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Heart Failure: Definitions, Guideline Directed Medical Therapy (GDMT), and Comorbidities

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January 2019

Introducing Your Faculty

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Brian Masterson, MD

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Objectives

At the end of this activity, participants should be able to:

- Identify current practices and recent advances in the management of Heart Failure (HF) based on evidence-based medicine.
- State best practices for HF management through the use of case study examples.
- Recognize when consultation with cardiologist is recommended.
- Explore potential medical ethical issues that may arise between the individual and health care provider (HCP).

Agenda

- Definition of HF
- Key Measures to Assess HF
- HF Classified by Ejection Fraction (EF)
- HF Stages and Functional Classes
- Treatment of HFpEF
- Clinical Case Part 1
- Common Causes of HF Exacerbation
- What Worse Looks Like
- Clinical Case Part 2
- Outbound Alert Call Parts 1 and 2
- Medications That Can Cause HFrEF Exacerbations
- Clinical Case Part 3
- Triggers for Referral to HF Specialist
- Clinical Case Part 4
- Common Psychiatric Disorders and HF
- Ethics and Existentialism
- Post-Discharge Follow Up Call Parts 1, 2, and 3

Overview

"HF is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood"

Cardinal Manifestations:

- "Dyspnea and fatigue, which may limit exercise tolerance
- Fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema"

Diagnostic Tests:

- "There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination"

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association. www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Section , 2. definition of HF

Overview

Clinical Syndrome May Result From:

- "Disorders of the pericardium, myocardium, endocardium, heart valves, or great vessels"
- "Certain metabolic abnormalities"
- "Most patients with HF have symptoms due to impaired left ventricular (LV) myocardial function"

Associated With:

- "HF may be associated with a wide spectrum of LV functional abnormalities, which may range from patients with normal LV size and preserved EF to those with severe dilatation and/or markedly reduced EF"
- "In most patients, abnormalities of systolic and diastolic dysfunction coexist, irrespective of EF"

Question 1

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Section, 2.definition of HF

Key Measures

Three key measures to assess with each HF patient:

1. **Ejection Fraction (EF)**
   - Left ventricular EF is important, as it determines our guideline directed medical therapy (GDMT) (aka EBM)
   - HF patients require different GDMT medications or interventions based on their EF

2. **New York Heart Association (NYHA) Functional Classification**
   - Assesses functional status and is key in understanding changes in your patients over time, especially after hospitalizations or health status changes

3. **Stage of HF**
   - Based on EF and symptoms, will guide interventions

Question 2

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Sections: 2.definition of HF & 3. HF Classifications

HF Classified by EF (ACCF/AHA)

Classification	EF %	Description
Heart Failure with Reduced Ejection Fraction (HF*r*EF)	≤ 40%	Also referred to as systolic HF. Randomized clinical trials have mainly enrolled patients with HF*r*EF and it is only in these patients that efficacious therapies have been demonstrated to date.
Heart Failure with Preserved Ejection Fraction (HF*p*EF)	≥ 50%	Also referred to as diastolic HF. Several different criteria have been used to further define HF*p*EF. The diagnosis of HF*p*EF is challenging because it is largely one of excluding other potential noncardiac causes of symptoms suggestive of HF. To date, efficacious therapies have not been identified.
HF*p*EF, Borderline	41% to 49%	These patients fall into a borderline or intermediate group. Their characteristics, treatment patterns, and outcomes appear similar to those of patient with HF*p*EF.
HF*p*EF, Improved	> 40%	It has been recognized that a subset of patients with HF*p*EF previously had HF*r*EF. These patients with improvement or recovery in EF may be clinically distinct from those with persistently preserved or reduced EF. Further research is needed to better characterize these patients.

