REACH-HF Training Schedule

Day 2 – 9.00am to 4.30pm HOST Sharon Cameron(SC)	
09:00 – 10:40	Family and Friends **Prof Rod Taylor (pre-recorded)**
10:40 – 10:50	*Break*
10:50 – 12.30	Facilitation (Bringing it all together) part 1 **Sharon Cameron**
12:30 – 13:00	*Lunch break*
13:00 – 14:10	Facilitation (Bringing it all together) part 2 **Sharon Cameron**
14:10 – 14:15	*Short Break*
14:15 – 15:15	Brief experiences of delivering REACH-HF during current pandemic – **Wirral Facilitators**
15:15 – 16:30	Q&A and Panel Discussion. **Sharon Cameron, Carolyn Deighan, Wirral facilitators, Prof Patrick Doherty, Prof Rod Taylor**

Updated August 2021

1

Aims for the day

- Feedback from previous day's training
- HF in context
- Overview of facilitation process and self management
- Preparation for role of facilitator
  - use of case studies, Training Pack and REACH HF resources (that includes you!)
- Integrating REACH-HF into your service
- REACH-HF in practice- **Wirral team**
- Summing up/questions

reachHF
Rehabilitation Enablement in Chronic Heart Failure

Facilitation -Bringing it all together

Sharon Cameron
Heart Manual Dept

Heart failure in the UK

A common complex clinical syndrome of symptoms and signs caused by impairment of the heart's action as pump supporting the circulation. (NICE 2018)

Increased risk of heart failure with age and co-morbidities are common (hypertension, diabetes, AF and COPD)

Prevalence of HFpEF is increasing, associated to the rise in obesity, Type II diabetes and hypertension – modifiable risks

Nearly 1 in 5 patients hospitalised with ACS will go on to develop HF(15 - 16/%) irrespective of STEMI or N-STEMI

HF Signs and Symptoms

- Congestion- ↑JVP, lower extremities oedema, weight gain, crackles in lung bases
- Increasing fatigue
- ↑ SOB

Diagnostic tests

- ↑NT-proBNP or BNP
- HFpEF- below normal (<60%) ranges mild-mod (<50%)
- HFrEF-generally (<40%)

reachHF
Rehabilitation Enablement in Chronic Heart Failure

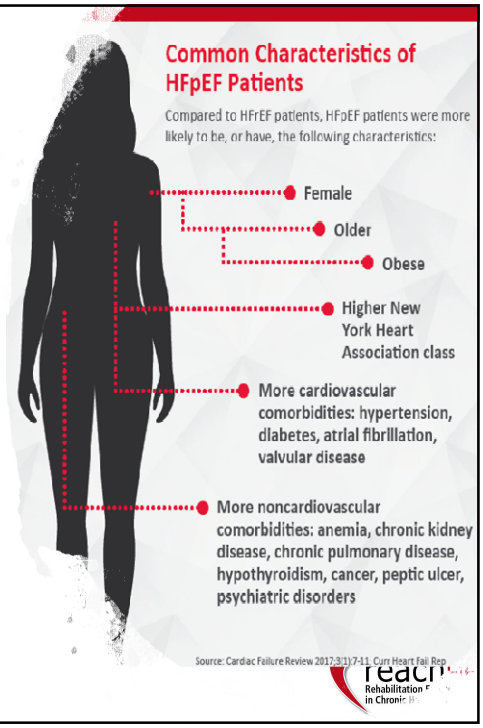
Hypertension and diabetes seem to have a great effect on cardiac remodelling leading to HFpEF in more women than in men.

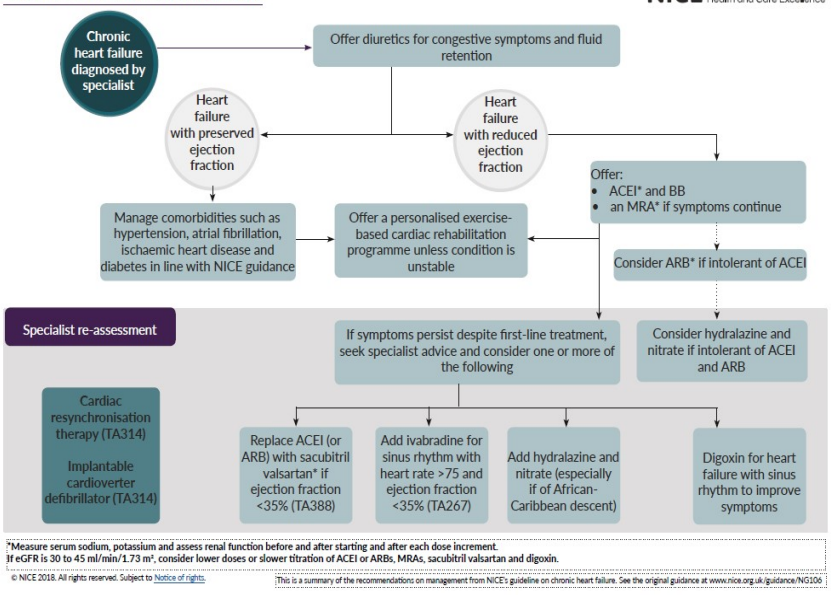
Target the underlying cause/disease in management of HFpEF

