DEMYSTIFYING HEART FAILURE MANAGEMENT– PRACTICAL TIPS

SharedCare
Partners for Patients

Surrey-North Delta
Division of Family Practice
An FPSC initiative

"The Light of Irene" was created by sɬáməxʷ

Territory Recognition

Our discussions are centered within the geographical region of Surrey-North Delta, and we respectfully recognize these are the shared traditional homelands of the Coast Salish First Nations and home to the Surrey Delta Métis Association.

The Surrey-North Delta Division of Family Practice is committed to learning and building relationships with the people whose lands we are on.

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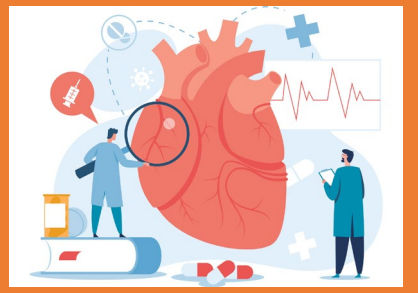
Rules of engagement

- Be curious and authentic
- Be gentle and kind
- Share the floor
- Collaborate with intention
- Share airtime
- Respect differences
- Listen to understand
- Have a learning mindset

Agenda



	Activity	Facilitator
1.	Welcome	Dr. Lamis Samaan/Alina
2.	Housekeeping	Alina
3.	Project updates	Alina
4.	Demystifying the Heart Failure Management-Practical tips Q&A	Dr. Tarun Sharma
5.	Conclusions & Evaluation survey completion	Alina

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Housekeeping

- Registration: Registration required upon arrival
- Sessional payment & Evaluation: You must stay for the whole duration of the event and complete the evaluation and sessional payment form provided to you at the end of the session to receive your payment and CMEs
- The CME certificate will be delivered to you in a pdf format via email in the days following the event

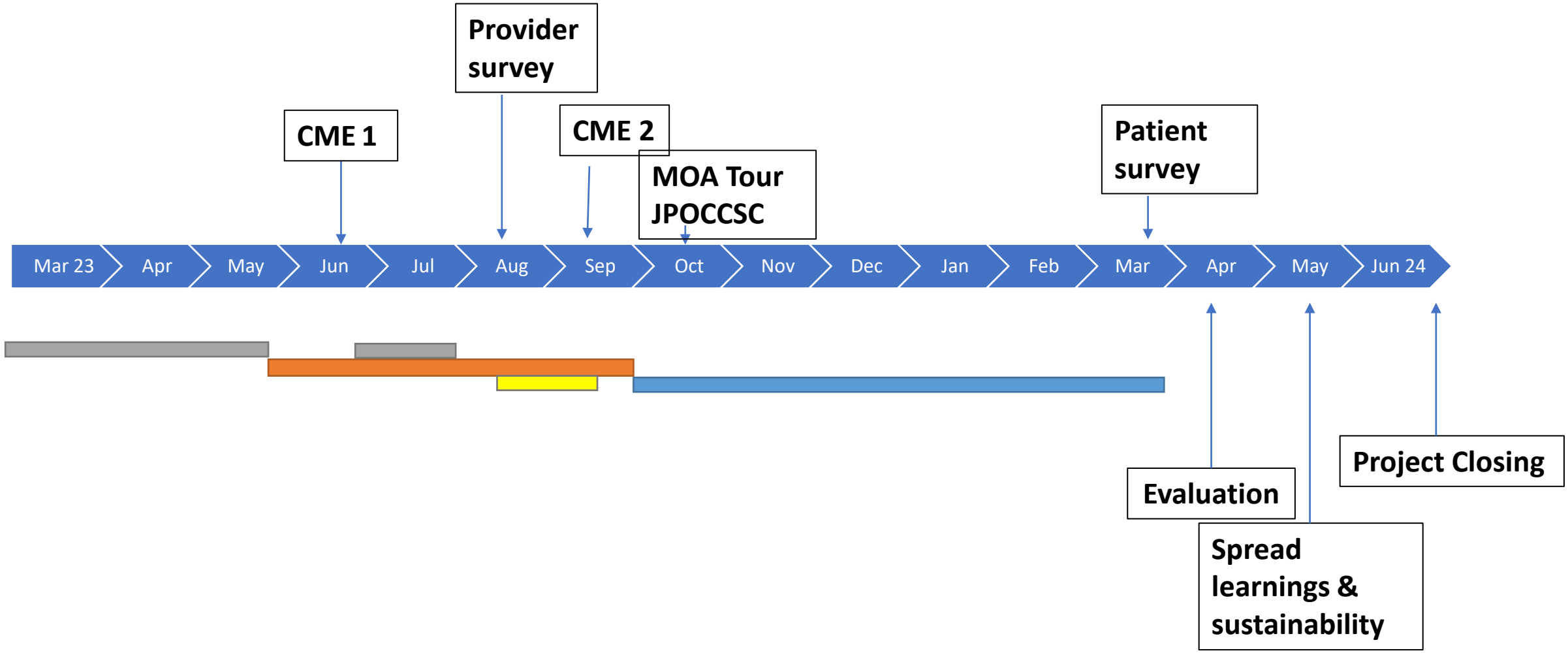
Project Team:

