Referral Guidelines

HEART FAILURE REFERRAL GUIDELINE FOR ADULTS

Developed January 2021

I. Introduction

There are approximately 6.2 million adults living in the United States with Heart Failure (HF) and the number of people with HF is escalating rapidly. The future population of HF patients will be older, sicker and have more complex needs. HF is one of the leading causes for hospitalization in the United States and the risk of mortality from HF is very high. But, fortunately, there is unequivocal evidence that guideline-directed care improves survival, decreases morbidity and substantially prevents hospitalizations for many people living with HF. However guideline-directed care is becoming increasingly more complex to deliver.

Sutter Health has created an integrated, multidisciplinary, longitudinal care pathway that will optimize HF outcomes by reaching across the entire arc of the patient's condition and coordinating best practice care by all members of the HF care team. This referral guideline is an integral part of providing guideline-directed care as part of this care pathway, and patients should be referred to the specialties and programs below based on these criteria.

This referral guideline is specific for adult ambulatory patients to be used in conjunction with the Sutter Health Ambulatory Heart Failure Guideline. It is not intended for pregnant patients, hospitalized patients, children or adolescents.

II. Referral to Cardiology

Refer patients to a **Cardiologist** for

- New onset or suspected HF for:
    - Evaluation of etiology (such as: evaluation for ischemia, invasive testing like cardiac catheterization or endomyocardial biopsy, advanced imaging like cardiac MRI, genetic counseling and testing, etc.).
    - Management recommendations
- Ongoing evaluation and management (individualized per cardiologist recommendations)

III. Referral to Specialized HF Cardiologist or HF Program

Refer patients to a **specialized HF Cardiologist or specialized HF Program** for:

- Advanced consultation about HF etiology (i.e., evaluation of right sided HF or infiltrative cardiomyopathies).
- Review current and potential therapies, HF disease trajectory and prognosis, patient preferences, and advance care planning.
- Assistance with choice of medications (including replacement of ACEI or ARB therapy with ARNI or consideration of SGLT2 inhibitor use), management of side effects of medications (such as hypotension, bradycardia, hyponatremia, or renal dysfunction), and evaluation for alternate treatment options.
- Treatment of Stage D HF or difficult to manage HF.
- Potential evaluation for a clinical trial.
- Patient meeting one or more of the **I NEED HELP*** criteria.

I	**IV Inotropes**: Requirement of IV inotropes, either chronic or within the past 12 months
N	**NYHA Class**: Persistent **NYHA** class III-IV symptoms, fatigue with activities of daily living, six-minute walk distance <300 meters, or persistently elevated natriuretic peptides (BNP > 500 pg/mL or NT–proBNP > 1500 pg/mL in ambulatory, non-decompensated patients)
E	**Ejection Fraction (EF)**: ≤ 35% despite GDMT for ≥ 3 months for consideration of device therapy in those patients without prior placement of ICD or CRT, unless device therapy is contraindicated
E	**End Organ Dysfunction**: Worsening renal (Cr ≥ 1.8 mg/dL or BUN ≥ 43 mg/dL) or hepatic function, persistent hyponatremia (Na < 134 mEq/L), cachexia (loss of 5% or more body weight in the previous 12 months), and/or worsening right HF with secondary pulmonary hypertension
D	**Defibrillator shocks**: Onset of AF or ventricular arrhythmias, or ICD shocks

H **Hospitalization**: Two or more emergency department visits or hospitalizations for worsening HF in prior 12 months or **High mortality risk** using validated risk model

E **Edema**: Clinical deterioration as indicated by worsening edema, **Escalating Diuretic** requirement, increasing BNP or NT-proBNP levels, worsening cardiopulmonary exercise testing, decompensated invasive cardiac hemodynamics, or evidence of progressive LV dilation or decrease in the LVEF on imaging

L **Low Systolic BP**: SBP $\leq$ 100 mm Hg or symptomatic hypotension or elevated heart rate (>100 bpm)

P **Progressive Intolerance of GDMT**: Unable to tolerate target-dose concordant GDMT, or need to down-titrate GDMT due to fatigue, hypotension, or renal dysfunction.