Loop diuretics (e.g. furosemide) main stay of treatment for fluid management

Incidence of HFpEF is growing by 10% every 10 years

https://www.cardiovascularbusiness.com/topics/heart-failure/tackling-hfpef-heart-failure-preserved-ejection-fraction-presents-diagnostic





Heart failure in the UK

200,000 people diagnosed with heart failure each year, 920,000 living with HF in 2020

Expensive: ~2 % of total NHS and 5 % of unplanned admissions per year

Be aware of possible patient prognosis – Younger people tend to do better, and in some cases the cause itself is reversible.

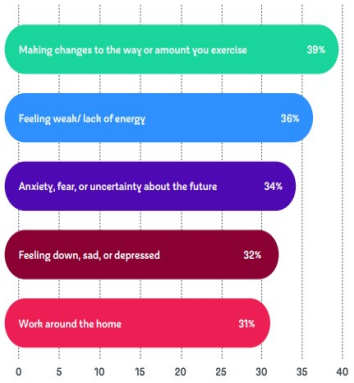
Social deprivation and demographics have an impact. African – Caribbean population > hypertension increases risk of HF. Asian population > increased risk in diabetes and obesity.

Enormous **impact on health-related quality of life**

"Contrary to popular belief, heart failure is not just a disease of the very old, and many people live with heart failure from an earlier age. While the average age of a UK heart failure patient is 75, this drops to 69 for people from Black and minority ethnic backgrounds. The average is in the low 60s for some cohorts, including the most socio-economically deprived."
Heart Failure : a blueprint for change (BHF2020)

reachHF Rehabilitation Enablement in Chronic Heart Failure

Addressing the challenges



Challenges HF patients identify and % need for help (BHF 2020)

- Mortality is 12% higher in those NOT REFERRED for cardiac rehabilitation
- Early intervention and better management has shown improvement in 6 month mortality (UK): down from 26% to 14% over a 10 year period.

" Programmes of cardiac rehabilitation can improve clinical outcomes and quality of life for people with chronic heart failure. People with chronic heart failure are typically older, and may be frail and have co-morbidities. This can make it difficult for them to attend group based programmes at hospital or clinics. Offering programmes of cardiac rehabilitation at different times of day and at different venues is likely to increase both uptake and adherence, and improve patient experience."

NICE 2018

8

REACH-HF response to COVID-19

Challenges

- CR staff redeployed to front line & policy of physical distancing and shielding
- Patient engagement (with healthcare services at point of need- as well as delivery of the patient care pathway)

European Journal of Preventive Cardiology
OnlineFirst
© The European Society of Cardiology 2020, Article Reuse Guidelines
https://doi.org/10.1177/2047487320923053

Letter to the editor

Correspondence to the *EJPC* in response to position paper by Ambrosetti M et al. 2020: Cardiovascular rehabilitation and COVID-19: The need to maintain access to evidence-based services from the safety of home

Hasnain Dalal[1,2], Rod S Taylor[2,3], Colin Greaves[4], Patrick J Doherty[5], Sinead TJ McDonagh[2], Samantha B van Beurden[2], Carrie Purcell[3], and on behalf of the REACH-HF Study Group

REACH-HF response

Switch 3-day face-to-face facilitator training to 2 day online course

Adapt the REACH-HF delivery so does not require visit to patient home and can be done entirely by phone/web-contacts (post manual to patient/caregiver home address)

COVID 19 and the heart

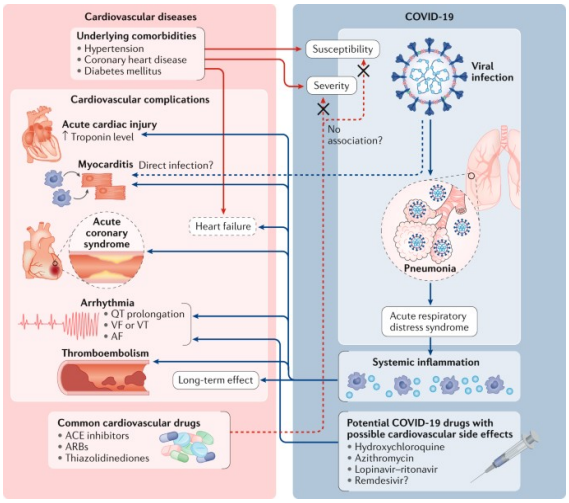


Fig. 2: Bidirectional interaction between cardiovascular diseases and COVID-19.