Dr. Lamis Samaan – FP, Physician Project Lead
Dr. Tarun Sharma – Cardiologist, Specialist Project Lead
Dr. Saroj Kumar - FP

Holly Kennedy-Simmons – FH, Cardiac Services, Regional Strategic Lead, RNLead
Jeraldine Washington – JPOCSC, HFC, RN

Moria Jones – JPOCSC, Clinical Ops Manager
Marissa Mcintyre – FH, Lead Indigenous Health
Kimberly Choi – FH, JPOCSC, Director of Ops
Tatjana RadosavljevicFH, Regional CNS, Cardiac Network,NP

Alina Alesu – SND DOFP, Project Manager
Jody Friesen – SND DOFP, Director of Strategic Initiatives & PCN


Provider survey
CME 1
CME 2
MOA Tour JPOCCSC
Patient survey
Mar 23
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun 24
Evaluation
Project Closing
Spread learnings & sustainability
CME planning & design
Communication tools exploration
Pilot of integrated care pathway
Provider Survey small group FPs

DE-MYSTIFYING HEART FUNCTION CLINIC

TARUN SHARMA, MD, FRCPC, FACC

CO-DIRECTOR, HEART FAILURE SERVICES

SURREY MEMORIAL HOSPITAL/JPOC

OBJECTIVE

- Help you recognize HF patients in office
- Define steps in management
- Review resources available

OUTLINE

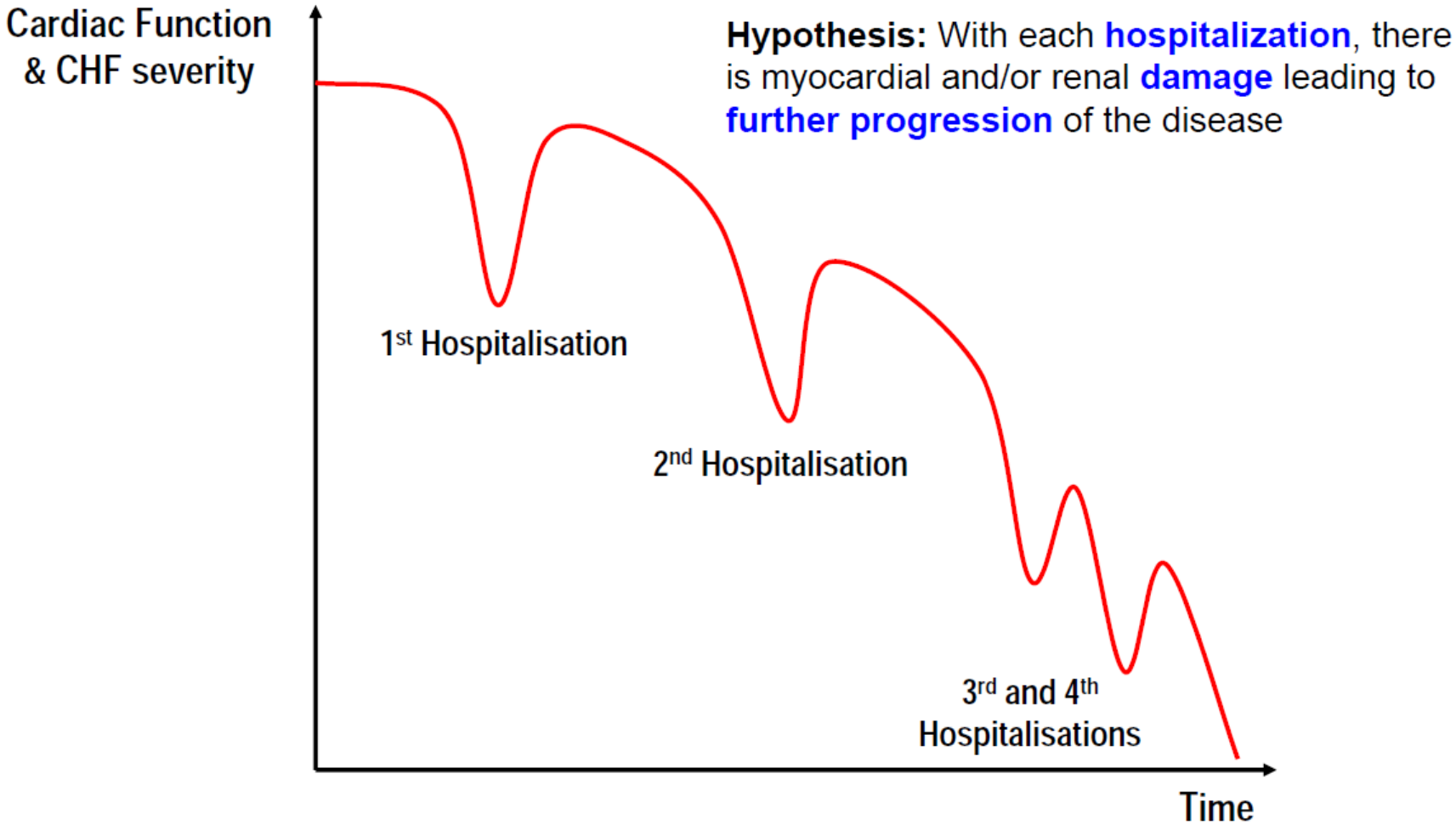
- Review logistics of HF clinic
- Define HF and phenotype of HF patient
- Drug management
- Review clinical cases