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 3, Definitions of HFrEF & HFpEF

HF Stages and Functional Classes (ACCF/AHA)

HF Stages		NYHA Functional Classifications***	
Stage	**Description**	**Class**	**Description**
A	**Asymptomatic but at risk for HF** • Risk for developing HF: CAD, diabetes, hypertension, familial cardiomyopathy, chemotherapy, etc. • In this stage, there is no structural heart disease	**None**	Asymptomatic
B	**Asymptomatic HF, identified structural heart damage** • For HF*r*EF (EF ≤ 40%) only; Guideline directed medical therapy (GDMT) from ACCF/AHA 2013 apply • All other patients may benefit from these meds, but they are not GDMT supported for HF*p*EF or HF-borderline EF	I	No symptoms with ordinary physical activity • No physical activity limitations

***It is important to assess symptoms to determine NYHA Classification at engagement, and at least yearly, with the patient.

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 4, Comparison of ACCF?AHA Stages of HF

HF Stages and Functional Classes (ACCF/AHA)

Heart Failure Stages		NYHA Functional Classifications	
Stage	**Description**	**Class**	**Description**
C	**Symptomatic HF** • Guideline directed medical therapy (GDMT) from ACCF/AHA 2013 and 2016 Update Guideline for the Management of HF apply • GDMT will reduce mortality and unplanned admits in HF*r*EF	I	No symptoms with ordinary physical activity • No physical activity limitations
		II	Comfortable at rest; ordinary physical activity results in fatigue, palpitations, dyspnea or anginal pain • Some physical activity limitations
		III	Comfortable at rest; less than ordinary physical activity results in fatigue, palpitations, dyspnea or anginal pain • Notable physical activity limitations
		IV	Symptoms at rest; discomfort increases with any physical activity • Unable to perform physical activity without symptoms

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 4, Comparison of ACCF/AHA Stages of HF

HF Stages and Functional Classes (ACCF/AHA)

Heart Failure Stages		NYHA Functional Classifications	
Stage	**Description**	**Class**	**Description**
D	**Symptomatic HF limits basic activities of daily living** • Advanced end stage HF, cardiac output is markedly reduced EF <30%, and patients may receive specialized therapies such as IV inotropes, LVAD, or Transplant • In patients not eligible for these treatments, they can benefit from palliative care or hospice	IV	Symptoms at rest; discomfort increases with any physical activity • Unable to perform physical activity without symptoms

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 4, Comparison of ACCF/AHA Stages of HF

Treatment of HFpEF (ACCF/AHA)

Recommendations	COR	LOE
Systolic and diastolic blood pressure should be controlled according to published clinical practice guidelines	I	B
Diuretics should be used for relief of symptoms due to volume overload	I	C
Coronary revascularization for patients with CAD in whom angina or demonstrable myocardial ischemia is present despite GDMT	IIa	C
Management of AF according to published clinical practice guidelines for HFpEF to improve symptomatic HF	IIa	C
Use of beta-blocking agents, ACE inhibitors, and ARBs for hypertension in HFpEF	IIa	C
ARBs might be considered to decrease hospitalizations in HFpEF	IIb	B
Nutritional supplementation is not recommended in HFpEF	III: No Benefit	C

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 21, Recommendations for Treatment of HFpEF

Clinical Case, Part 1
Mrs. Jones: Patient in HF program for 11 months

- Mrs. Jones is a 74 year old woman with HF (EF 55% Dec 2017), COPD, oxygen 2L by nasal cannula at bedtime, she quit smoking 3 years ago (60 pack-years), DM 2, osteoarthritis hips, and HBP. She is followed by internist (PCP) and pulmonologist
- Medications: Furosemide 20 mg qd, Albuterol nebulizer qid, tioproprium 1 inhalation qd, metformin 500 mg bid, atorvastatin 20 mg qd, and amlodipine 5 mg qd
- She had her husband drive her to the ER on May 17, 2018, c/o increased shortness of breath (SOB), now can't walk 100 feet to mailbox without stopping, and productive cough x 3 days
- Physical Exam: T 99.8, BP 148/90, P108 regular, RR 24-28
  Lungs: Fair air movement diffuse wheezes. Cardiac: Regular rhythm, no significant murmurs. Lower Ext: w/o edema
- Lab notable for normal BNP, EKG sinus tach with no acute changes, CXR shows hyper expanded lung fields with no effusions
- Mrs. Jones was treated in the ER for exacerbation of COPD with solumedrol 125 mg iv, nebulizers and sent home on a tapering course of oral steroids, oral antibiotics, and her usual medications

Questions 3 & 4

Some Common Causes of HF Exacerbation

Coronary Artery Disease
New coronary ischemia (silent or with chest pain)

Hypertension
Poorly controlled BP is a cardiac strain

Valvular Heart Disease
Valves failing can lead to HF symptoms

Environmental Factors
Alcohol, stress, tobacco use, sodium intake, and medications

Arrhythmias
Patients with HF may develop a new rhythm disturbance (bradycardia, tachycardia, atrial fibrillation, etc.)

