Suggested Guidelines for the Diagnosis and Management of Heart Failure in Adults

Post-discharge systems of care are recommended to facilitate the transition to effective outpatient care for patients hospitalized with heart failure.

**Management of post-discharge care for heart failure should include the following:**

- Multidisciplinary HF disease – management programs for patients at high-risk for hospital readmission are recommended
- A follow-up visit within 7-14 days and/or a telephone follow-up within 3 days of hospital discharge is reasonable
- At the first discharge visit and subsequent follow-up visits, the following should be addressed:
  - Causes of HF, barriers to care and limitations in support
  - HF education, self-care, emergency plans and medication adherence
  - Palliative or hospice care as appropriate
  - Assessment of volume status and blood pressure with adjustment of HF therapy
  - Renal function and electrolytes
  - Management of co-morbid conditions
  - Optimization of chronic oral HF therapy
  - Review of discharge medications

**Non-Pharmacological Interventions for Management of Heart Failure:**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>RECOMMENDATION</th>
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</thead>
<tbody>
<tr>
<td>Education</td>
<td>Patients with HF should receive specific education to facilitate HF self-care, including: monitoring symptoms, daily weight monitoring, parameters for when to call physician, medication adherence and staying physically active.</td>
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<tr>
<td>Sodium Restriction</td>
<td>Sodium restriction is reasonable for patients with symptomatic HF to reduce congestive symptoms. 1,500 mg/day appears to be appropriate for most patients with stages A and B. Clinicians may consider some degree of sodium restriction (e.g. &lt;3 gm/day) in patients with stages C and D.</td>
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<tr>
<td>Treatment of Sleep Disorder</td>
<td>Continuous positive airway pressure (CPAP) can be beneficial to increase LVEF and improve functional status in patients with HF and sleep apnea.</td>
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<tr>
<td>Activity/Exercise/Cardiac Rehab</td>
<td>Exercise training (or regular physical activity) is recommended as safe and effective for patients with HF who are able to participate to improve functional status. Cardiac rehabilitation can be useful in clinically stable patients with HF to improve functional capacity, exercise duration, health-related quality of life and mortality.</td>
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</tbody>
</table>

To enroll a member in ConnectiCare’s Total Population Health Program, call 1-800-390-3522. To learn more about the program, refer to ConnectiCare’s Physician and Provider Manual or connecticare.com.
## Stages in the Development of Heart Failure/Recommended Therapy by Stage

<table>
<thead>
<tr>
<th>Stage A</th>
<th>Stage B</th>
<th>Stage C</th>
<th>Stage D</th>
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</thead>
<tbody>
<tr>
<td>At-risk for HF but without structural heart disease or symptoms of HF</td>
<td>Structural heart disease but without signs or symptoms of HF</td>
<td>Structural heart disease with prior or current symptoms of HF</td>
<td>Refractory HF requiring specialized intervention</td>
</tr>
</tbody>
</table>

**Patients with:**
- HTN
- Atherosclerotic disease
- DM
- Obesity
- Metabolic syndrome

Or **patients:**
- Using cardiotoxins
- With family history of cardiomyopathy

**THERAPY Goals:**
- Treat hypertension
- Encourage smoking cessation
- Treat lipid disorders
- Encourage regular exercise
- Discourage alcohol intake, illicit drug use
- Control metabolic syndrome

**Drugs:**
- ACEI or ARB in appropriate patients for vascular disease or DM
- Statins as appropriate

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**Patients with:**
- Previous MI
- LV remodeling including LVH and low EF
- Asymptomatic valvular disease

**THERAPY Goals:**
- Prevent HF symptoms and further remodeling.
- ACEI or ARB as appropriate
- Beta blockers as appropriate

**In select patients:**
- ICD
- Revascularization or valvular surgery as appropriate

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**Patients with:**
- Known structural heart disease and HF signs & symptoms

**THERAPY Goals:**
- Control symptoms
- Prevent hospitalization

**Routine drugs:**
- Diuretic for fluid retention
- ACEI or ARBs or ARNI
- Beta blockers
- Aldosterone antagonists

**Drugs for select patients:**
- Hydralazine/Isosorbide DN
- ACEI and ARBs
- Digoxin
- Ivabradine

**Treatments for select patients:**
- ICD
- CRT
- Revascularization or valvular surgery as appropriate

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**Patients with:**
- Marked HF symptoms at rest
- Recurrent hospitalization despite GDMT

**THERAPY Goals:**
- Control symptoms
- Reduce readmissions
- Establish end-of-life goals

**Options:**
- Advanced care measures
- Palliative care
- Heart transplant
- Chronic inotropes
- Temp/permanent mechanical support
- ICD deactivation
- Experimental surgery or drugs

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The combination of hydralazine and isosorbide dinitrate is recommended for African Americans with HFrEF who remain symptomatic despite concomitant use of ACE inhibitor, beta blockers, and aldosterone antagonists.

pEF = preserved Ejection Fraction, rEF = reduced Ejection Fraction, GDMT = Guideline Directed Medical Therapy, ARNI = Angiotensin Receptor-Neprilysin Inhibitor

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