Guidance for Using
Caring for your Heart: Living Well with Heart Failure
Educational Material

Background

We developed this education material for a research study designed to test the effectiveness of two different approaches for helping patients of all literacy levels to manage their heart failure. This document briefly reviews the research study theory and protocol and makes accessible the procedures, scripts, and forms that we devised for the study. You may use any or all of the supporting documents listed below or you may decide to develop ones that better suite your situation. However you decide to incorporate this material into your patient education component, we hope that the guidance here will give you insight into how to deliver the education so that it successfully teaches patients not only the facts regarding managing their heart failure but also helps them achieve the long standing behavioral changes they will need to control their disease and minimize the chances of hospitalization due to exacerbation.

Materials Overview

The literacy sensitive education materials focus on four areas of self-care for Heart Failure. The materials review the following topics:

- How to Take your Medications
- How to Eat Less Salt
- Exercising Well with Heart Failure
- Daily Check-Up and When to Call

The materials are available in English and Spanish, and will easily fit into a 1" binder. You may put your organizational logo on the material in a 2" x 2" area on the front cover and/or back cover but do not remove any of the credits.

Study Overview

All of the participants in our study received a binder containing the education material and a digital scale. Each participant took part in a 40-minute education session to review and discuss the self-care information in the education materials and learned how to use the digital bathroom scale we provided. At the end of this session, the participants in the control group completed the meeting with a brief summary of the information discussed and received no further education or follow-up from the study team. The participants in the intervention group received an additional 20-minute education session about diuretic self-adjustment and daily record keeping for weight and medication administration. In addition, over the course of the next year, the intervention participants received an average of 20 phone calls from the study educator following the teach to goal protocol. The purpose of these calls included:

- Monitoring patient safety
- Confirming patient understanding and reviewing knowledge about self-care for their heart failure
- Promoting program adherence

- Offering encouragement and addressing barriers to behavior change

Outcome data from this study will be available in late 2011. A paper detailing the study protocol is available at: http://www.biomedcentral.com/1472-6963/9/99

This study was modeled after a pilot study that showed benefits in reducing hospitalizations. These results are available at: http://www.biomedcentral.com/1472-6963/6/30

Rationale for using the Teach To Goal (TTG) Protocol

During the education session, each patient has an opportunity to review and discuss a variety of information related to heart failure. **Our experience shows that it takes repetition and reinforcement for patients to learn new skills and to integrate new behaviors into their life.** Therefore, for those patients in the intervention group we used the TTG protocol because it represents a method for overcoming the integration of complex self-management into daily practice. After the initial education session, the educator conducted structured telephone follow-up using a script and log to assess the patient's understanding of key self-management topics. If the patient demonstrated correct understanding of a topic on two different calls then they have mastered that topic and the time on subsequent calls is spent discussing other topics until mastery is achieved.

Using the Education Materials

The education material covers a range of information and was designed to be used during an in-person education session. Because this material includes guidance on several topics related to heart failure, **providing follow-up to confirm understanding and repeat key information will be essential to promoting retention.** Therefore, when using these materials with your patients we recommend some form of follow-up such as telephone calls and/or in-person sessions during a visit to the clinic. This follow-up should focus on 1-2 topics at a time and confirmation of the understanding of this information should also be incorporated. This is an essential part of the full program particularly if you include diuretic self-adjustment.

The modular feature of these materials provides you with some flexibility about what aspects of the program you will cover with your patients. Therefore, we suggest that you consider the following information when assessing how to use these materials in your practice.

1. Education Session

The educator should be familiar with the materials as well as basic concepts about heart failure and use of diuretic medications. In addition, we suggest educators become familiar with literacy related barriers and strategies for effective communication. The following resources may be helpful:

- Guide for Delivery of the Initial In-Person Education Session
- The Heart Failure Society of America has several education modules available to learn about various aspects of heart failure. http://www.hfsa.org/heart_failure_education_modules.asp

- Health literacy and patient safety: Help patients understand" a video from the American Medical Association (23 minutes) http://www.ama-assn.org/ama/no-index/about-ama/8035.shtml

2. Patient Follow-up

After the initial session, patient follow-up is recommended. More immediate and frequent follow-up (within 1 week) is advisable if diuretic self-adjustment is included in the session. If self-adjustment is not taught, less frequent follow-up (weekly or semi-weekly at first) is beneficial to ensure that the patient knows what to do for self-monitoring and worsening heart failure related symptoms. The amount of follow-up provided for other self-care topics depends on the resources available. Follow-up can be provided using different methods including telephone calls and/or meeting before or after clinic visits.

- Guide for Follow-up Telephone Calls

  This provides the study protocol for phone calls made to patients in the intervention group.

3. Clinician Support

Clinicians and staff involvement are important in supporting the (1) educators as they educate patients and (2) patients as they manage their heart failure.