In the last episode…

Background

- 750,000 patients with heart failure
- >100,000 patients diagnosed per year
- >2.8 billion/year in healthcare cost by 2030

Recurring Hospitalizations Impair Outcome



Gheorghiade et al. *Am J Cardiol*. 2005; 96:11-17

Team

- Cardiologists
- Registered Nurses
- Nurse Practitioners
- Pharmacists
- Dietitian
- Social worker
- Cardiac rehabilitation

Staff at HF Clinic at JPOCSC

Co-Directors of Heart Failure Service

Dr. Tarun Sharma

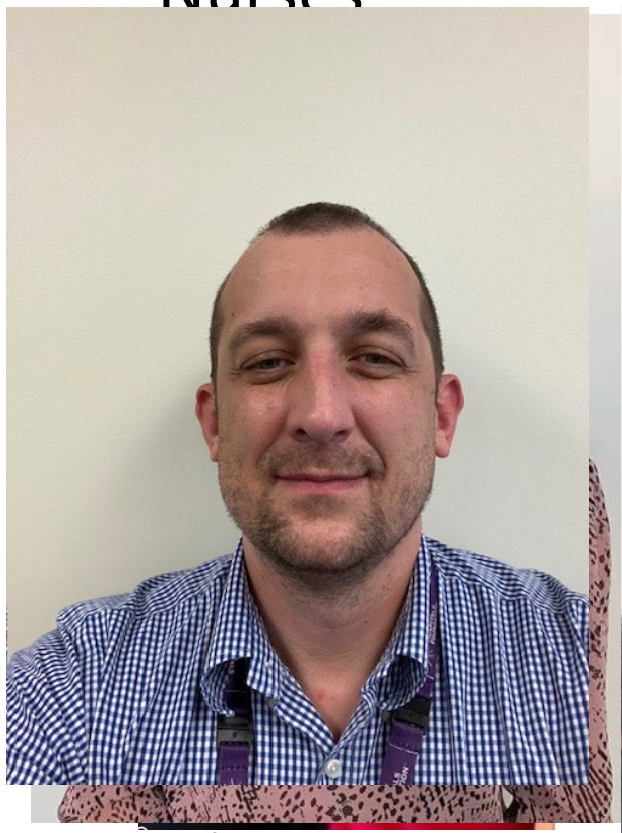
Dr. Calvin Tong

Staff at HF clinic at JPOCSC

Nurses

Pharmacists

Nurse Practitioners



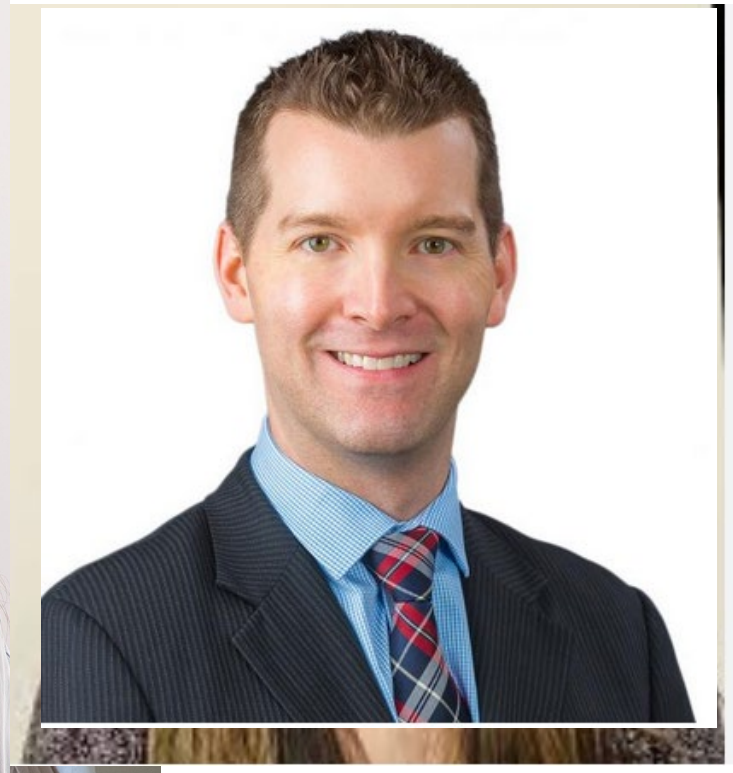
Mark

Roshima

Jeraldine (PCC)

Soomi

Mona



Arden

Pamela

Rohini

Joan

Latest Specialist / Clinic Updates

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News Updates

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Featured Content

Clinician Tools

- Prostate Cancer - PSA Screening Guidelines (Canadian Urological Association)
- Thinking about Weight Differently (This changed my Practice)
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- Infant Formula Shortage- Decision Tree for Specialized Formula for Infants with Food Allergies during a Shortage (Canadian Pediatric Society)

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- Miscarriage - Pregnancy Loss Information and Resources (BC Women's Hospital)

Pearls

- Chronic Low Back Pain - Effectively Treated

fraserhealth

HEART FUNCTION CLINIC REFERRAL

☐ ARH ☐ BH ☐ JPOCSC ☐ LMH ☐ RCH ☐ RMH

Form ID: MSXX104940C Rev: Feb 20/2020 Page: 1 of 1

*Patient	*Referring Provider
Name: _____	Name: _____
City, Province: _____	Phone: _____
Postal Code: _____	Fax #: _____
Contact #: _____	MSP #: _____
PHN#: _____	☐ GP ☐ NP ☐ ED ☐ In patient
DOB: _____	☐ Specialist, Specify: _____

Referral Criteria:

1. Established heart failure of any etiology with an LVEF < 40%
2. LVEF > 40% with sign's and/or symptoms of heart failure, with an elevated BNP or NT-PRO-BNP.

