 ***Tufts Evaluation needs: Coordinating and planning CT, CXR, PFT's, Colo, Abdominal US]***

March 2022 RHC. Hemodynamically therapeutic with current GDMT
March 2022 **Transplant Eval FOUND: Distal 5cm AAA** - Vascular studies/appts

[Care Management continued with Coordination of anticoagulation DC to ASA Continues GDMT on Captopril, Metop Succ, Eplerenone, Torsemide prn, Amio for VT/VF]

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Spring 2022 to now….

April 2022 Palliative Care Appointment: Major medical impacts on his life

April 5, 2022 **Tufts Appointment with Transplant Team**

April 18, 2022 **Tufts Presentation Tufts Listing status UNOS 6 NYHA class 2-3**

May 2022 AAA repair

August 2022 Tufts Follow-up: Continued testing ECHO, CPET

November 2022 CPET for continued evaluation of heart function for decisions of furthering advanced therapies.

Jan 2023 Entresto – F/U appt March 2023 !

[Care that Continues!]

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