Education staff will need to work with the clinicians to identify and assess potential patients. In addition, the clinicians should be familiar with the terminology and guidance listed in the manual regarding daily assessment of symptoms and when to call. Thus providing reinforcement during clinic visits and responding to patient calls about worsening symptoms is critical to its success.

Refer to Heart Failure Patient Clinical Assessment for a list of information that is needed by the educator from the clinician prior to the education session:

4. Diuretic Self-Adjustment

In addition to the information listed above, including diuretic self-adjustment teaching requires an additional level of support and follow-up from the education and clinical staff. Furthermore, it is important to discuss the requirements with each eligible patient and ensure they are aware of the requirements and are willing to participate. It is likely that self-adjustment is not a suitable strategy for all of your patients and thus you can offer it when appropriate. When including diuretic self-adjustment education for a patient, we recommend that you educate and support the patient's use of the Daily Water Pill Plan (Spanish) for tracking weight and medication.

Clinical staff responsibility:

- Review and approve of each patient's participation (self-adjustment may not be appropriate for all patients)
- Review and approve diuretic self-adjustment protocol for each patient, see Diuretic Adjustment Algorithm
- Assess fluid status and diuretic dosing at each clinic visit

- Communicate any changes in diuretic dosing or related treatment goals with the staff providing patient follow-up.

Education staff responsibility:

- Confirm patient's understanding of self-adjustment process
- Confirm patient' ability to obtain a reliable weight each day
- Set a Target Weight – refer to Guidelines for Setting a Target Weight
- Prepare and update the patient's Water Pill Guide (Spanish).
- Provide telephone follow-up with the patient to assess and confirm patient understanding and knowledge about diuretic self-adjustment and other self-care behaviors. For suggested call frequency, see Guide for Follow-up Telephone Calls.
- Recognize patient safety issues and have awareness about appropriate guidance and when follow-up with a clinician is needed.
- Develop system for documenting patient information, reviewing completed daily water pill plans and providing follow-up with patient and clinical staff as needed.

Patient Responsibility:

- Access to a working telephone
- Access to a reliable scale at home.
- Ability to use a consistent method to obtain daily weight.
- Follow diuretic dosing instructions as per water pill guide.
- Complete daily water pill plans and submit as instructed.
- Telephone clinician as indicated.

Complete list of Patient Educational Materials, forms and guidance for the Caring for Your Heart: Living Well with Heart Failure Program:

The following is a complete list of the patient educational documents and educator forms and procedural documents made available in this guidance with a brief explanation of what they contain

- Education Materials:
  1. Version 1 (Spanish) – Patient education materials with no diuretic self-adjustment (30 pages)
  2. Version 2 (Spanish) – Patient education materials with diuretic self-adjustment (31 pages)

- Supplemental resources for the initial patient education – The following are documents used to explain and support the initial education session. You will find documents a-f listed within document 1 with an explanation of when and how to use them. Document a contains links to the 2 document listed below it.
  1. Guide for Delivery of the Initial In-Person Education Session – This is an educator script for conducting the initial education session. This includes an option to deliver the education with the diuretic self-adjustment component or without.

a. Heart Failure Clinical Assessment – This educator worksheet is to be filled out by the patient's physician collecting important information needed for the education and diuretic self-adjustment.
    1. Diuretic Adjustment Algorithm – This algorithm offers guidance to the educator or clinician on determine the diuretic adjustment dosage for patients.
    2. Assessing Volume Overload in Heart Failure Patients This document gives guidance to educators and clinicians on assessing a patient's euvolemic status
b. My Daily Medications (Spanish) – This is an easy to understand chart to be used by patients to organize their daily medications.
c. Guidelines for Setting a Target Weight – This provides guidance and considerations for educators when setting a patient's target weight.
d. Water Pill Guide (Spanish) - This chart is to be filled in by the educator and instructs the patient on how to adjust his/her diuretic according to their weight.
e. Daily Water Pill Plan (Spanish) – This weekly log is to be copied several times and handed to patients so they can record their weight and diuretic doses every day.
f. Patient Contact Sheet – This form helps educators record patient contact info and notes from the initial in-person education session.

- Supplemental resources for providing the follow-up contacts – The following documents can help your clinic assess the type and frequency of patient follow-up you would like to provide. They not only further explain the process but also assist with providing structure for the follow-up calls. Documents a and b are linked and explained in document 2 and document b contains links to the 2 listed documents below it.
    2. Guide for Follow-up Telephone Calls – This document gives educators a brief description of how the follow-up telephone calls are delivered.
        a. Behavior Requirements to Meet Teach-To-Goal Standards – This document lists the behaviors, (i.e. Weighing self daily) that a patient needs to reach in the program.
        b. Follow-up Call Script and Log – This document contains a script for the follow-up calls with knowledge questions that a patient needs to answer correctly.
            1. Looking at Labels (Spanish) – These are example nutrition labels that can be given to patients for review in the follow-up calls.
            2. Follow-up Call Tracking Sheet – A form for educators to record data from a follow-up call.