Heart Failure (Chronic) REFERRAL GUIDELINE

MaineHealth

HIGH RISK
Heart Failure Specialist Consult or Co-Management

Refer or Co-manage with Heart Failure Clinic (CC-HF)

CLINICAL PRESENTATION

- 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 ≤ 30
- Frequent sbp >90 mm hg & high HR

SUGGESTED PREVISIT WORKUP

- 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

MODERATE RISK
Cardiology Consult or Co-Management

Refer or Co-manage with Cardiology (CC) or HF Clinic (CC-HF)

CLINICAL PRESENTATION

- NYHA ≥II
- At least one ED visit or admission in last year
- Frequent exacerbations

SUGGESTED WORKUP

- 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

LOW RISK
Suggested Routine Care

Managed primarily by Primary Care (PC)

CLINICAL PRESENTATION

- 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

SUGGESTED MANAGEMENT

- 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

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