***Primary Community Cardiologist:**

BNP Reference:

Age	*NT Pro BNP*
<50 YRS	> 450
50-75 YRS	> 900
> 75 YRS	> 1800

Indicative of HF	*BNP*
Does not support HF	*<100*
Borderline Zone	100-250
Supports HF	250-400
Strongly supports HF	>400

***Reason for Referral:** Wait times are allocated within published benchmarks as listed below.

☐ **Emergent referral - speak with on-call Cardiologist**	**Emergent heart failure consultation is for cardiogenic shock, inotrope/vaso pressor requirements or respiratory distress.**
☐ New diagnosis of heart failure and UNSTABLE **OR** Post MI heart failure **OR** Post hospitalization HF **OR** Progressively worsening HF	**Appointment within 2 weeks**
☐ Heart Failure with symptoms but NOT decompensated, **OR** New diagnosis of heart failure and STABLE	**Appointment within 4 weeks**
☐ Chronic heart failure management **OR** Asymptomatic LV dysfunction	**Appointment within 6 weeks**

Every effort is made to maintain benchmark times however timing may vary due to volume of referrals.

***Care Management:** *all options will be invited to HF Group Education*

- ☐ Shared care (for 6 months or until discharge criteria met)
- ☐ HF Medication Optimization (Titrations done by Pharmacist, Cardiologist or NP)
- ☐ Education only
- ☐ Advice only (consultation but no changes) Specific question referring provider would like answered?

Please attach a list of current medications, relevant history and investigations.

*Primary Language Spoken, if not English, please ensure there is someone with the patient who can speak English

* Referring Physician/ NP: _____ Date: _____ # of pages faxed _____

* Fax: ☐ ARH: 604-851-4782 ☐ BH: 604-412-6189 ☐ JPOCSC: 604-582-3783 ☐ LMH: 604-514-6012 ☐ RCH: 604-528-5067 ☐ RMH: 604-463-1887

To expedite care PLEASE ensure ALL aspects of this form are completed

HEART FUNCTION CLINIC ROADMAP

TIME LINE 6 MONTHS

REFERRAL
- Determine Urgency
- Register For Education Class
- Register For Intake Appointment

MD INTAKE
- Assessment
- Pre-Printed Orders
- Treatment Plan
- Referrals/Diagnostics

RN/RX FOLLOWUP
- Implement Plan
- Medication titration
- Diuretic titration
- Continue Education

MD/NP FOLLOW UP
- Evaluate Plan
- Assessment

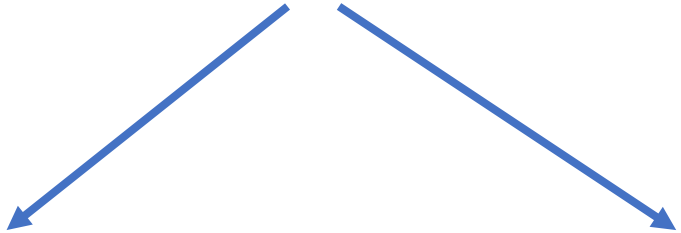
NP FOLLOW UP
- Evaluate Plan
- Assessment

