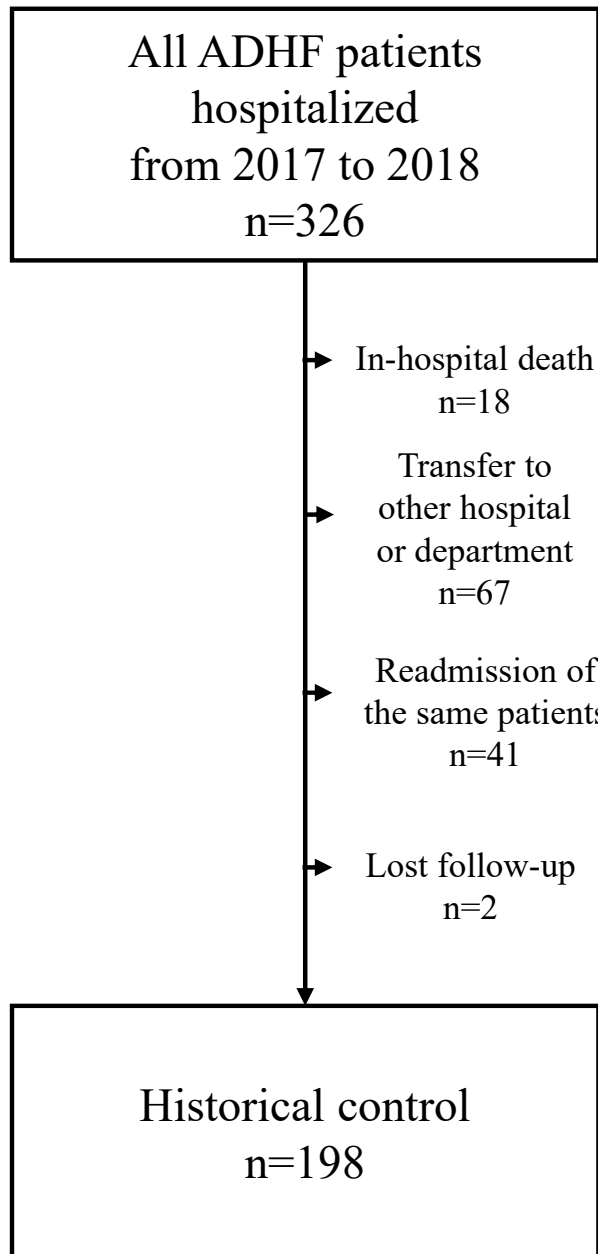




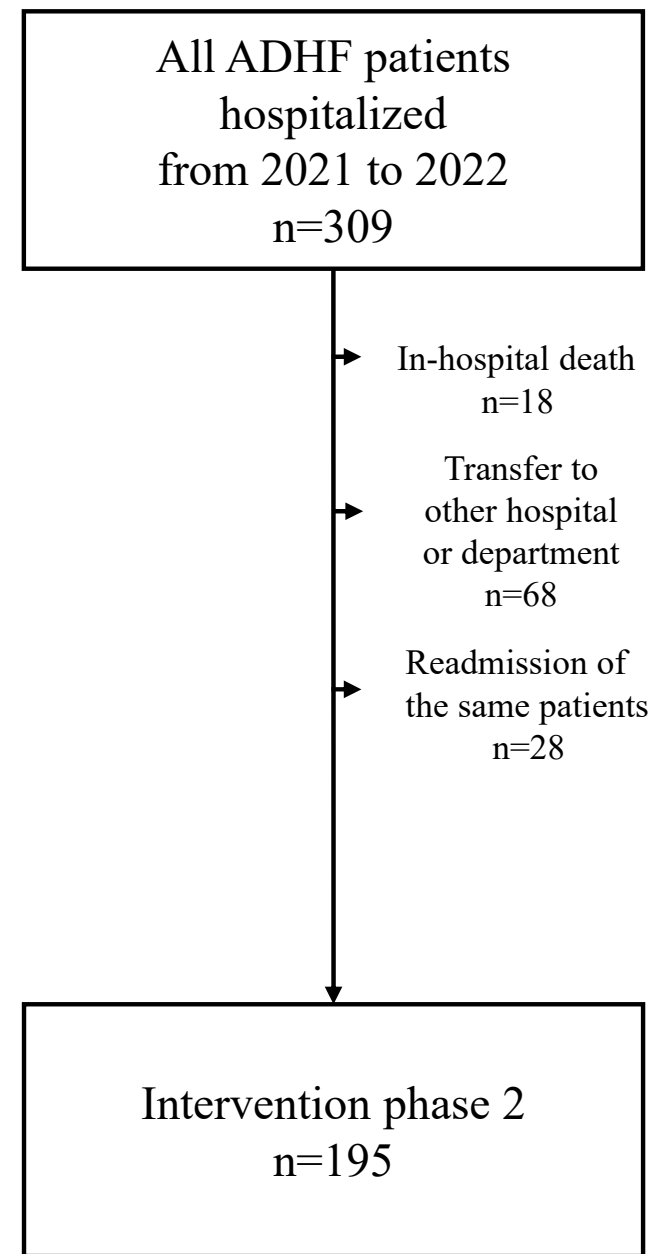
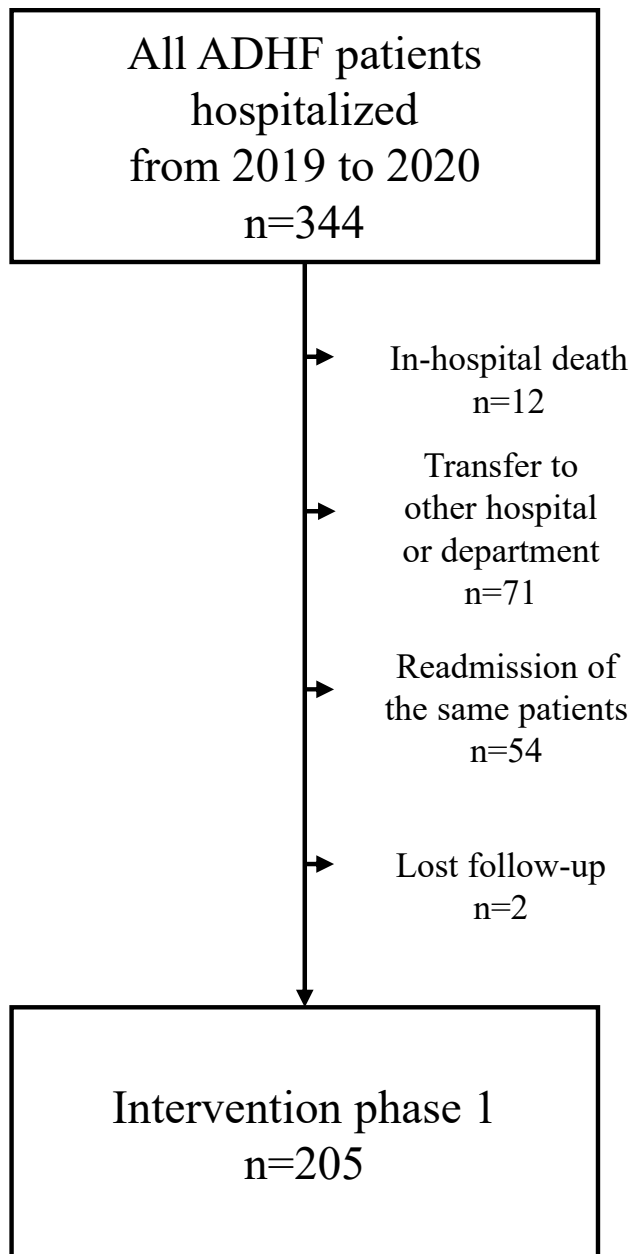
Association of a Transitional Heart Failure Management Program With Readmission and End-of-Life Care in Rural Japan

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Before intervention



After intervention



Supplementary Figure 1

Heart failure collaboration sheet

1 Achieving patient's goals ! ()

2 Don't overlook worsening heart failure ! (if any of these are present)

- Stable weight +3kg () kg ➔ () kg or more
A sudden weight gain of 2 kg in one week
- Worsening of shortness of breath or swelling
- More than twice the stable BNP () /NT-proBNP ()



3 Patient education to prevent worsening heart failure !

♥ Don't forget to take your medications !

- (medication bag single packet medicine calendar)



♥ Balanced diet !

- Active intake (fish meat dairy products vegetable seaweed potato egg soybean fruits)
- Reduce intake (miso soup pickles dried food Noodles soy sauce processed food) ◦ delivered meal
- Water restriction None Yes () mL/day or less



◦ Important point ()

♥ Moderate exercise !

- Balance exercise, difficulty (1. 2. 3) ◦ Thigh exercise, difficulty (1. 2. 3)
- Calf exercise, difficulty (1. 2. 3) ◦ Endurance exercise, difficulty (1. 2. 3)



♥ Reduced alcohol, No smoking, Infection prevention !