*The same I NEED HELP criteria organized by category as an alternate way to review

Category	Detail
Vitals	SBP < 100 mm Hg or symptomatic hypotension; Elevated HR (>100) Cachexia
Labs	BNP or NT–proBNP persistently high (BNP > 500pg/mL or NT-proBNP > 1500pg/mL) or increasing in an ambulatory, non-decompensated patient Cr $\geq$ 1.8 or BUN $\geq$ 43 Na < 134
Symptoms	Persistent edema; persistent NYHA class III-IV symptoms, profound fatigue, or 6-minute walk distance <300 m
Medication	Unable to tolerate target-dose concordant GDMT; progressive Intolerance of GDMT; alternate treatment options for GDMT; replacement of ACEI or ARB therapy with ARNI; addition of SGLT2 inhibitors, management of side effects of medications (such as BP, HR, K, Na or Cr)
Comorbidity	A Fib, ventricular arrhythmias, or ICD shocks Worsening renal or hepatic function
ED & Hospital visits	Two or more ED visits or hospitalizations for worsening HF in prior 12 months
Mortality	High mortality risk score
Advancing Disease	Worsened exercise testing; progressive remodeling on imaging; decompensated hemodynamics; Need for past (previous 12 months) or chronic IV inotropes

IV. Referral to Cardiac Rehabilitation

Cardiac Rehabilitation is a medically supervised program designed to improve a patient's cardiovascular health.

Refer patients to **Cardiac Rehabilitation** for HF if the following key indications are met:

- Left Ventricular Ejection Fraction (LVEF) $\leq$ 35%, and;
- New York Heart Association (NYHA) class II to IV symptoms, and;
- On optimal GDMT > 6 weeks, and;
- Has not had recent (within last 6 weeks) or planned (within next 6 months) major cardiovascular hospitalizations or procedures.

V. Referral to Palliative Care

Palliative Care is specialized care that focuses on improving quality of life through relief of stress and symptoms for patients with serious illness.

Refer patients to **AIM/Palliative Care** who meet the following criteria:

- Patient has Stage D HF, or meets criteria for NYHA class III or higher*, or has other components of limited prognosis (such as treatment intolerance or multiple complex comorbid conditions), OR
- Overall life expectancy of patient is less than 12 months.

*NYHA class III or higher: *Patients with limitations of physical activity; they are comfortable at rest; less than ordinary activity causes fatigue, palpitations, dyspnea or angina.*

Refer patients to **Hospice** who meet the following criteria:

- Optimally treated with vasodilators and/or diuretics, and;
- NYHA class IV**, and;
- < 6 months to live

**NYHA class IV: *Patients who are unable to carry on any physical activity without discomfort*

NOTE: The referral decision would additionally align with the patient's choices, values, and preferences for care/readiness for Palliative Care and/or Hospice.

VI. Transfer of Care to Multidisciplinary Programs

Patient care can be transferred to multi-disciplinary geriatric programs if the patient has complex medical and social needs, multiple comorbidities, geriatric syndromes, special needs or frailty. (2) Sutter Health programs are listed below.

For patients in other geographic regions or with other payers, consider review and refer/transfer care to similar local programs when available.

Grove by Sutter Health

Grove is a wrap-around care program that integrates social services into primary medical care for adults with serious illness. The Grove team delivers care in a hybrid model (in-person, by video, or at home) and prioritized care coordination, person-centered care planning and ensures 24/7 access to team. A Grove team consists of a geriatrician, geriatric nurse-practitioner, licensed clinical social worker, and care coordinator.

Patients with a HF diagnosis can be referred to Grove who meet the following criteria:

- Patient must be over 60 and belong to the United Healthcare HMO or Alignment Medicare Advantage Plans.
- Patient must have complex medical needs.
- Patient must be able to live safely in the community and is accepting of team-based care.

PACE (Program of All-Inclusive Care for the Elderly)

PACE provides high quality comprehensive home and community-based healthcare services to participants, anticipating problems to help avoid hospitalizations and premature nursing home placement.

Patients with a Heart Failure diagnosis can be referred to PACE who meet the following criteria:

- Patient must be at least 55 years old.
- Patient must live in one of PACE's zip code service areas (PACE serves Sacramento County).
- Patient must be eligible for nursing home level of care as determined by the State of California.
- Patient must be able to live at home or in a community setting without jeopardizing their health or safety.