MD/NP DISCHARGE
- To Community Cardiology
- To Primary Physician

Back to the Basics

Heart Failure

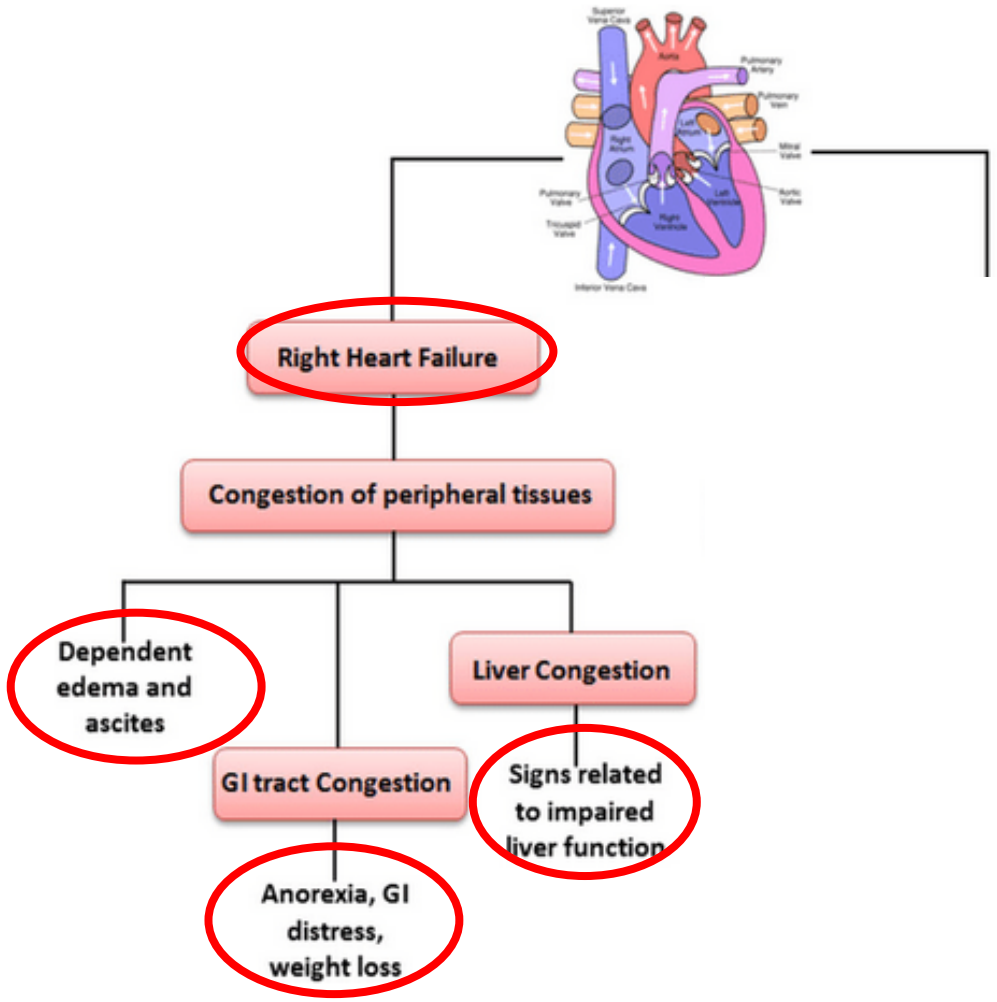
- Inability of heart to meet metabolic demands of the body



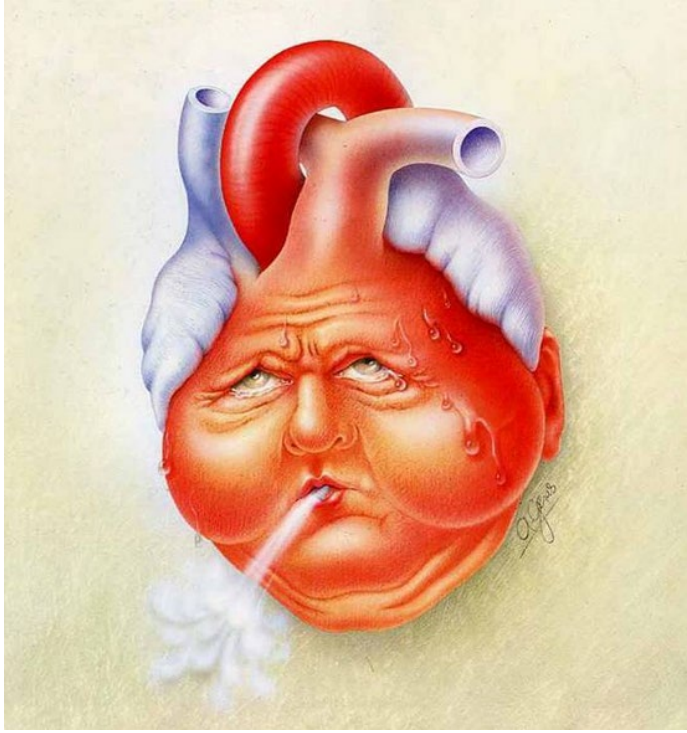
Reduced EF (HFrEF, HFmrEF)

Need high pressures to keep up (HFpEF)

Clinical presentation



Symptoms of right and left heart failure



Case #1:

- 69 year old male
- PMH: HTN, otherwise unknown
- Home meds: None
- First clinic visit, “I feel short of breath and tired”
- Vitals: BP 180/100 mmHg, pulse 80 bpm.
- Exam: No acute distress, Lungs clear, No edema, JVP cant see (refuses to remove his scarf)

