Coordinated Care to Help Manage Congestive Heart Failure (CHF)

With our accountable, coordinated care model, KelseyCare helps patients with chronic congestive heart failure (CHF) better manage their condition. CHF care management includes personalized outreach to involve patients in making healthier lifestyle choices and assuring proper follow-up with their primary care physicians, Kelsey-Seybold cardiologists, and other specialists as needed. Our case managers are registered nurses who share the same electronic medical record as our doctors.

Clinical resources for patients with CHF include:

- **The Kelsey-Seybold electronic medical record (EMR):** The EMR allows Kelsey-Seybold physicians to coordinate care with a full picture of a patient's recent test results, best practice alerts, and compliance monitoring.
- **Online resources:** With their secure MyKelseyOnline accounts, patients can email their doctors' offices, check most test results, and schedule appointments.
- **After-Hours Nurse Hotline:** Patients can call 713-442-0000 after regular business hours, on weekends, and on holidays to speak to a Kelsey-Seybold registered nurse. The after-hours nurse can answer questions, page the doctor on call, and schedule appointments.
- **Access to Kelsey-Seybold cardiologists:** No referrals are required to see a Kelsey-Seybold specialist in Cardiology. Depending on the class of CHF, the patient's treatment plan and care will involve the primary care physician and cardiologist, both of whom have access to the patient's EMR.

The CHF Care Management team includes:

- The patient's primary care physician (PCP).
- CHF nurse case manager.
- Access to Kelsey-Seybold cardiologists with no referrals required.

The physicians, case managers, and nurses on the care team share a common EMR system to ensure coordinated care.

By the numbers: Heart disease is the No. 1 killer of Americans. That's why Kelsey-Seybold's primary care physicians and cardiologists also act as prevention specialists who counsel patients on lifestyle strategies to lower the risk of congestive heart failure.

How Congestive Heart Failure Care Management Works

Step 1

We identify patients who have CHF and personally reach out to them.

Using our EpicCare electronic medical record (EMR), we identify patients who are diagnosed with congestive heart failure (CHF). CHF patients are required to have an echocardiogram once every five years. They are also required to have visits with their primary care physicians, or cardiologists every six months. The nurse case managers review their EMR to assure patients are compliant with the recommended guidelines and personally reach out to patients to schedule any needed testing or office visit.

Step 2

We help patients make healthier lifestyle choices.

The patient's primary care physician (PCP) or cardiologist and the nurse case manager help guide the CHF patient o make positive lifestyle changes. This includes tobacco cessation, switching to a low or no-salt diet, keeping an eye on potential fluid retention, and taking prescribed medications.

Step 3

The goal is to help prevent loss of function.

We make sure our patients see their PCPs or cardiologists twice yearly and follow the physicians' prescribed treatment plans. We encourage patients to weigh themselves daily to help manage their weight. The goal is to help keep symptoms from progressing to an advanced stage with severe limitations.

Classes of Congestive Heart Failure*

Class 1 (normal): Few observable symptoms, no limitations in ordinary physical activity.

Class 2 (mild): Mild observable symptoms and slight limitation during ordinary activity. Comfortable at rest.

Class 3 (moderate): Marked limitation in physical activity due to symptoms even during less-than-ordinary activity. Comfortable only at rest.

Class 4 (severe): End-stage heart failure. Severe limitations. Experience symptoms even while at rest.

*Source: National Institutes of Health