Guide to Heart Failure Referral

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<th><strong>Cardiology Referral Centre or Community Cardiologist/Internist</strong></th>
<th><strong>Advanced Heart Function Clinic</strong></th>
<th><strong>Advanced HF Therapies (VAD &amp; Heart Transplant)</strong></th>
<th><strong>Cardiac Supportive and Palliative Care</strong></th>
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Consider referring if a patient has **one or more** of the following:
- Primary care physician looking for plan of care
- Second admission for HF in last 12 months
- >2 visits to the ER in last 12 months
- Poor access to primary care
- Multiple (>3) chronic co-morbid diseases
- LVEF< 25%
- Kidney disease or blood pressure limitations to titration of medications
- History of poor compliance with treatment regimen

Program services include:
- Medical assessment and follow-up
- Personalized testing and treatment to best meet patient needs
- Assistance with managing medication and therapies for heart failure treatment
- Ongoing patient and family education about the disease process, diet, lifestyle, self-monitoring, and self-assessment
- Optimization of quality of life, symptom management and prevention of hospital admissions
- Ongoing support through follow-up visits and telephone monitoring

Consider referring if a patient has **two or more** of the following:
- Second admission for HF in last 12 months
- >2 visits to the ER in last 12 months
- Multiple (>3) chronic co-morbid diseases
- LVEF< 25%
- Kidney disease or blood pressure limitations to titration of medications
- History of poor compliance with treatment regimen

Program services include:
- Medical assessment and follow-up
- Personalized testing and treatment to best meet patient needs
- Assistance with managing medication and therapies for heart failure treatment
- Ongoing patient and family education about the disease process, diet, lifestyle, self-monitoring, and self-assessment
- Optimization of quality of life, symptom management and prevention of hospital admissions
- Ongoing support through follow-up visits and telephone monitoring

Consider referring if a patient has **all** the following:
- LVEF ≤ 25%
- NYHA FC III or higher
- Maximum tolerated goal directed HF therapies
- **Plus** 1 or more of the following:
  - One or more HF admissions in the past 6 months
  - Hypotension with SBP < 90mmHg
  - High diuretic dose (furosemide > 120mg daily)
  - Recurrent appropriate ICD shocks
  - Worsening renal and/or liver dysfunction
- **Exclusion Criteria:** Advanced non-cardiac co-morbidities with <1 year anticipated survival

Program services include:
- Symptom management
- Goals of care discussion
- Future care planning (e.g. advance care planning, POA, end-of-life care planning)
- Emotional support/coping with life-threatening illness
- Community care referral and coordination
- Caregiver support

Consider referring if your advanced heart failure patient requires the following:
- Performance status poor; e.g. limited self-care; in bed or chair over 50% of the day
- Persistent symptoms despite optimal tolerated therapy; e.g. NYHA Class III or IV
- Two or more unplanned hospital admissions in the past 6 months for any reason
- Two or more acute episodes needing IV diuretic and/or inotropes in the past 6 months
- Renal impairment: eGFR less than 30mL/min/1.73m² or creatinine on admission greater than 200 mcgmol/L
- Cardiac cachexia: progressive loss of lean body mass; reduced muscle strength; anorexia; fatigue
- Patients and/or families with unclear goals of care

Program services include:
- Symptom management
- Goals of care discussion
- Future care planning (e.g. advance care planning, POA, end-of-life care planning)
- Emotional support/coping with life-threatening illness
- Community care referral and coordination
- Caregiver support