HEART FAILURE SERVICE MAP

Objective

Clinician tool to support patient care through lifestyle behaviour modification so patients can self-manage their condition

Refer

Family Physician (FP) refer to their Neighbourhood Nurse (NN) or Nurse in Practice (NIP)

Assess

Clinician contacts the patient to arrange initial in-person appointment

Assess understanding and management of their Heart Failure
Conduct a patient review at each visit using the Heart Failure Zones ☑

Initial Appointment (in-person)

Newly Diagnosed

During appointment, clinician can:

- Discuss purpose of appointment (i.e. referral reason), and consult with patient to determine what they want addressed
- Review Heart Failure diagnosis & Heart Failure Zones with patient ☑
- Co-develop a self-management plan
- Recommended referral to Heart Function Clinic
  - Offers heart failure education and care
  - *Eligibility:* Established heart failure of any etiology with an LVEF < 40%; LVEF . 40% with sign's and/or symptoms of heart failure, with an elevated BNP or NT-PRO-BNP
  - Referral to be completed by FP/NP
  - *Wait* :
    - New Dx & Unstable/Post MI HF/Post hospitalization HF/Progressively worsening HF ~ 2 wks
    - New Dx & stable/HF with symptoms but not decompensated ~ 4wks
    - Chronic heart failure management ~ 6wks
    - Patient Brochure ☑
- Identify relevant resources for patient to review on resource list
- Email or provide physical copies of each recommended resource

Communicate back with FP regarding visit

Mild / Moderate

During appointment, clinician can:

- Discuss purpose of appointment (i.e. referral reason), and consult with patient to determine what they want addressed
- Review Heart Failure Zones ☑
- Consider referral to Heart Function Clinic for education and/or medication optimization
  - (See Newly Dx box on left for full criteria)
- Co-develop a self-management plan with patient
- Identify relevant resources for patient to review on resource list
- Email or provide physical copies of each recommended resource

Communicate back with FP regarding visit

Acute / Exacerbation

Clinician to contact patient to set up initial appointment within **24 hours**

During appointment, clinician can:

- Use the Heart Failure Assessment Tool
- Review the Heart Failure Zones ☑
- Co-develop a self-management plan
- Identify relevant resources for patient to review on resource list
- Email or provide physical copies of each recommended resource

Communicate back with FP regarding visit

If visit with FP is deemed necessary, connect with FP right away and discuss booking patient in for an appointment

Discuss with FP their preference for continued follow up

- Suggest clinician continue to follow up with patient until they are back in Green of the Heart Failure Zone ☑

Follow-up Appointments (virtual/phone)

During follow up appointment(s), clinician can:

- Follow up to see if the patient has been contacted by referral site OR
- Follow up with patient after completion of the service from referral site
- Review the self-directed material sent, and address any questions
- Check in on patient's compliance with self-management plan
- Discuss next steps in their self-management plan (i.e. continued exercise plan, compliance with daily weigh ins etc.)

Communicate back with FP regarding visit(s)

Appointment will take approximately: 10 - 15 minutes

Discuss with FP on number of follow up visits. Number of follow up visits at discretion of clinician.

Let patient know during last visit if any new concerns or needs arise to connect with their FP.

During appointment(s), clinician can:

- Use the Heart Failure Assessment Tool during the appointment
- Review the Heart Failure Zones with patient ☑
- Review the self-directed material sent, and address any questions
- Discuss next steps in their self-management plan (i.e. continued exercise plan, compliance with daily weigh ins etc.)
- Check in on patient's compliance with self-management plan

Communicate back with FP regarding visit(s)

Appointment will take approximately: 15 - 20 minutes

Discuss with FP their preference for continued follow up. Suggest follow-up occur within 2-3 days after initial apt.
Suggest clinician continues to follow up with patient until they are back in the Green of the Heart Failure Zone ☑

Number of follow up visits at discretion of clinician.

Let patient know during last visit if any new concerns or needs arise to connect with their FP.

Other PCN & Indigenous Referrals

If there are *mild* mental health and/or psychosocial issues raised during assessment, refer to Mental Health Service Maps (Anxiety Service Map / Depression Service Map), or consider Sources referral for counselling, and commincate back to FP.

If there are *significant* mental health and/or psychosocial issues raised during assessment, refer to Mental Health Service Maps (Anxiety Service Map / Depression Service Map), discuss case with Neighbourhood Social Worker (NSW), and communicate back to FP (faciliate a follow-up with FP as appropriate).

If the patient is facing significant financial concerns, and is a potential candiate for support, discuss case with NSW.

Consider Pharmacist referral in the following cases (after discussion with FP):

- Patient is on 8+ medications
- Patient is on opioid/benzodiazapine combination
- Experiencing side effects

*Before referral to Pharmacist, check if patient has recently been reviewd by Specialized Seniors Service

For Indigenous specific services, contact the Aboriginal Health Liaison (1-866-766-6960)

HEART FAILURE SERVICE MAP
CLINICIAN RESOURCES

Self Management Resources

SELF-DIRECTED RESOURCES

Living With Heart Failure
Full Resource Booklet
Video

Understanding Heart Failure ☑

Heart Failure Zone ☑

Daily Weight Information & Tracker

Limiting Fluid When you have Heart Failure ☑

Limiting Sodium (salt) when you have Heart Failure ☑

Foods High in Potassium

Benefits of Physical Activity & Exercise

Depression

Stress

Anxiety

Travelling when you have Heart Failure

Medications

- Angiotensin converting enzyme (ACE-I)
- Angiotensin II receptor blockers (ARBs)
- Angiotensin receptor neprilysin inhibitor (ARNI)
- Beta blockers
- Digoxin
- Diuretic (water pill)
- Herbal medication
- Ivabradine
- Mineralocorticoid receptor antagonist (MRA)
- Nitrate and hydrazine
- Warfarin

Smoking Cessation

Smoking Cessation Clinic at JPOCSC ☑
- Free 12 week group program that guides patients to become smoke-free through education, behavioural support and counselling
- *Eligibility:* Anyone looking to quit or reduce tobacco use
- Referral to be completed by FP/NP
- *Wait:* Several months (runs 1x per quarter)

QuitNow BC ☑
- Free program for individuals looking to quit or reduce tobacco and e-cigarette use. Offers personlized quit-smoking plans, one-on-one coaching, group support by phone, chat, email and video conferencing, and an online discussion form.
- *Eligibility:* Patient looking to quit or reduce tobacco and/or e-cigarette use
- *Referral Options:*
  - Self-refer AND Health Professional can refer
    - Online or Fax referral form to 1-888-857-6555
- *Wait:* None

PROGRAMS

Health Heart Program - Cardiac Rehabilitation ☑
- Helps patients manage their well-being through weight management, smoking cessation, stress reduction and exercise therapy. Services include heart health screening, counseling and education to support cardiac risk reduction and rehabilitation.
- *Eligibility:* STEMI/NSTEMI/US or CAD; CABG/Valve surgery; Heart Failure; PVD; Arrhythmia
- Referral required by FP/NP
- *Wait:*
  - Peace Arch Hospital: ~ 1 week
    - Languages offered: English
  - Jim Pattison Outpatient Centre: Intake ~2 weeks
    - Languages offered: English, Punjabi & Chinese

PEER SUPPORTS

Heart & Stroke Online Peer Support Group

Patient Experiences - HeartLife Foundation (video)

Clinician Resources

Heart Failure: Management & Support FHA Learning Hub Course #10892

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