

Heart Failure (Chronic) REFERRAL GUIDELINE

HIGH RISK Heart Failure Specialist Consult or Co-Management	MODERATE RISK Cardiology Consult or Co-Management	LOW RISK Suggested Routine Care
Refer or Co-manage with Heart Failure Clinic (CC-HF)	Refer or Co-manage with Cardiology (CC) or HF Clinic (CC-HF)	Managed primarily by Primary Care (PC)
<p>CLINICAL PRESENTATION</p> <ul style="list-style-type: none"> ● Intolerant to cardiac medications ● Worsening cardiac function ● ≥ 2 ED visits or admissions in last year ● Frequent calls to PCP/Cardiology office with signs/symptoms of exacerbation ● Failure to diurese or maintain Target Weight ● Worsening renal function ● Progressive decline in sodium usu. <133 ● Frequent ICD shocks ● Recent escalation of Lasix equivalent > 160/day and or metolazone ● Unknown etiology of cardiac dysfunction ● Evidence for restrictive or infiltrative heart disease ● $EF \leq 30$ ● Frequent sbp >90 mm hg & high HR <p>SUGGESTED PREVISIT WORKUP</p> <ul style="list-style-type: none"> ● Labs: CMP, BNP, LFT, TSH, CBC, Fe Studies ● EKG, Chest X-Ray ● Consider R & L Heart Catherization ● Consider MRI ● Daily weights ● Sodium intake 2500 mg/day ● Fluid intake 1.5 – 2 L/day ● Optimized Guideline Directed Medical Therapy ● Advance Care Planning & Goals of Care Discussions 	<p>CLINICAL PRESENTATION</p> <ul style="list-style-type: none"> ● NYHA \geqII ● At least one ED visit or admission in last year ● Frequent exacerbations <p>SUGGESTED WORKUP</p> <ul style="list-style-type: none"> ● Target Weight established, documented and taught to patient using Teach-back ● Patient education using Healing Hearts guide and Teach-back ● Cardiac rehab referral for systolic heart failure ● Daily weights ● Sodium restriction 2500 mg/day ● Fluid intake restricted ≤ 2 L/day ● Optimize Guideline Directed Medical Therapy ● Labs: CMP, BNP, LFT, TSH, CBC, Fe Studies ● Consider workup: OSA, Obesity, BC, COPD ● EKG, Chest X-Ray ● Consider Right & Left Heart Catherization ● Consider MRI ● Work up other causes-COPD, OSA, obesity, ischemic heart disease ● Advance Care Planning & Goals of Care Discussions ● Advance Care Directive 	<p>CLINICAL PRESENTATION</p> <ul style="list-style-type: none"> ● NYHA I-II ● No hospitalization or ED in past year ● Target Weight easily maintained ● $EF >45\%$, normal heart structure and systolic function, no valve disease, no restrictive physiology ● Maintains normal sinus rhythm <p>SUGGESTED MANAGEMENT</p> <ul style="list-style-type: none"> ● Baseline Labs: CMP, BNP, LFT, TSH, CBC ● EKG, Baseline Chest X-Ray, Stress Test, Echocardiogram ● Target Weight established, documented and taught to patient using Teach-back ● Patient education w/ Healing Hearts booklet and Teach-back ● Daily weights ● Sodium intake 2500 mg/day ● Consider fluid intake restriction ≤ 2 L/day ● Optimize Guideline Directed Medical Therapy (BB, ACEI, SNRA) ● Advance Care Planning & Goals of Care Discussions

See Clinical Pearls next page

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CLINICAL PEARLS

- Echocardiographic assessment of heart structure and functioning is a fundamental step in the workup of dyspnea
- Target Weight is essential: establish, teach, document and communicate. Go to MaineHealth.org/HF for tools.
- Guidelines for diuretic management of CHF exacerbation call for aggressive increases for effective diuresis (more aggressive than current comfort level of many providers). To access these guidelines, supported by evidence - go to MaineHealth.org/HF
- Consider switch to equivalent dose of Bumetanide or Torsemide if repeated decompensation on Furosemide. Bioavailability for Bumetanide & Torsemide is better (~80%) vs. oral Furosemide (~50%)- go to MaineHealth.org/HF
- Cardiac rehab has demonstrated value in the management of CHF, improving patient self-management skills, reducing morbidity and improving QOL.
- Diabetic regimen choices can affect cardiac outcomes

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances. V 1.0 6/17

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