Respiratory Compromise/Hypoxemia
Due to COPD, pneumonia, pulmonary embolus, sleep apnea, or pulmonary hypertension from a number of causes

Non-Adherences
Not adherent to medications for HF and/or comorbidities which increase risk of HF

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, pp e-285

Clinical Case, Guest Speakers

Michelle D. Arnold, RN, CCM | Optum
Manager Heart Failure Program with Navigate4Me
OptumHealth Population Health Solutions

Stacey Tickle, RN, CCM | OptumHealth
Case Manager Heart Failure Program with Navigate4Me

"What Worse Looks Like"

Worsening Symptoms of HF Such as:

- New or worsening SOB with activity or when laying down
- New or worsening swelling in feet, ankles, legs, or abdomen
  - Clothes tighter than usual
  - Can't fit into shoes
- New or worsening fatigue or weakness in arms/legs making normal tasks harder (walking to mailbox, stairs, standing to make a meal)
- New or worsening weight gain (+/- 5 lbs across 3 readings)
- New or worsening cough / wheeze
- Nausea / lack of appetite
- New or worsening confusion or memory loss

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Table 6, History and Physical Examination in HF, and JA, Biometric Device Process, Section 15

Clinical Case, Part 2
Mrs. Jones: Patient in Denial

- Her RN CM confirmed timely follow up with her PCP and her pulmonologist. By June, 1 month after ER visit, she is back to her baseline and able to walk 8 blocks with minimal SOB.
- In September 2018, Mrs. Jones began to notice exertional chest pain with walking associated with SOB. She didn't mention this to her husband or RN CM, and when using remote patient monitoring (RPM) tablet she didn't answer the questions about SOB accurately.
- By November 2018, she couldn't walk out to the mailbox without getting SOB, and found that an extra nebulizer treatment didn't help relieve this. She also noticed that her feet were swelling, and clothes fitting more tightly around her belly than usual.
- She started answering SOB questions more accurately. Her RN CM received an alert, and contacted the patient.

Outbound Alert Call, Part 1

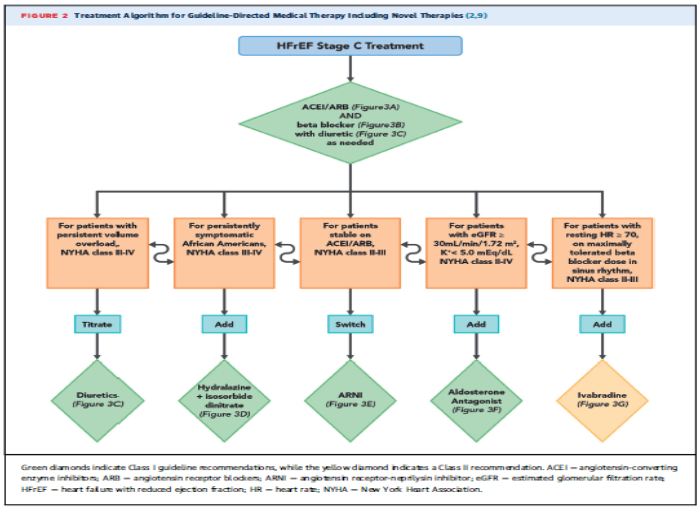
- **Case Manager (CM):** Good Morning Mrs. Jones, this is Michelle, **your Heart Health Registered Nurse.** Is this a good time to chat for a few minutes?
- **Mrs. Jones:** Oh, hi Michelle, it sure is. I always look forward to my calls with you.
- **CM:** Oh, thanks… I feel the same way! You know though, I got your responses from the tablet in this morning and I thought we should talk about some of those symptoms you reported.
- **Mrs. Jones:** Well, yeah, I guess I should tell you that I have been feeling this way for a while now, but I just didn't say so on the tablet. I know that tablet is for my heart symptoms. I didn't mark down my breathing trouble since it was just my COPD acting up again and not my heart. But, you know, it's been going on for a while now and it's just not been getting any better…guess I thought I'd better let you know.
- **CM:** Well, I am glad you did, Mrs. Jones. I see you have checked off that you are more short of breath than usual both at rest and with activity. Also, you have some increasing swelling in your feet and ankles. Is that correct?
- **Mrs. Jones:** Yes. I'm having an awful time. My inhaler is just not doing its job anymore. I'm so short of breath, I just wanna sit in my recliner all day with my feet up. I can't even make it to the mailbox anymore without huffing and puffing and needing to rest. Sometimes my breathing is so bad when I walk to the mailbox that my chest even starts to hurt and I have to stop until the pain passes!
- **CM:** Oh Mrs. Jones…! You certainly have been having a time of it, and these are worsening symptoms that we need to look more closely at. You know, sometimes it's really hard to tell when the symptoms are related to your COPD or your heart. We want you to use the tablet for the symptom, not for what you think it might be related to. Are you having any pain or difficulty breathing right now?
- **Mrs. Jones**: Ok, Michelle. I understand. And I am fine right now. I'm just sitting here watching Price is Right. So, do you think this is my heart acting up and not my COPD?