https://www.nature.com/articles/s41569-020-0413-9

10

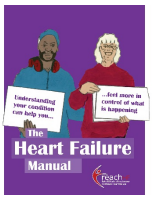
Inclusion criteria

- Confirmed diagnosis of HFrEF on echocardiography (ejection fraction <45% within the past 5 years)
- No deterioration of HF symptoms in the past 2 weeks resulting in hospitalisation or alteration of HF medication
- Full list of exclusion criteria used in REACH _HF Trial is listed under Table 1 in the protocol paper:

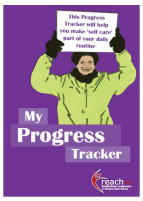
https://bmjopen.bmj.com/content/5/12/e009994

The REACH HF patient resources

- The Heart Failure Manual
  - Part 1 Understanding Heart Failure
  - Part 2 Managing your condition
  - Part 3 Further information



- Progress Tracker



- Family and Friends Resource

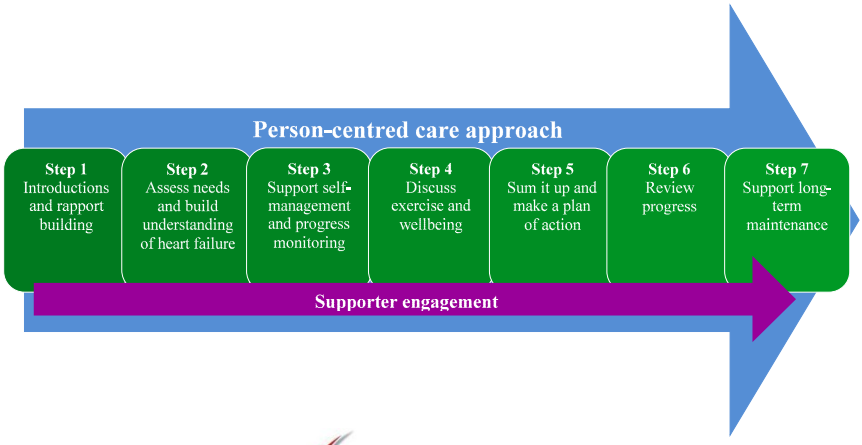
- Relaxation

CD inside cover of patient resource or
download at https://www.heartmanual.scot.nhs.uk/heartfailure

- Chair Based Exercises (CBE)

DVD inside cover of patient resource or
download at http://sites.exeter.ac.uk/reach-hf

The Facilitation Process



The Facilitation Process: Key Points

- Can use the "Seven Steps" chart as a format or plan for each contact/visit
- **Flexibility**: Not necessarily linear
- Allows focus on **what matters to patient and caregiver**
- **Integrate** use of the resources within the pathway and **encourage self management**
- **Monitor progress** and help **plan for the future**

Step 1
Introductions and rapport building

Tasks

- Introduce the programme
- Build a rapport and discuss your role as a facilitator
- Engage supporter(s)
- Normalise the reaction to the diagnosis /condition
- Identify and acknowledge any major concerns
- Clinical assessment (any concerning symptoms only)

Your focus as a facilitator

- **Have a conversation with the patient** and their supporter(s) to identify and find ways to address their individual needs and concerns

Introducing REACH-HF to patients

Don't spend 30 minutes going through the manual page by page – keep it brief!

"This programme aims to assess your current situation around living with heart failure and find ways to improve your health and wellbeing. It is all about what you can do to manage this condition and get the best out of life going forwards. There are four main components - Firstly we have this huge book (the Heart Failure Manual) which is full of information that might be useful over the next 12 weeks – don't be scared! You don't have to read it all or read it all at once, but we will be dipping into this as needed. Second we have a booklet here to track your Progress over the next 12 weeks. Thirdly (if applicable) we have some additional information for friends and family who might be involved in helping to manage the condition. And finally, there is me - I am here to guide you through all this lot and figure out what is going to be most helpful or relevant for you. Do you have any questions or concerns at this stage?"

Introducing the resources

Part 1: Understanding Heart Failure
- This section gives you plain facts about heart failure. You should read this section first and you may want to come back to it several times.
- If you live with someone, it can be helpful for them to read this too.

Helps you to understand what HF is

Part 2: Managing Your Condition
- This part of the manual has several sections dealing with topics that are important for most people with heart failure. You should agree with your facilitator which topics to work on first. This might include some topics from this section and some from Part 3.

Helps you to recognise and manage symptoms

Tracking Your Progress
- The separate Progress Tracker booklet provides some tools to help you to keep track of your progress. It has been designed to help you get the most from your health care and your 'self care'. It will help you to learn what things improve your symptoms and to know when to seek help from your health care service.