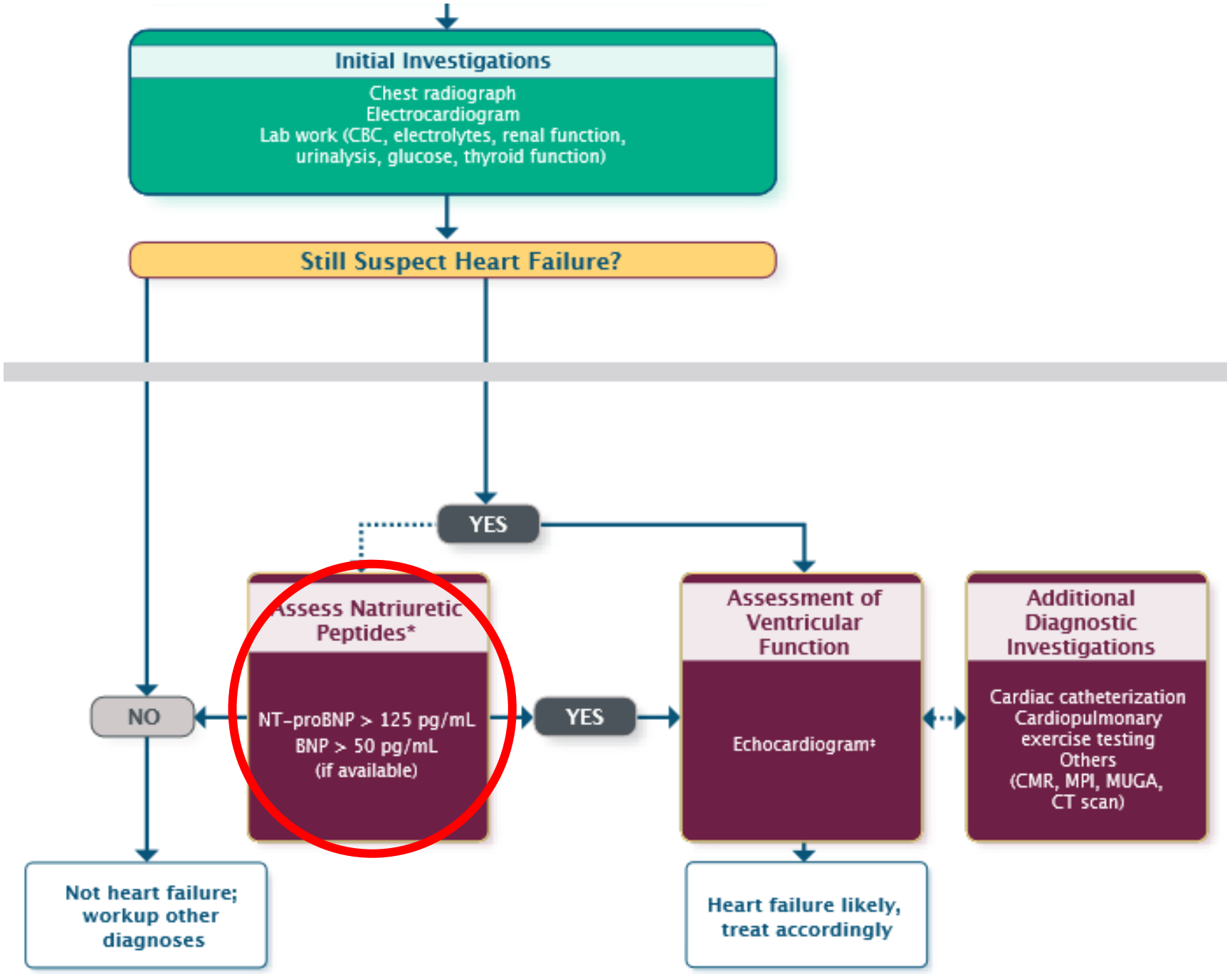
Case #1

- How do you want to manage this patient with shortness of breath with no other history?
- Order more testing
- Send patient to hospital
- Refer to cardiology
- Start Lasix 40 mg daily

What tests would you order?

- #1) Presuming usual things have been assessed for shortness of breath
    - i.e. fever, chills, cough ->infectious process, smoking hx -> COPD,

    - CBC (infection, anemia)
    - Chem 7 (renal failure, hyponatremia, hyperkalemia), TSH
    - BNP or NTproBNP (assess for HF)
    - ECG (assess for arrhythmias)
    - CXR
    - Echocardiogram (will take some time)


Initial Investigations
Chest radiograph
Electrocardiogram
Lab work (CBC, electrolytes, renal function, urinalysis, glucose, thyroid function)
Still Suspect Heart Failure?
YES
Assess Natriuretic Peptides*
NT-proBNP > 125 pg/mL
BNP > 50 pg/mL
(if available)
NO
YES
Assessment of Ventricular Function
Echocardiogram‡
Additional Diagnostic Investigations
Cardiac catheterization
Cardiopulmonary exercise testing
Others
(CMR, MPI, MUGA, CT scan)
Not heart failure; workup other diagnoses
Heart failure likely, treat accordingly

Case #1:

- Tests ordered. What would like to do to conclude the visit?
- See him next in 1-2 months
- See him in next 2 weeks
- Start ramipril (or amlodipine)
- Start Lasix 40 mg daily

Treatment

- DEPENDS on
  - Volume status
  - Associated co-morbidities
  - Ejection fraction (maybe)
  - Only Right sided vs Left sided/biventricular