- (reduced alcohol no-smoking) ◦ Recommend vaccination



4 Supporting everyday life ! Fill in the person to be supported

1. Heart failure handbook records ()
2. Check heart failure handbook and consult a health care provider
3. Checking taking medication ()
4. Cooking ()
5. Laundry ()
6. Cleaning ()
7. Put out the trash ()
8. Toilet ()
9. Bath ()
11. Go up stairs ()
12. Shopping ()
13. Going out () (Walking alone Cane/elderly car Wheelchair Bus/train Taxi Private car)



I=Independence, Support needs : F=Family () N=Home nursing R=Home rehabilitation

P=Pharmacy H=Home helper D=Day care S=Skilled nursing home O=Others ()

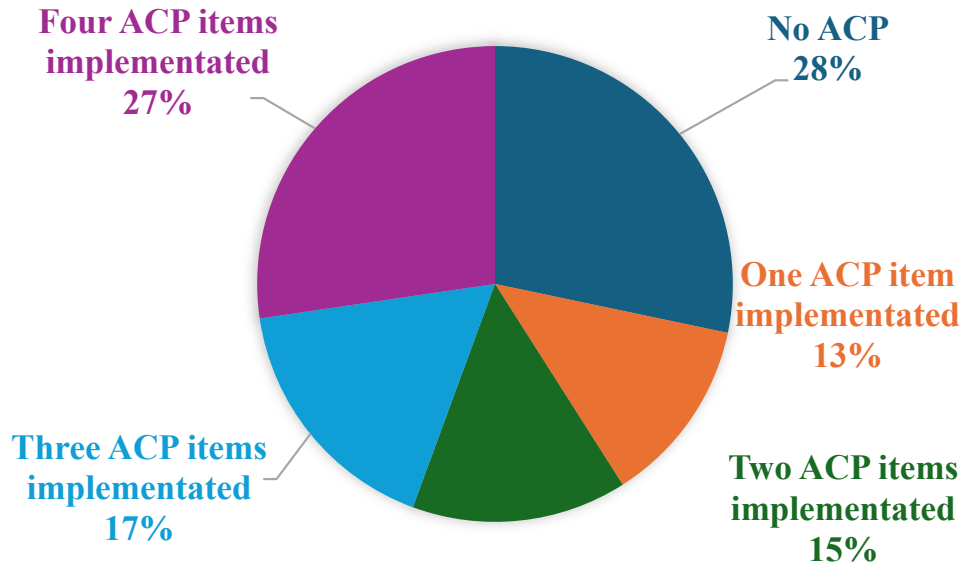
- Notes on daily life ()
- Economic problems () ◦ Cognitive function ()
- Family structure and family information ()
- Nursing care level () Care providers ()

5 Sharing advance care planning !

- Patient values ()
- Surrogate decision maker ()
- Treatment preferences ()
- Preferred place of care (home hospital skilled nursing home)

