

Queensland Health Heart Failure Services Referral and Discharge Guide

Endorsed by the Statewide Heart Failure Steering Committee 8/12/11

The Queensland Heart Failure Services steering committee (2011) recommends that all persons with symptoms of heart failure, regardless of aetiology, should be considered for enrolment into a heart failure program. No general blanket exclusion criteria are recommended and patients may be referred from GPs, outpatients or inpatient settings.

Heart Failure Services should automatically accept referrals from any other program Heart Failure Service in Queensland.

Much of the evidence supporting the benefits of multidisciplinary care focuses on patients recently hospitalised with heart failure; and those at high risk of readmission including patients with active co morbidities and symptomatic heart failure; the elderly, and patients with inadequate social and economic support¹. Multidisciplinary care for people with chronic heart failure most commonly targets those at high risk of worsening heart failure².

Inclusion Criteria for Heart Failure Multidisciplinary team

- Diagnosed Heart Failure including systolic dysfunction, preserved systolic function (diastolic heart failure) , and right heart failure
- Anyone over the age of 16 years and no upper age limit

Discharge Criteria

There are no absolute criteria for discharge as this will depend on availability of local health services such as GPs, palliative care, community nurses etc. However heart failure is a chronic condition and heart failure services should consider managing patient flow to ensure that there is capacity to appropriately manage new patients.

Prior to discharge from a heart failure service patients should, at a minimum:

- Be able to self manage (or have a carer who can support the patient and/or support services organised if required)
- Be in the care of GP
- Have reached target doses or maximum tolerated doses of heart failure medications and a medication plan provided to GP. In cases where an Ejection Fraction (EF) has returned to normal, heart failure medications such as beta blockers and ACE-Inhibitors/ARB need to be continued; other medications should be reviewed, eg. need for ongoing diuretics. (Patients being titrated by GPs still require involvement by Heart Failure Service until target is achieved.)
- Be considered for an Electrophysiology review for BiV PPM/ICDs if EF is <35%, the patient is on maximum medication therapy for a number of months and it is deemed medically appropriate to refer for EP review.
- Have Genetics review by RBWH genetic service if indicated (ie patients with hypertrophic or familial cardiomyopathy; family history of sudden cardiac death and themselves have cardiomyopathy)

¹ Haputman PJ, Rich MW, Heidenreich PA, et al. The heart failure clinic: a consensus statement of the Heart Failure Society of America. J Card Fail 2008; 14:801-15

² National Heart Foundation of Australia. Multidisciplinary care for people with chronic heart failure. Principles and recommendations for best practice, 2010.