Heart Failure Outreach Program patient goals

- Increased quality of care.
- Improved access to healthcare and regular follow-up
- Decreased admissions and ER visits
- Higher satisfaction and improved self-management
- Personalized care
- Increased knowledge and reporting of symptoms
- Improved quality of life

Referral from your doctor or nurse practitioner is required. Referral forms can be provided upon request by calling **651-6203.**

CH CDM 007

CHRONIC DISEASE PREVENTION AND MANAGEMENT

Central Health

HEART FAILURE OUTREACH PROGRAM

Patient Information

Empowering patients with support & information to better manage their health

Heart Failure Outreach Program

Heart failure occurs when your heart muscle does not pump blood as well as it should. Certain conditions gradually leave your heart too weak or stiff to fill and pump properly.

Your heart is affected by many things such as what you eat and drink, what activities you do, the weather where you live, every medication you take, as well as what you think and feel.

Heart failure cannot be cured but it can be managed successfully.

One way to prevent heart failure is to control the conditions that cause heart failure, such as coronary artery disease, high blood pressure, diabetes and obesity.

Not all conditions that lead to heart failure can be reversed, but treatments can improve the signs and symptoms of heart failure and help you live longer. Lifestyle changes such as exercising, reducing salt in your diet, managing stress and losing weight can improve your quality of life.

The Heart Failure Outreach Program offers:

- Active partnership between patient, family doctor or nurse practitioner, registered nurse (RN) and other health care professionals.
- RN led assessments and care plan development.
- Self-management model of care to help guide patient decision making for optimal health.
- Knowledge and tools for controlling heart failure that patients are interested in learning.
- Active involvement from patients with the ongoing process of creating and reviewing a plan of care that meets their specific needs.
- Standard health-related topics for education, coaching, referrals and resources:
  - medication usage
  - nutrition and weight management
  - physical activity and exercise
  - smoking cessation
  - substance use

Program benefits:

- Should, at any point, the patient present with ***acute symptoms, the RN will offer a triage***.
- Exclusive telephone contact.
- A patient-centered care and personalized approach to heart failure management.