Helps you identify changes that may need action

Part 3: Further Information
- This section includes further information about topics that are important for some people, but not everyone, so you may want to dip into these or leave them depending on your own situation.

More information on living with HF

Figuring out what causes changes and how to manage them

Because heart failure can be quite unpredictable, it is important to keep an eye on how your signs and symptoms change over time and to try and figure out what causes these changes (i.e., what makes you feel better or worse). If you do this you may be able to avoid more serious problems which require attendance at a hospital. For instance, you might be able to improve things by getting a better night's sleep, by building up your fitness or by working with your health care team to adjust your medications.

A Progress Tracker has been provided as a separate booklet to use alongside this manual. This allows you to record how you have been feeling from week to week over a 12-week period. Using this tool may help you to learn what things seem to make your symptoms better or worse. An example of how you might use this is given on the next page…

The Heart Failure Manual

18

Role of the REACH facilitator

- Ensure patient/caregiver are aware of the role of the facilitator and how **you can support progress**
  - Primarily facilitating a **self management** resource and providing additional support in key areas
- Discuss **time frame** and outline **number of contacts**
- **Involve the caregiver** where possible
- **Communication is key**: building a rapport will help the patient and caregiver to engage with the resources
- Patient assessment is basic but any "red flags" should be reported to HFSN or GP
- Make sure everyone is clear about where the boundaries are and patient knows who to contact when (Checklist ✓)

Address key concerns

Facilitation Process: Step 2

Step 2

Assess needs and build understanding of HF

Tasks

- Review patient's and supporter's current knowledge and understanding of Heart Failure /their situation
- Note **accurate** responses (ID, Cause, Timeline, Cure/Control, Consequences)
- Identify what Physical, Social, Psychological support is needed
- **Introduce the Heart Failure Manual** and the Family and Friends Resource
- Exchange specific condition information and offer support

Break out session 1

- How will you determine patient/carer understanding?
- What questions will you ask?
- What key information will you provide?
- What resources will you use to help you/ and your patient?

Assessing needs and understanding

- Example questions (start with general questions)
  - *Can you tell me about your situation?*
  - *What does the term heart failure mean to you?*
  - *What are your main concerns about living with heart failure?*

Assessing needs and understanding

- Example questions (more specific focus on our "Big 4" intervention targets)
  - *How would your **physical fitness** affect your heart failure symptoms?*
  - *What do you know about **fluid build-up** in relation to heart failure?*
  - *How are you (both) **coping mentally**/emotionally with all this?*
  - *Do you have any concerns about your **medication**? - what are they?*

Building understanding

- Use your **Ask-Tell-Discuss** skills to …
  - Address any misconceptions
    - e.g. *What do you know about the benefits of exercise for older people? (more energy, maintaining independence, better sleep etc)*
  - Add usefully to existing knowledge
    - E.g. "You are right – with exercise, it is a case of '**use it or lose it**' – and that means you need to keep your exercise levels up even after this programme is finished"

Role of the Facilitator- assessment

- Check patient and carer **understanding** of the condition
- Assess patient needs and concerns
  - This should be a substantial conversation to assess the patient's **Physical, Social, Psychological** needs /what you need to work on
- **Correct any misconceptions** the patient or caregiver have
- Introduce the HF manual resources and direct to **relevant information** e.g ICDs, medication
- Direct to contact details and support resources in the manual should they have concerns/questions- **sign post**
- Liaise with HFSN and other community team members as condition dictates

Next steps

- You should now have established some **motivation** and reasons to engage with a range of **self-care** actions
- The next steps are to assess their current self-care behaviours (Step 3), especially in relation to exercise (Step 4) and move on to **making a plan** of action (Step 5)

Step 3

Support self-management monitoring of progress

Tasks

- Assess and discuss knowledge and current actions of self-care behaviours including:
  - Managing medication, fluid balance, signs and symptoms, stress, anxiety and depression.
- For Exercise and Physical Activity see Step 4.
- Identify supporter involvement in current self-care activities
- Introduce the Progress Tracker and sign post to the HF Manual and F&F Resource
- Identify and address barriers to self-care
- Encourage self-care facilitation from the supporter

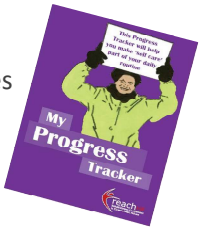
"Stop telling us what to do

and tell us how to do it"

CHF patient

Self-management: Objectives

- Gain an **understanding and acceptance** of the condition
- Learn to prioritise and **plan**
- **Set** short, medium and long term **goals** -Think SMART (Specific Measurable Achievable Realistic Timely) !
- Learn to **pace** appropriately and effectively
- **Introduce exercise** in a realistic manner
- Self **monitor** one's own **progress** and condition/symptom changes (Progress Tracker)
- **Maintain behaviour change** and deal with setbacks
- Recognise and deal with common psychological responses