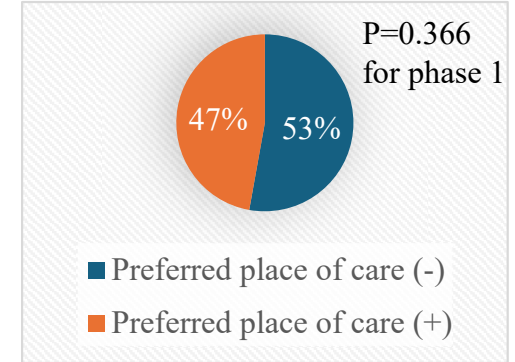
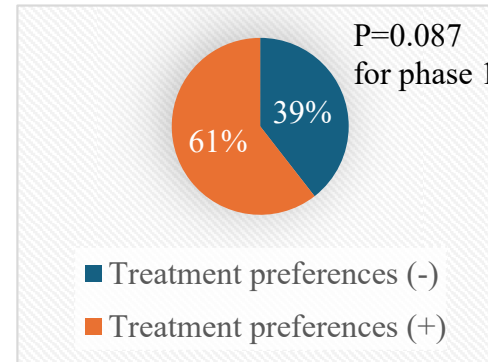
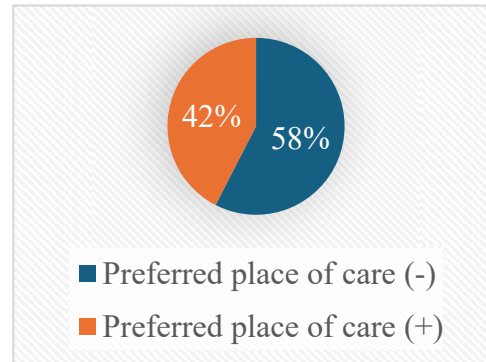
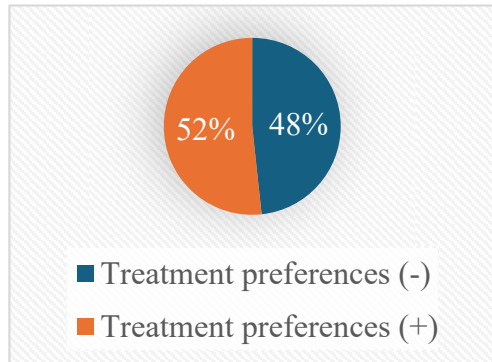
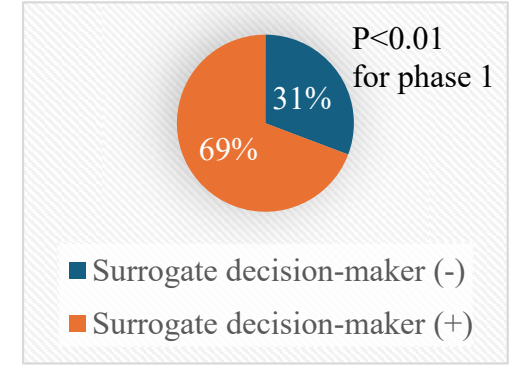
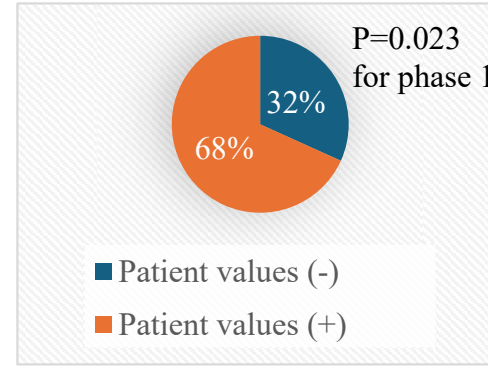
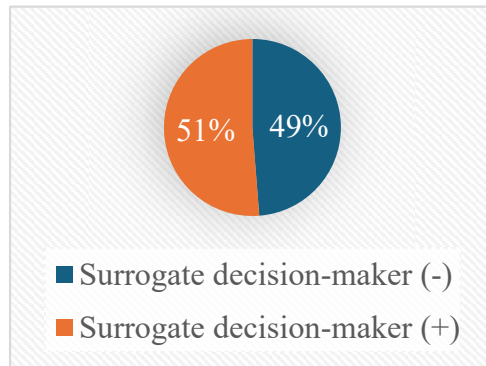
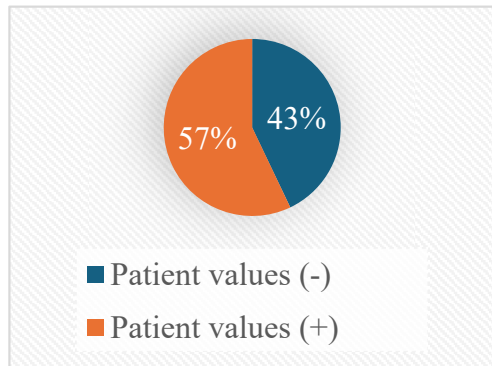
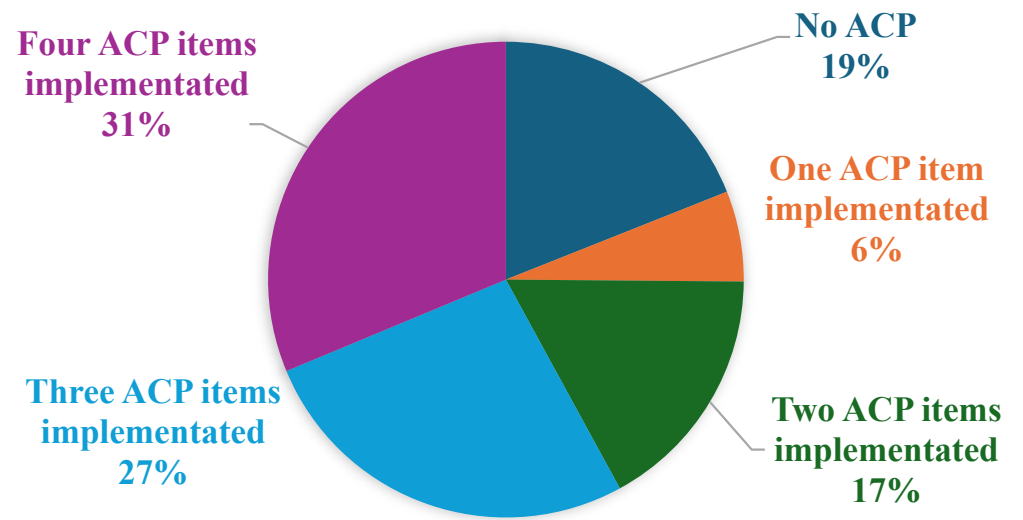


Phase 1



Phase 2

P=0.01 for phase 1



Supplementary Figure 3