

Example of research paper on congestive heart failure in the united states

[Experience](#), [Failure](#)



Medicine

Congestive heart failure (CHF) is a chronic disease which is increasing in the United States. On the one hand baby boomers are aging and have become at risk for CHF. People are also living longer. (Ideal, 2009, p. 2) The rate of people under 65 years old entering hospitals for CHF has increased. (Hall, Levant, and DeFrances, 2012, p. 1) In 1900 the number of people over 65 years was approximately 3 million but in 2010 the number is over 34 million; in 2020 the number is predicted to include about 20 percent of the US population. (Quaglietti, Atwood, Ackerman, and Froelicher, 2000, p. 259) Therefore CHF has become a problem that needs monitoring for a good understanding of the problem. This paper covers the topic of CHF in the United States by reviewing the degree of the problem, the psychosocial risk factors, and current research. Examples of community programs and CHF interventions have also been reviewed.

Medical Definition and Description of Cognitive Heart Failure (CHF)

Hall (et al., 2012) explains that CHF is a condition of the heart “ when the heart cannot pump enough blood to meet the body’s needs” (6). Blood carries oxygen through the body to all the organs but when this cannot happen an individual is likely to experience heart failure. A common symptom is fluid retention and can be identified from swollen ankles, feet, legs or even the abdomen or lower back. Other symptoms include problems with breathing, shortness of breath, while carrying out daily tasks. Trouble breathing occurs when the individual is lying down resting or sleeping. Too

little oxygen to the organs causes a person to feel weak and tired. Heart failure has many causes and some are related to bad habits like smoking, not enough exercise, and not eating healthy foods. High blood pressure and coronary heart disease are two common causes of CHF (Heart, 2009, p. 1) Other causes of CHF include decreased size of arteries so less blood passes through and/or earlier heart problems like heart attacks.

CHF in the United States with statistics

The Center for Disease Control and Prevention (CDC) reported the heart failure death rates in the two years from 2007 to 2009 for adults above the age of 35. Unfortunately approximately 50 percent of the people diagnosed with heart failure “ within 5 years of diagnosis” (Heart, 2009, p. 1). In the US 55, 000 people or more die from heart failure each year, but not only that 280, 000 deaths per year list CHF as one of the causes of death (Heart, 2009. p. 1) These figures mean that CFH is involved in approximately 335, 00 deaths per year. An interesting fact is that for all adults (aged 16 to 64) who were diagnosed with CFH as a secondary required a large cost for hospitalization, \$25, 325. (Heart, 2009) According to the CDC if the primary health problem had been diagnosed as DFC over \$7000 would have been saved. (Heart, 2009)

The National Center for Disease Statistics published a Data Brief in October 2012 which reported exclusively on the statistics for CHF hospitalization from 2000 to 2010 in the United States. Hall, Levant and DeFrances (2011) were authors of the data brief; they reported that approximately “ 5. 8 million people in the US have CHF” (p. 1). Out of the one million hospital patients

counted in both 2000 and 2010, the number of patients younger than 65 increased by 6 percent which is statistically significant (Hall et al., p. 1). African American men living in the United States suffer disproportionately from CHF than any other demographic group. The differences between the percentage of black men with high blood pressure to white and Mexican-American men is significant; between the years 2003 to 2006, 27 percent of black men compared to 17 percent of whites and 15 percent of Mexican Americans suffered from hypertension. (CDC, 2010, p. 10) Hypertension is caused by high blood pressure. Awareness and taking the correct medicine do not seem to always make a positive difference. For example in the years 1999 to 2004, the CDC reported that 56 percent of the demographic knew they had high blood pressure but only 30 percent were controlling their blood pressure with medicine or better habits. (CDC, 2010, p. 10) Another interesting fact is that death rates caused by hypertension from 1999 to 2004 increased for three demographic groups; African American men, African American women, and Caucasian men. But the degree of increase in deaths caused by hypertension was twice as much for the African American groups. (CDC, 2010, p. 10)

Psychosocial Risk Factors

Understanding the psychological and social risk factors is important because when the factors can be improved fewer people will die from CHF each year. Rod, Andersen and Prescott (2011, p. 1) explained that there is a problem in gaining access to useful data because so little epidemiological research has been published on the subject. Epidemiological studies would be very useful

because they would report the impacts of low income, depression and work related stress on the occurrence of HCF.

