CONGESTIVE HEART FAILURE (CHRONIC) REFERRAL GUIDELINE

For more information or referral questions, contact your local cardiology practice. For a complete listing, visit mainehealth.org/services/cardiovascular/service-locations

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 referral to cardiology for R & L Heart Catherization

Consider MRI

Daily weights

Sodium restriction 2500mg/day

Fluid intake 1.5 – 2 L/day

Optimized Guideline Directed Medical Therapy

Advance Care Planning & Goals of Care Discussions

MODERATE RISK

SUGGESTED CONSULTATION 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

Labs: CMP, BNP, LFT, TSH, CBC, Fe Studies

EKG, Chest X-Ray

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

Consider workup: OSA, Obesity, COPD

Consider referral to cardiology for L&R Heart Catherization

Consider MRI

Work up other causes-COPD, OSA, obesity, ischemic heart disease

Advance Care Planning & Goals of Care Discussions

LOW RISK

SUGGESTED ROUTINE CARE

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 using Healing Hearts booklet and teach-back

Daily weights

Sodium restriction 2500mg/day

Consider fluid intake restriction ≤ 2 L/day

Optimize Guideline Directed Medical Therapy (BB, ACEI, SNRA)

Advance Care Planning & Goals of Care Discussions

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
- Avoid NSAIDS
- Consider cardiac risk of chemotherapy regimen

Maine Medical PARTNERS

A department of Maine Medical Center

Approved 10/16/18; Rev. 3/20/19
MaineHealth CHAT Team; Clinical owner Sam Coffin; Administrative owner Richard Veilleux

MaineHealth

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.

V1.0 10/19