Question 5

Outbound Alert Call, Part 2

- **CM:** Well, let's talk a little more about the breathing. Are there any times when you notice it being better or worse?
- **Mrs. Jones**: Yep, it is for sure worse when I do anything, but even resting I feel like I can't quite catch my breath.
- **CM:** And the CP? Can you tell me where and when that happens?
- **Mrs. Jones**: Well, it's always when I am walking and getting short of breath, and it's always sharp and on the left side of my chest . But it goes away when I can catch my breath, so I think it's probably nothing.
- **CM:** Are you still taking all of your medications… including the water pill?
- **Mrs. Jones:** Indeed I am young lady.
- **CM:** Ok, here is where we are: You have actually been gradually gaining some weight over the past 3 weeks that I suspect is water weight. You answered that your clothes were tighter and your feet & ankles are swollen…plus, your breathing is not responding to your inhalers AND on top of all that, we have a new onset of some chest pain with activity. It's time to share all this with your doctor and figure out just what is going on here.
- **Mrs. Jones:** Ok, Michelle, I trust your judgement.
- **CM:** So stay on the line with me while I put in a call to your doctor's office.

Guideline Directed Medical Therapy (GDMT) for Stage C Heart Failure Reduced EF (HFeEF) and NYHA Class 2-4



Journal of the American College of Cardiology, 2017 ACC Expert Consensus Decision Pathway, www.fmda.org/Journal/OptimizationofHFTreatment.pdf, Figure 2

Clinical Case Part 3: Urgent Appointment with Dr. Kildare

- After warm conference call: Talking with Dr. Kildare's nurse, appointment made for that afternoon, 2PM.
- History: Intermittent chest pain with exertion x 2 months with progressive SOB even at rest not responding to albuterol inhaler.
- Physical Examination
  - Vital signs (VS) revealed T 98.1, BP 172/98, P 116 irregular, RR 28, and weight 172 (increased 14 lbs since visit 4 months ago), Oxygen saturation room air 85%
  - Lungs: Fair air movement bilaterally with bibasilar rales and diffuse wheezes
  - Cardiac: Irregular rhythm, no significant murmurs
  - Lower ext: 2+ pitting edema to mid shins bilaterally
- EKG reveals afib with new anterolateral q waves and ST depression consistent with previous (not acute) anteroalateral myocardial infarction
- CXR reveals changes consistent with moderate pulmonary edema.
- Mrs. Jones was admitted directly from Dr. Kildare's office with heart failure. Cardiology consultation obtained, and echocardiogram demonstrated EF 35% with moderately decreased anterolateral wall motion, no significant valvular abnormalities.
- Mrs. Jones was treated with iv furosemide with 15 lb weight loss during 2 day stay. She was started on carvedilol and lisinopril with excellent control of BP, able to walk independently without assistive device over 100 ft. with minimal SOB. She was D/C home on carvedilol 6.25 mg bid, lisinopril 10 mg qd, furosemide 20 mg qd, albuterol nebulizer qid, titraproprium 1 inhalation qd, metformin 500 mg bid, Eliquis® 2.5 mg bid, and atorvastatin 20 mg qd. amlodipine was D/C.