Self-management: Recognising decompensation

- Important for patient/carer to manage the condition with support from health professionals
- HFSN usually first contact along with GP
- **Symptom monitoring** and **compliance** with medical treatment central to stability
- If patient and carer can gain confidence and independence through an increased understanding of the condition, **early recognition** of changes to symptoms will allow prompt action and **may prevent admission to hospital**

HFM- Part 2

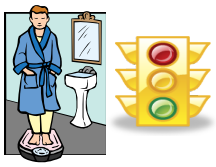
Managing your fluid balance P56-61

Managing Breathlessness P77-79

Managing Changes in Your Symptoms P80-84

My Progress Tracker

Symptom Monitoring



- Patients/carers should be encouraged to do **daily weighs** and observe ankles/abdomen to alert for signs of fluid retention
- A weight **increase of 4-5 lbs (2.3kg) over 3 days** should be reported
- Check if slippers, shoes or trousers getting more tight?
- An **increase in SOB** on usual activity may indicate fluid retention in the lungs or chest infection which may limit exercise tolerance
- Aim to observe fluid intake as instructed by HFSN (usually 2l/day approx.)
- Note if **additional pillows** required at night/unable to lie reasonably flat due to SOB
- Note if **fatigue** becoming worse/motivation or mood low
- Ensure patients know how to use their **Traffic Light Plan** and know when to contact their HFNS for advice
- **Support** patients/carers **with** their **progress tracker** and **review** with them at visit

Progress Tracker: Checking for fluid build up

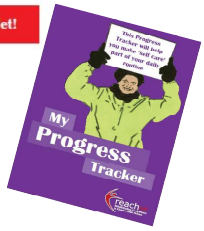
Checking for fluid build up

	M	T	W	T	F	S	S
Weight today							
Weight gain							
2.3kg or 5lbs? over 1-3 days							
More breathless							
More swelling							

ACTION

2 or more ticks? → Check the Traffic Light Action Plan at the end of this booklet!

Other tips-Weigh yourself in the same place, with the same type of clothing or without any clothes if you prefer, before you eat or drink, with the same scales, sticking to the same type of measurements either stones (st) and pounds (lbs) or kilograms (kg)



Dealing with set-backs 1

- **Not uncommon to have ups and downs** in condition trajectory
- Set-backs can happen: patient may not have done anything "wrong" but try to look back and **identify any triggers** before the symptoms worsened
- If re-admitted to hospital, it is distressing for everyone.
- **Acknowledge** feelings of **worry and frustration,** consider the **impact on confidence to manage their condition**
- Could relaxation or mindfulness help?

Dealing with set-backs 2

- If there has been a set-back, it is important to **adjust base-line activity**
- Encourage to **take a step back** from where they were previously and gradually build back up to that point
- HFSN or facilitator can advise if required

- **Encourage involvement of family and friends** if extra help needed for a few days or if confidence is affected re: walking
- Encourage patient/carer to **document changes to medication and goals** in the **progress tracker**

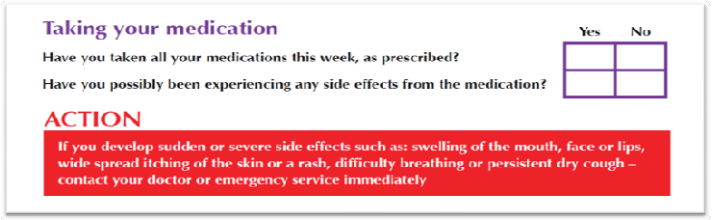
Role of Facilitator- self management

- Explain where to find the relevant information in the manual and additional resources
- Introduce the progress tracker/relaxation audio
- Ensure patients/carers know when and who to contact if they notice a change in their symptoms
- Encourage use of the Traffic Light Plan 
  - **Don't forget, it is ok for patients to access other support such as their GP or HFSN, this is recommended in the Traffic Light Plan and is a good habit to get into for after facilitation ends.**
- Introduce the concept of goal-setting/pacing/how to deal with setbacks
- Refer to the crib sheet for ideas and use the self reflection form to consider what went well and what can be improved on next time. **Note**: this is a process, not a one off intervention!

Medicine management and recording

- Often lack of understanding can result in anxiety over medication or medication changes
- Patients can be reassured that this is a beneficial process
- Patients should be aware of the need for follow up blood tests and symptom reporting
- A good routine and recording changes in the Progress Tracker can help

- Encourage patient or carer to create a list of current medications to keep this somewhere easy to hand and to regularly update this list when changes are made.
- Encourage the patient or carer to note in the **Progress Tracker** whether the patient has taken their medication as prescribed and whether they are experiencing any side-effects.