Treatment for decreasing mortality/hospitalization/worsening HF

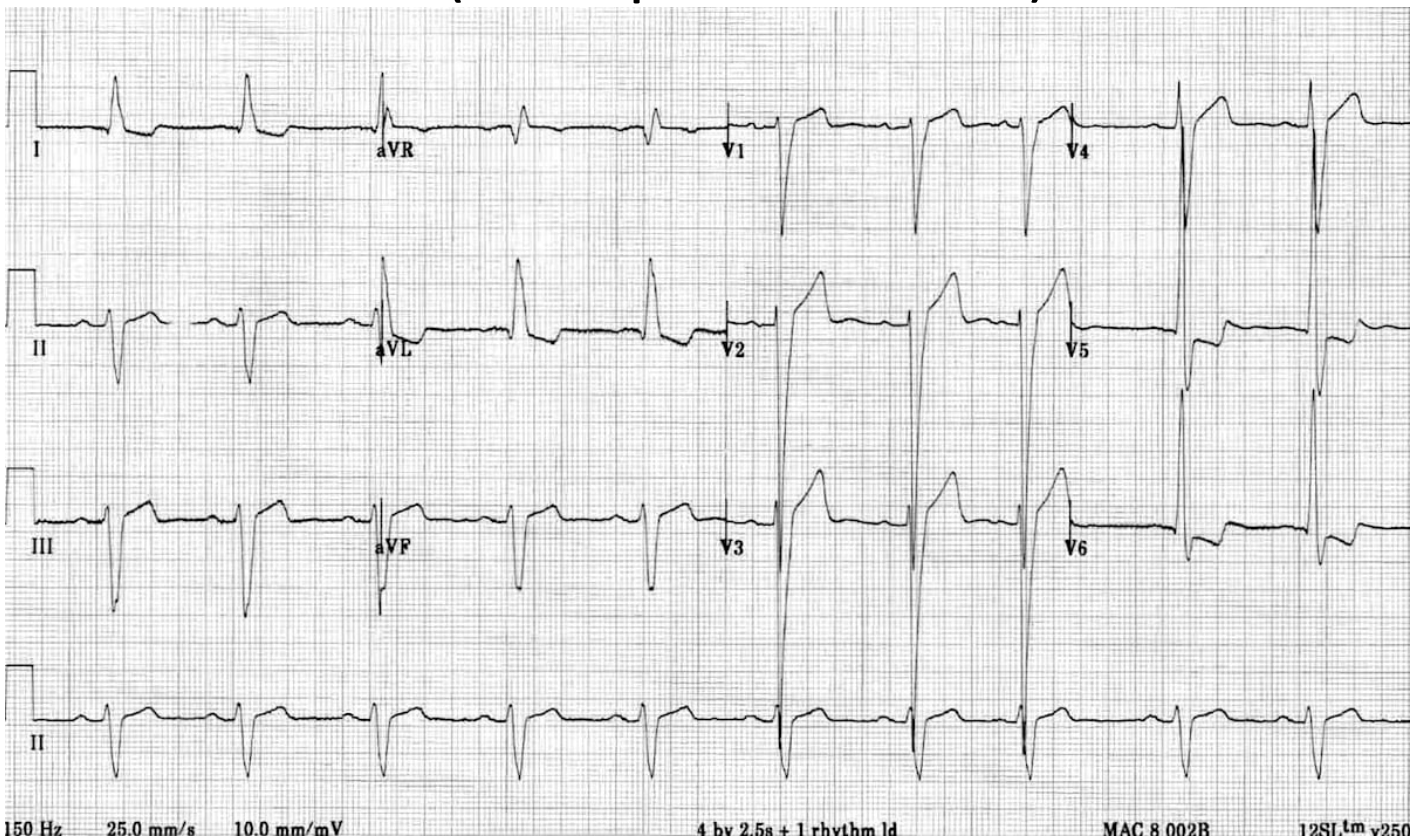
- Reduced EF (HFrEF i.e. LVEF <40%)
  - Beta blocker
  - ARNI (or ACE-i/ARB)
  - MRA (spironolactone)
  - SGLT2 inhibitors

Practical tip for treatment

- Target causes of heart failure (irrespective of EF)
  - If significant excess volume → then need diuresis
  - If Afib with RVR -> then beta blocker
  - If CAD suspected -> needs referral for cath [so cardio referral]
  - If HTN → then needs BP control (prefer foundational meds)
  - If murmur on exam → needs further assessment

Results are in!

- WBC 9, Hg 130, Plt 220
- Sodium 130, K 4, Cr 110, eGFR 45
- BNP 500 (or NTproBNP 2100)



Sinus rhythm with LVH and repolarization abnormality

Now, what would you like to do?

- Refer to heart function clinic → Reasonable to do now we have symptoms and biomarker evidence of HF (i.e elevated BNP)
- Refer to cardiology
- Increase ramipril to 10 mg daily → Especially if BP elevated
- Continue Lasix 40 mg daily → Reasonable based on volume status
- Start spironolactone 12.5 mg daily → Helps irrespective of EF (good for both HFpEF and HFrEF)
- Start SGLT2 inhibitor (dapagliflozin 10 mg daily or empagliflozin 10 mg daily)

Case #1 Continues

- Echo: LVEF 35%, mild RV failure
- BP 120/80 mmHg, pulse 80 bpm. Not volume overloaded.
- Meds: Ramipril 10mg daily, Furosemide 40 mg daily
- Labs: HgA1c 8, TSH 3.20, Sodium 135, K 5.5, Cr 130, eGFR 38 (prior 45)

What would you do next?