Questions 6 & 7

Triggers for Referral to HF Specialist: Use the Acronym I-NEED-HELP.

- **I:** **I**ntravenous inotropes
- **N:** **N**ew York Heart Association (NYHA) class IIIB/IV or persistently elevated natriuretic peptides
- **E:** **E**nd-organ dysfunction
- **E:** **EF** ≤35%
- **D:** **D**efibrillator shocks
- **H:** **H**ospitalizations >1
- **E:** **E**dema despite escalating diuretics
- **L:** **L**ow systolic BP ≤90, high heart rate
- **P:** **P**rognostic medication-progressive intolerance or down-titration of guideline-directed medical therapy (GDMT)

2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction, www.onlinejacc.org/content/71/2/201, Figure 4

Medications That Can Cause HFrEF Exacerbations

"Drugs known to adversely affect the clinical status of patients with current or prior symptoms of HF*r*EF are potentially harmful and should be avoided or withdrawn whenever possible." *Text reprinted with permission of the American Heart Association*

- Nonsteroidal anti-inflammatory drugs {NSAID}, such as Advil® (Ibuprofen):
  - Increase fluid retention leading to worsening of HF by reducing flow through the kidney
  - Many patients do not report over the counter NSAID use to their provider. ***This is an opportunity for patient education and to notify NSAID use to the provider's attention.***
- Most antiarrhythmic drugs (such as Cordarone® {amiodarone}, Tambocor ® {flecainide})
- Most calcium channel–blocking drugs (except Norvasc® {amlodipine})
- Actos® (pioglitazone)

2013 ACCF/AHA Guideline for the Management of Heart Failure: American College of Cardiology/American Heart Association. Text reprinted with permission of the American Heart Association, www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776, Class III: Harm

Clinical Case (Part 4):Mrs. Jones Follows Up with Dr. Kildare Post Discharge

- Mrs. Jones follows up with Dr. Kildare 1 week after hospital discharge. She notes she is feeling better than she has in several months, now able to walk 2 blocks from home and back.
- Mrs. Jones does note with increased walking that her R hip is painful, and has started taking ibuprofen 200 mg 2-3 tabs bid prn. Otherwise she is taking medications as instructed at time of discharge.
- Physical Examination:
  - VS revealed T 98.2, BP 130/82, P 68 regular, RR 18, and weight 161 lbs. (decreased 11 lbs. since visit 10 days ago when directly admitted)
  - Lungs: Fair air movement bilaterally without wheezes, rales
  - Cardiac: Regular rhythm, no significant murmurs
  - Lower ext: Trace pedal edema bilaterally
- Follow up
  - Dr. Kildare explains to Mrs. Jones that he is going to refer her to the cardiologist he works with, Dr. Welby to advise regarding further evaluation and treatment of heart failure.
  - 1 month office visit with Dr. Kildare

Question 8

Behavioral Health Paradigm for Evaluation

- Biological
  - Genetic predisposition and Exposures
  - Medical Causes of Brain Dysfunction
    - Rule out the WHIMP (**W**ernicke's: **H**ypo's & **H**yper's (K+, Ca++, Thyroid, etc.) & **H**IV; **I**nfections & **I**ntracranial events; **M**etabolic & **M**etastases; **P**oisonings & drugs
- Psychological
  - What are the rules we learned along the way?
- Social
  - What are the interactions?
  - What are the social determinants?
- Community and Health Systems
  - What are the complexities to getting care and assistance?

Kathol RG, Perez R, Cohen JS. C, *The Integrated Case Management Manual*, Springer Publishing Co, NY, 2010.