Role of the Facilitator

- Check understanding of patient and care-giver with regards to medication: action of medication and possible side-effects
- Encourage compliance by encouraging a good routine and using medication boxes/dosette box or similar: check adherence/barriers
- Check that patients are aware of the need for drug titration to therapeutic doses which necessitates ongoing monitoring of their symptoms and blood tests/BP
- Highlight the importance of medication adherence and normalise titration.

HFM- Part 3

About Your Medications P122

Frequently Prescribed Medications P123-131

My Progress Tracker

Case Studies: Breakout session 2

- **P154: James Carmichael- 64 year old gentleman**
- **P155: Lucy Poole- 31 year old woman**
- **P156 :Joseph Brown- 78 year old gentleman**
- **P157: Madeleine Sitwell- 85yr old woman**
- **P158: Manish Pranjol- 76 year old gentleman**
- **P 159:Tariq Bethi 57 year old gentleman**

Address questions on P162- Case Study Exercise 3 on Facilitation

Case Studies 2

- Charles age: 68yrs Diagnosis: NYHA II: EF 42%. Diabetic. Past History: PCI. Lives alone in rural location. Son and daughter live in neighbouring village. Active with grand-children.

ISWT 120 metres walked: Minnesota 14

- Florence age 89. Diagnosis: NYHA II; EF 26%. AF; Osteoarthritis; bilateral knee replacements, walks with 1 stick; awaiting bilateral cataract surgery. Widowed. Lives alone in very large detached house. Drives

ISWT-120m: Minnesota: 19

- Bobby age 67yrs, NYHA II, EF was 21%, commenced Entresto now 50%: AF; Mod AS.

Lives with his wife and 2 dogs.

No ISWT due to COVID 19. Minnesota requested

Step 4

Discuss exercise and wellbeing

Tasks

- **Discuss a normal day** to identify activity strategies.
- Introduce **exercise and walking plan**
- Identify start **level for exercise** and physical activity (are results from an ISWT or 6MWT available?)
- Introduce to **Stress Management**
- Assess and discuss smoking, alcohol, and any other relevant **lifestyle risk factors.**
- Discuss other lifestyle components (e.g**., work, holidays, social activities, sex, and fatigue**.

Physical Activity: Why include?

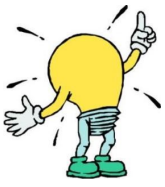
- **Physical activity improves heart health** and increases your years of healthy life (and reduces risk of future cardiac events and death)
- Builds confidence and sense of control
- Improves mood /reduces anxiety
- Can improve sleep quality

Gets the family involved /can be fun

- Patient is in control of decisions – what to do /**what would they enjoy doing?**
- May need to **address the misconception** that rest is good, or that **exercise will damage or stress the heart**
  - The heart is a muscle – what happens to muscles if you use them?

Building understanding

- **Key ideas** to build /develop around physical fitness /exercise …
- Ongoing physical activity or exercise is necessary for you to maintain your quality of life. **"Use it or lose it"**
  - This is **not just a 12-week programme**
  - To **keep going after the programme**, you need to build some physical activities into your day to day life: Ideally, things that will be enjoyable or useful to you
- To increase your fitness /physical ability, you have to work at a moderate intensity
  - Breathing harder and working your heart.
  - **Pushing the level up over time**. You have to *work* at it



Getting the patient started

- Think about baseline activity for the patient based on patient history
- Consider information from **ISWT (if available)** and METs value reached
- Think about modification of exercise as required - co-morbidities e.g. OA
- Set level for CBE and/or walking programme assisting patient to set SMART goals and document/review progress using the Tracker
- **Involve family where possible**

Protocol for checking the starting exercise level

- Start the **warm up section** with the patient using the appropriate CBE level based on the ISWT result*
- Where this is not possible and in very rare cases when there is no exercise tolerance test carried out (not ideal) then **start at CBE level 1**
- During this period of exercise check their breathing and ability to carry on a conversation. Use the Effort Scale (see next slide) to check the level of effort they perceive the exercise involves (0 to 10). Ideally, aim for the level of exertion to be between 4 and 7 on this scale
- If at any point patients are unable carry on a conversation, are panting heavily (getting exhausted), or the Effort score is 8 to 10, then ask them to slow down (do every other movement) and gradually warm down for 5 minutes. Their exercise level should be lowered
- If patients get through the warm up without any of the above issues, **progress to the next stage of the CBE level**

***Preferred practice is to assess a patient's fitness (exercise tolerance) and response to exercise through the ISWT or an equivalent test prior to starting an exercise programme.*

