CONGESTIVE HEART FAILURE (NEW DIAGNOSIS)

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

Difficulty with Fluid Retention

AKI or CKD

Abnormal cardiac structure and/or function (e.g., valve disease, systolic dysfunction)

Unknown etiology of cardiac dysfunction

Evidence for restrictive or infiltrative heart

EF ≤ 30

SUGGESTED PREVISIT WORKUP

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

EKG, Chest X-Ray, Echocardiogram

Optimized Guideline Directed Medical Therapy

R & L Heart Catherization

MRI

Daily weights

Sodium restriction 2500mg/day

Fluid intake 1.5 – 2 L/day

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

Challenges adhering to care regimen

ED visit or admission in last year

Frequent exacerbations

Moderate or greater aortic or mitral valve disease

SUGGESTED WORKUP

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

EKG, Chest X-Ray, Echocardiogram

Consider referral to cardiology for R & L Heart Catherization

Consider MRI

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

Target Weight established, documented and taught to patient using teach-back

Optimize Guideline Directed Medical Therapy

Patient education using Healing Hearts guide and Teach-back

Daily weights

Sodium restriction 2500 mg/day

Fluid intake restricted ≤ 2 L/day

Advance Care Planning and Goals of Care Conversations

Cardiac rehab referral for systolic heart failure

LOW RISK

SUGGESTED ROUTINE CARE

CLINICAL PRESENTATION

NYHA I-II

No hospitalization or ED

Target weight easily maintained

Normal heart structure and systolic function, trace to mild valve disease, mild diastolic dysfunction

Maintains normal sinus rhythm (NSR)

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

Optimize Guideline Directed Medical Therapy

Patient education w/ Healing Hearts booklet and Teach-back

Daily weights

Sodium restrcition 2500mg/day

Consider fluid intake restriction ≤ 2 L/day

Advance Care Planning and Goals of Care Conversations

CLINICAL PEARLS

- Echocardiographic assessment of heart structure and functioning is a fundamental step in the workup of dyspnea
- Consider stress testing for evaluation of ischemic heart disease
- 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 byevidence - 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

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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.

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