Common Psychiatric Disorders

- **Depression:** Symptoms should be at least two weeks in duration, hallmark symptoms are low mood and anhedonia, followed by the SIGECAPS (**S**leep, **I**nterest in pleasurable activities, **G**uilt/remorse, **E**nergy/ fatigue, **C**oncentration/Focus, **A**ppetite, **P**sychomotor retardation/agitation, **S**uicidal)
  - 20-35% prevalence (4-5% higher than general population)
  - Possible etiologies: nervous system dysfunction, Inflammation, arrhythmias, altered platelet function
  - No correlation of depression treatment and altered course of HF outcome
- **Anxiety:** "Sense of impending doom," may be existential in nature
  - 28% prevalence (10% higher than inpatient psychiatric patients)
  - Possible etiologies associated with effects of catecholamine excess
  - Treatment with benzodiazepines may inhibit platelet aggregation and raise ventricular fibrillation threshold
- **Delirium:** Acute mental status change with disorientation, lability, distorted perceptions
  - 3-72% prevalence (10% higher than inpatient psychiatric patients)
  - Multiple factors account for presentation – premorbid medical issues, meds and environment
  - Treatment depends on the cause, Haldol is most commonly used agent to control symptoms in hospital

Stern TA, et. al., *Handbook of General Hospital Psychiatry*, 7th Ed., Chapter 26, Elsevier, 2018.

Common Psychiatric Disorders

- **Insomnia:** Multiple causes – sleep hygiene needs evaluation
- **Suicidal Ideation:** A psychiatric emergency – don't be afraid to ask about thoughts of self-harm – you won't give the person ideas
- **Assaultive Behavior**: Intentional or unintentional – always make sure you have an unobstructed exit
- **Treatment Refusal and Capacity:** Capacity is the ability to understand and articulate the ramification of one's decisions

Stern TA, et. al., *Handbook of General Hospital Psychiatry*, 7th Ed., Chapter 26, Elsevier, 2018.

Ethics and Existentialism

- **Autonomy**: The right to make own decisions
- **Beneficence:** Do good
- **Non-maleficence**: Do no harm
- **Distributive Justice:** Wise use of limited resources
- **Mortality**: As a human, there is only one certainty
- **Self Worth:** What is our legacy
- **Connectedness**: We are sociable
- **Freedom:** The right to make own decisions, with accountability for them

When all else fails talk to the patient.
Be where the patient is.

Question 9

Post Discharge Follow up Call Part 1

- **CM:** Hi Mrs. Jones, it's Michelle again from the Heart Health Program. How are you today?
- **Mrs. Jones:** Oh, hi Michelle. It's good to hear from you. I'm doing better since we found out that my symptoms were a mix of both COPD and Heart Failure. I never would have guessed that. I'm so glad I started answering those questions right and you knew that we needed to talk to my doctor. You know, I'd had a heart attack and didn't even know it??? I still can't believe that!
- **CM:** Well, our bodies are complicated and we have to listen when they give us clues. I'm glad we were able to get you back on track again. So, when I spoke to you after your discharge, we discussed some of the new medications that you were prescribed for your heart failure. Are you still taking the carvedilol, lisinopril, and furosemide?
- **Mrs. Jones:** I most certainly am. I don't want to go back to feeling like I did before I was admitted.
- **CM:** Agreed….and staying adherent to your medications is one of the most important things you can do for your health. So how are you feeling today?
- **Mrs. Jones:** Well, I'm not short of breath or anything like that, but my darn hip is bothering me something awful. Now Dr. Kildare has told me that he wants me to get up and walk around the block each day, but my left hip is giving me all sorts of problems.
- **CM:** Oh, no. I'm so sorry. Have you spoken to the doctor about it?
- **Mrs. Jones:** Yes, when I saw him the office for the first time after being in the hospital. Ibuprofen helps most of the time, but the doctor told me now that I have these heart problems I can't take that and to try Tylenol instead. Last year he told me that Ibuprofen would be good for my arthritis. This is just all getting to be too much. I try and try to follow all the instructions, but it's hard. I have to watch my salt and fluid intake, take more medications, get my exercise, weigh every day. How am I going to get my walk in with that darn hip? It seems all I do now is worry about my health.