Current options for REACH-HF exercise prescription during pandemic

1. Carry out a sub-max fitness test using a social distance version of the ISWT or 6MWT or any other test that gives a measure of metabolic equivalents (METs). Once this data is available the appropriate chair based exercise (CBE) level or walking speed is allocated at 70% of a patient's sub-max METs value

2. Use a subjective assessment of fitness using a physical activity METs compendium to evaluate the intensity of activity carried out as part of an average week. The physical activity intensity derived through this process can be used to select an appropriate starting level of CBE or walking programme

3. Titration from level one of the CBE with progression based on patient perception of exertion and fatigue following each session of exercise

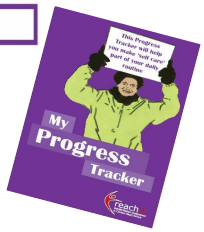
Exercise goal-setting, planning, monitoring, and rating

My exercise

	M	T	W	T	F	S	S
Target							
Done							
It felt	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

Too easy 1 | Fairly easy 2 | Fairly hard 3 | Too hard 4

Steps per minute:



Break out session 3: Physical activity

In your groups look at your allocated case study and using your resources:

1.Consider how you would set the baseline activity for your patient

2. What are the potential barriers?

3. How would you support Health Behaviour Change?

Case Studies: Breakout 3

- **P154: James Carmichael- 64 year old gentleman**
- **P155: Lucy Poole- 31 year old woman**
- **P156 :Joseph Brown- 78 year old gentleman**
- **P157: Madeleine Sitwell- 85yr old woman**
- **P158: Manish Pranjol- 76 year old gentleman**
- **P 159:Tariq Bethi 57 year old gentleman**

Case Studies: Breakout 3

- Charles age: 68yrs Diagnosis: NYHA II: EF 42%. Diabetic. Past History: PCI. Lives alone in rural location. Son and daughter live in neighbouring village. Active with grand-children.

ISWT 120 metres walked: Minnesota 14

- Florence age 89. Diagnosis: NYHA II; EF 26%. AF; Osteoarthritis; bilateral knee replacements, walks with 1 stick; awaiting bilateral cataract surgery. Widowed. Lives alone in very large detached house. Drives

ISWT-120m: Minnesota: 19

- Bobby age 67yrs, NYHA II, EF was 21%, commenced Entresto now 50%: AF; Mod AS.

Lives with his wife and 2 dogs.

No ISWT due to COVID 19. Minnesota requested

Role of Facilitator- exercise & lifestyle

- Help patient to **set appropriate baseline for activity and encourage use of the progress tracker**
- **Involve care giver/family** where appropriate for additional support in making sustainable changes
- Help to **modify exercises as required or combine CBE with walking**
- Offer support **and refer on where appropriate to specialist services** in smoking cessation/weight loss
- Support **SMART goal-setting** with regards to exercise and HBC
  - Specific (e.g. I will complete CBE)
  - Measurable (e.g. At level 3, every second day)
  - Achievable (e.g. progress from level 2)
  - Relevant (e.g. enjoyable, social activities)
  - Time-specific (e.g. on Wednesday evening, I will …)

Your focus as a facilitator

- **Have a conversation with the patient** to identify and find ways to address their individual needs and concerns

Without a dedicated facilitator the programme would be a lot more difficult to complete

What did you find most useful?

"Talking to the facilitator and the support given, explanations of heart failure and how the heart works"

Step 5

Sum it up and make a plan of action

Tasks

- **Summarise everything discussed** with patient and supporter.
- **Set goals** and objectives (that are relevant and matter to the patient).
- **Ensure patient and supporter have their concerns addressed** (prompt questions - to make sure)
- **Refer to Progress Tracker** to note their priorities and encourage monitoring of exercise.
- **Arrange next follow-up** (when? By telephone or as home visit?

Step 6

Review Progress

Tasks

- **Refer to the Progress Tracker**
- Identify challenges and barriers faced by the patient and their supporter and prompt problem solving
- Discuss **setting new goals and priorities**
- Discuss **ongoing /sustainable physical activity**
- **Review support network** (e.g., social support, caregivers' support)

Step 7

Support long-term maintenance

Tasks

- Final review in relation to self-management
- Encourage ongoing review of goals and progress (blank form at the back of the Progress Tracker)
- Support patient planning for setbacks, prompting problem-solving, planning ongoing /life-time physical activity
- Include discussion (where appropriate) about getting back to work, planning for holiday, sexual activity, and living with uncertainty.