Outpatient management is an important strategy used by health care providers to identify and try to address psychosocial issues leading to CHF. Racism for example may be a leading reason for the high rates in African American men and women. Diabetes has been shown to be an important factor causing heart disease African Americas so outpatient strategies to help patients successfully manage their health care is with outpatient services. Outpatient services traditionally include support with health insurance, family responsibilities and personal budgets. (Rod, Andersen and Prescott, 2011, p. 1) In contemporary times follow up services in the outpatient sector include sending informative emails and personal phone calls to people's homes from National Medical Association (NMA) doctors.

Aims and checklists are another strategy used to identify, prioritize and manage

MDwise Hoosier Alliance Congestive Heart Failure Disease Management Program is a good example of how organizing guidelines in to aims (goals) and checklists can help with CHF management. The Alliance uses guidelines from the American College of Cardiology Foundation/American Heart Association (ACCF/AHA) in order to organize its members into subpopulations and then targets those groups to receive relevant information on CHF prevention or facts. The objective of the Alliance's program is to enhance the ability for people to self-manage CHF problems with development of a personal plan and then implementation. The people who are face with CHF health issues are numerous and varied so the goals are also numerous and

varied. One goal is to help the individual find the most suitable case management and resources by offering a referral system. Another goal it to be sure that case management activities are really helping the patient; this is done by regular assessments. Case management activities are making sure the patient's information is correct. A few of the data categories for each patient include history, medications, health status, health issues related to CHF, as well as daily habits. (Hoosier, 2008, p. 2) Case management also includes the patient's caregivers and directing the patient to the correct resources. (Hoosier, 2008, p. 2)

CHF research

Rod, Andersen, and Prescott (2011) carried out a study to learn more about how heart failure and psychosocial factors are linked. Eight thousand six hundred seventy Danish men and women were originally interviewed in 1991 and then a follow up was done in 2007. In 1991 none of the participants showed any heart problems. After the 2007 follow up the researchers reported that " the vital exhaustion score" was linked with a doubling of heart failure in both men and women participants. (Rod et al., 2011, 1) The researchers were surprised that major life events, social network and sleeping medication did not show a strong link with heart failure and hospitalization. (Rod et al., 2011, 1) The researchers concluded that preventive strategies could be developed from the finding that vital exhaustion has such a big role to play in connection with heart failure. A working group was formed to study how chronic disease impacts neurocognitive and psychosocial functions. Jain, Ness, Sklar, Diller, Patel (et

al., 2011, p. 1) studied childhood cancer survivors because in over 70 percent of the cases, a chronic medical condition (such as coronary). Therefore the researchers wanted to find how “ neurocognitive and psychosocial late effects” in the population have an impact. (Jain et al., 2011, p. 1) The areas of the psychosocial factors studied included learning abilities, speech, memory, focus and attention and even mood. (Jain et al., 2011) This research study was included to show what psychosocial factors have been studied and how they fit into medical research studies.

Community based CHF programs

The Kansas Association of Homes and Services for the Aging (KASHA) is an example of an ongoing and successful community based DHF program. Kasha focuses on the special needs of the elderly to meet each of their patient’s personal needs instead of a one-size-fits-all plan. The elderly have to deal with many changes such as aging, changes in the family, facing mortality, losing a spouse, not being as strong as in the past and a change in the money they have available. (Needs, 2007, p. 4) The most interesting part of Kasha’s program is to attempt to end some of the psychosocial myths about elderly people like they are sickly, they have disabilities, most elderly people must live in a nursing home, they are senile, unhappy, cranky, don’t want sex and have stopped their psychological development. (Needs, 2007, p. 4)

MDwise Hoosier Alliance Congestive Heart Failure Disease Management Program was mentioned earlier. The difference between the KASHA strategy and MDwise is that MDwise has many more elderly people involved. The two

programs are similar because they both use their different strategies to meet the unique needs of each person. They both see the patients as all having individual wants and needed. So although KASHA is much smaller than MDwise success is measured in both organizations by how patient satisfaction.