Question 10

Post Discharge Follow up Call Part 2

- **CM:** I hear you, Mrs. Jones. I know you have had a lot of change recently. Incorporating so much in so short of a time is a lot to adjust to.
- **Mrs. Jones:** Oh, Michelle, yes. I'm just so overwhelmed. I want to follow all the instructions, but it's hard. And I just can't do the things I did 10 years ago. I feel like I either cry a lot or get so nervous I don't know what to do.
- **CM:** Well, let me ask you a couple of questions here…
- PHQ question 1. Thinking back over the past couple of weeks, how often have you found that you have had little interest or pleasure in doing things?
- **Mrs. Jones:** Oh sometimes I guess, but I still like getting outside and tending my garden when the weather is good.
- **CM:** PHQ question 2. Ok, Mrs. Jones…During that same time, how often have you felt kinda down or depressed ?
- **Mrs. Jones:** …Oh, just about every day, Michelle. I just want to roll the clock back and feel like I used to without always worrying about my breathing or my heart.
- **CM:** Thanks for letting me know that Mrs. Jones… now does Dr. Kildare know how you've been feeling?
- **Mrs. Jones:** Oh, no! I couldn't bother him with my feelings. He's a busy man. He doesn't have time for that.
- **CM:** Well, actually, Mrs. Jones, this is very important to talk to Dr. Kildare about. Your doctor cares just as deeply for your emotional well-being as well as your physical well-being. If you are feeling discouraged or down, it's harder to motivate yourself to make healthy choices and stay on track with your treatment plan. That could lead to a change in your condition that may even lead to a hospital admission! No one wants that for you!

Post Discharge Follow up Call Part 3

- **Mrs. Jones:** Well, I guess I had not thought of it that way.
- **CM:** So, I know you have an appointment soon with Dr. Kildare. Do you think that this is something you can talk about with him? Just let him know that you are feeling down and discouraged. And be truthful about how much that worry is impacting you. Can you do that?
- **Mrs. Jones:** I will, I promise.
- **CM:** Wonderful: I'm going to call you the day after your appointment to see how the conversation went. By the way…we also have a fabulous behavioral health team that is available to speak with you regarding the way you have been feeling. Are you up for that?
- **Mrs. Jones:** Yeah, I'll give that a try too. I really want to feel better!
- **CM:** Wonderful…here is what I am going to do:
  - I'll put in a referral to Behavioral Health to have someone give you a call
  - In the meantime, you chat with Dr. Kildare and I will call you back after your visit!
- **CM:** Does that sound like a good plan?
- **Mrs. Jones:** Yes, I can do this! Thank you so much, Michelle.

Lago Atitlan, Guatemala: Hands of Healing Missions
October 2014, 2015, 2016, April 2018 and Planned October 2019

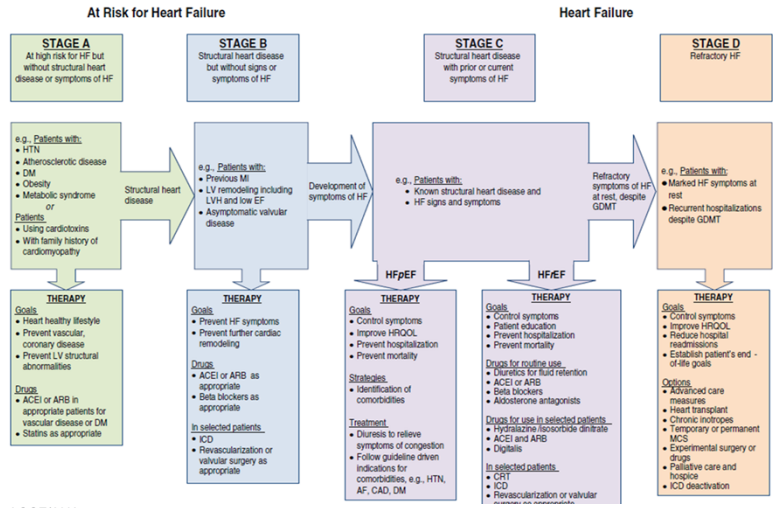
OPTUMHealth™
Education

Questions from the Audience

APPENDIX

Appendix: Managing Co-morbidities in HF

Required throughout the progression of illness



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