Closing down the intervention

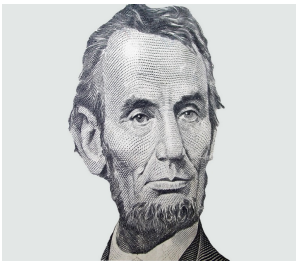
- Make a SMART plan for **ongoing exercise** beyond the REACH-HF programme (e.g. what kind of physical activity might you enjoy /what might be easy to build into your routine?
- Discuss **social support** for their plans /the need to manage any negative social influences
- Make an ongoing plan for addressing **psychological needs**: e.g. stress management practice, joining a yoga or mindfulness group, further learning
- Identify and **problem-solve** any possible obstacles (What might stop you or get in the way of doing that? What could you do to stop that happening?)
- Reiterate use of **Traffic Light Plan** and how to deal with setbacks
- Discuss sources of support - GP, HF/CR team, any local **cardiac support groups?**
- Make a "grand summary" of their plans
  - Review the benefits /how far they have come, focus on the positives and self care activities that work for them
  - Wish them well
  - Reminder to complete patient feedback form and return (P135)

Keeping Well

- Focus is on **Quality of Life** and **keeping active/independent**
- Encourage to **think about the "Up" things** and practice relaxation breathing/techniques if anxious
- Patients should be proactive when it comes to their health: ensure appointments are kept or home visits organised, use calendars or diaries to prompt
- Any other long term conditions need to be well managed and **vaccination** for influenza encouraged
- Any **health behaviour change** should be maintained /**encouraged and supported** by health professionals
- Encourage **referral back to manual and additional resources** as needed

End on a high note!

Heart failure is a tricky condition, but with a bit of care and effort you can still live a happy and healthy life!



"In the end, it's not the years in your life that count. **It's the life in your years".**

Abraham Lincoln

Integrating REACH HF in your local services

Group Discussion

- How will REACH HF fit in with existing CR or HF support in your area
  - What will be the challenges?
  - What would help you overcome these?
- How do your referrals come in? – what are the criteria
- What is the discharge process?

- What are the local support services you would be able to refer your patients on to where necessary?
  - for managing clinical depression /anxiety
  - Assessment of benefit/social care needs
  - Carer support networks, groups, or charities?

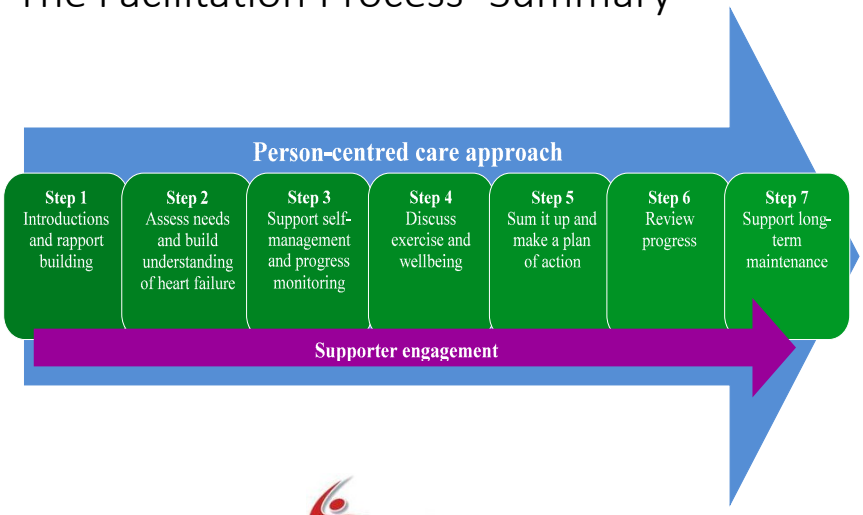
BACPR Education Programme

- **BACPR Standards and Core Components online modules** www.bacpreducation.co.uk
- **Dietary Approach to Managing Cardiovascular Disease and Weight**
- **Health Behaviour Change and Psychological Support**
- **Physical Activity and Exercise**
  - Part 1 : Principles and Practicalities
  - Part 2 : Advanced Applications
  - Physical Activity and Exercise in Heart Failure
  - Monitoring Exercise Intensity and Assessing Functional Capacity
  - Adapting Exercise: enhancing skills to accommodate all abilities from seated to high level activity within a group setting
  - Principles and Applications of Resistance Training
  - Physical Activity and Exercise in Type 2 Diabetes
  - Exercise Instructor training (Level 4 Specialist Instructor qualification)

www.bacpr.com

CPD MEMBER The CPD Certification Service

The Facilitation Process- Summary



reachHF Rehabilitation Enablement in Chronic Heart Failure

Finishing up

- What now? Expectations or fears?
- Questions/Concerns?
- Help/advice/support is available

REACH-HF Team

Heart Manual Team

PLEASE COMPLETE AND RETURN YOUR EVALUATION FORMS

https://nhslothiansurveys.onlinesurveys.ac.uk/reachday1

https://nhslothiansurveys.onlinesurveys.ac.uk/reachday2

Don't forget, you have access to all the resources. It will be useful for you to read the training folder and familiarise yourself with the patient resources again before your first consultation.