CHF Interventions to minimize impact of CHF

The IDEAL LIFE Solution™ plan uses population interventions to help raise the quality of life for CHF patients. A current priority is put on interventions to address the problems of too much body weight. The reason reducing body weight is seen as a priority is because when changes in body weight are observed by keeping records, actions can be taken to prevent heart failure during certain weights that signal a high risk period for the patient. A population based conventional intervention uses Integrated Voice Response (IVR) is used so patients can self report directly to their health care providers over the internet. Internet ‘ bathroom’ scales are used to measure body weight. Care-givers can instruct patients over the telephone calls from nurses who can also answer many questions the patient may have. On the other hand the Ideal Life platform uses a “ wireless internet embedded scale” (IDEAL 3) and a remote information management platform. The weight is automatically input into the care provider’s data files and the program will send an alert if there is a problem. The Ideal Life strategy has resulted in high patient retention rates which have been attributed to the fact that the patient does not have to change their routine.

The Ideal Life platform also resulted in a reduction of hospital check-ins. For

a three month study the usual care system had 31.5 out of 200 participants being admitted into the hospital. (IDEAL, 2009, p. 5) On the other hand the Ideal Life platform showed hospital admissions of 13.5 out of 200. The cost for 200 patients over three months was \$180,000 less in the Ideal Life platform than in the conventional care setting. The savings for the technology implementation was reported to be \$159,000 for Ideal Life but zero for conventional care which resulted in a 54 percent savings. Finally the return on investment for the Ideal Life platform was reported to be \$7.57 per \$1 invested. (IDEAL, 2009, p. 5)

African American men are impacted more than any other demographic group with high blood pressure leading to CHF related issues. Many strategies for using psychosocial factors and systems-level interventions have been designed. The US Department of Health and Human Services at the CDC and the National Center for Chronic Disease Prevention and Health Promotion have initiated a series of studies to learn more about the unique problems and needs of the African American male demographic. The strategy of systems-level intervention was used because it encompasses all the factors that may have an impact. The CDC definition for systems related intervention is “ a change in policy, legislation, training, or environmental supports that impacts individual and community level outcomes” (CDC, 2010, p. 11). In order to study the psychosocial aspects the CDC divided the aspects into several categories. The topic of racism was subdivided into three areas “ perceived racism, experienced racism, and racial discrimination” (CDC, p. 28). Another topic they carefully researched was “ knowledge, beliefs and attitudes about hypertension” (CDC, p. 30). Other

topics addressed access to health care, health insurance, and quality of care, socioeconomic status, and residence in rural areas, social support, depression, substance abuse, and obesity.

The research concluded that enlisting family members to help support the man with high blood pressure helps make a positive change. Peer-to-peer communications result in more participation in interventions. Group discussions or blood pressure screenings are more attractive to African American men leading to more participation by the demographic.

Interestingly the age group from 18 to 49 years shows the biggest trend for recruiting and retaining into regular health care practices, especially the newly diagnosed. Because so many in this age group of African Americans do not stay in contact with care providers they have the least education about blood pressure which makes them more at risk. (CDC, p. 41)

Conclusions

The problems associated with CHF are not so bad when the patients are involved because the patient has the power to make the positive changes necessary. The issue of CHF is very complicated and each demographic group as well as each individual has unique expectations and needs. When people with high blood pressure become involved in education about hypertension and heart failure they have more data to use to improve on past behaviors. Communities are becoming more involved in designing health care solutions and regulations especially as the practicality of systems level interventions have become evident. The strategy is no longer the

doctor passing down information to the patient but a collaborative dynamic so everyone is involved.

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