- Wait for cardiology/HF clinic appointment
- Stop/reduce furosemide
- Reduce ramipril
- Start spironolactone
- Start dapagliflozin
- Start beta blocker

Common issues

- Renal dysfunction
  - <30% change in Cr/GFR is reasonable
  - Try to get patients on lowest possible dose of diuretic

- Hyperkalemia
  - 5.5 or lower can be monitored
  - Reinforce reduction of potassium lowering foods

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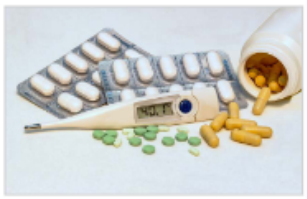
Other common issues

- 3 months later:

- Patient is back:
  - Now on: carvedilol 25 mg BID, Entresto 49/51 mg BID, spironolactone 12.5 mg daily, dapagliflozin 10 mg daily
  - Had flu 2 weeks ago, feels tired and recovering from flu
  - Sodium 138, K 5.4, Cr 180, eGFR 28 (prior Cr 110, eGFR 51)

What would do you do next?

- Refer to Nephrology
- Stop all meds
- Hold meds for 3 days, then resume at half dose
- Repeat renal function (must be an error)



WHAT TO DO WITH Heart Failure Medications IF I'M SICK

Adapted from the 2020 Canadian Cardiovascular Society Heart Failure and Diabetes Canada Guidelines

Rx FILES

Name: _____ **Date:** _____

- When you are sick, it is easy to become dehydrated from throwing up, diarrhea, and/or a fever.
- If you become dehydrated, your body may be stressed. This can make certain medications cause problems.
- This means that **some** medications should be PAUSED when you are sick to prevent side effects.
- These medications can then be STARTED AGAIN once you have recovered from being sick.

MY PLAN

If I have been throwing up, having diarrhea, or a fever and I am worried that I am dehydrated because I cannot keep "anything down" for more than 24 hours, I will PAUSE (temporarily stop) the following medicine(s):

Type of Medication		My Medication
diuretic (water pill; e.g. furosemide **LASIX**, metolazone **ZAROXOLYN**)	❑	
ACE inhibitor (e.g. ramipril **ALTACE**)	❑	
angiotensin receptor blocker (e.g. valsartan **DIOVAN**)		
sacubitril-valsartan (**ENTRESTO**)		
spironolactone (**ALDACTONE**) or eplerenone (**INSPRA**)	❑	
SGLT2 inhibitor (e.g. dapagliflozin **FORXIGA**, empagliflozin **JARDIANCE**) **Go to the emergency department if you have abdominal pain, severe vomiting, or severe drowsiness.**	❑	
others (such as metformin **GLUCOPHAGE**, glyburide **DIABETA**, gliclazide **DIAMICRON**)	❑	

For medications not included in this list, continue taking them as prescribed or consult your cardiologist, family physician, pharmacist, or heart function clinic.

I will START these medications again at my usual dose when I am feeling well and my body has recovered from the illness.

For cough and cold products, do not take any products that contain:

- anti-inflammatory drugs such as ibuprofen **ADVIL**, **COMBOGESIC**, **MOTRIN** or naproxen **ALEVE**
- acetylsalicylic acid **ASPIRIN** for pain or fever; daily low-dose for cardiovascular protection is okay if prescribed
- decongestant tablets or sprays containing pseudoephedrine or phenylephrine

Instead, you can use:

- acetaminophen **TYLENOL** for pain or fever
- saline (salt water) nose spray **SALINEX** or rinse for congestion

SIGNS OF DEHYDRATION

unusually weak or tired
confused or trouble focusing
thirsty, dry mouth
cool, clammy skin
less peeing
new or worsening dizziness or light-headedness when standing or sitting up

WHEN YOU ARE SICK IT IS OKAY TO PAUSE THESE MEDICATIONS FOR A FEW DAYS.

REMEMBER TO:

HYDRATE
try to keep total fluids to around 2 litres per day, limiting caffeinated beverages and replacing fluid loss from throwing up or diarrhea

WATCH SODIUM INTAKE
canned soup & packaged foods are convenient but can cause your body to hold onto extra fluid

KEEP TRACK
continue weighing yourself daily and if you have a machine at home, check your blood pressure and heart rate twice a day, especially if you feel lightheaded

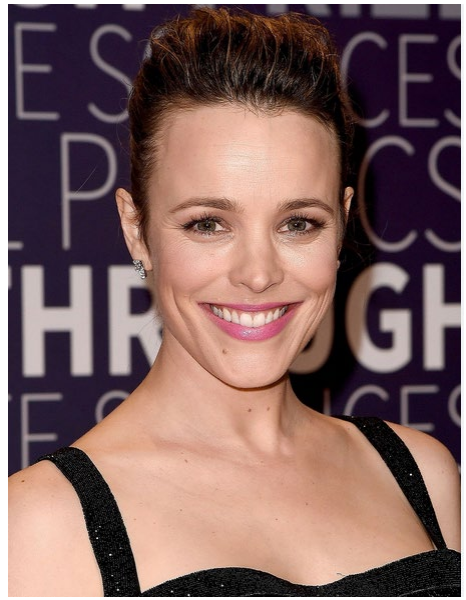
CONSULT
your provider if you have questions, if your weight goes ↑or↓ by more than 1.5 kgs (~ 2lbs) over 2 days, if your blood pressure is unusually low for you, or if you need to PAUSE your medications for more than 2 days

S sulfonylureas
A ACE inhibitors
D diuretics, direct renin inhibitors

M metformin
A angiotensin receptor blockers
N nonsteroidal anti-inflammatory
S SGLT2 inhibitors

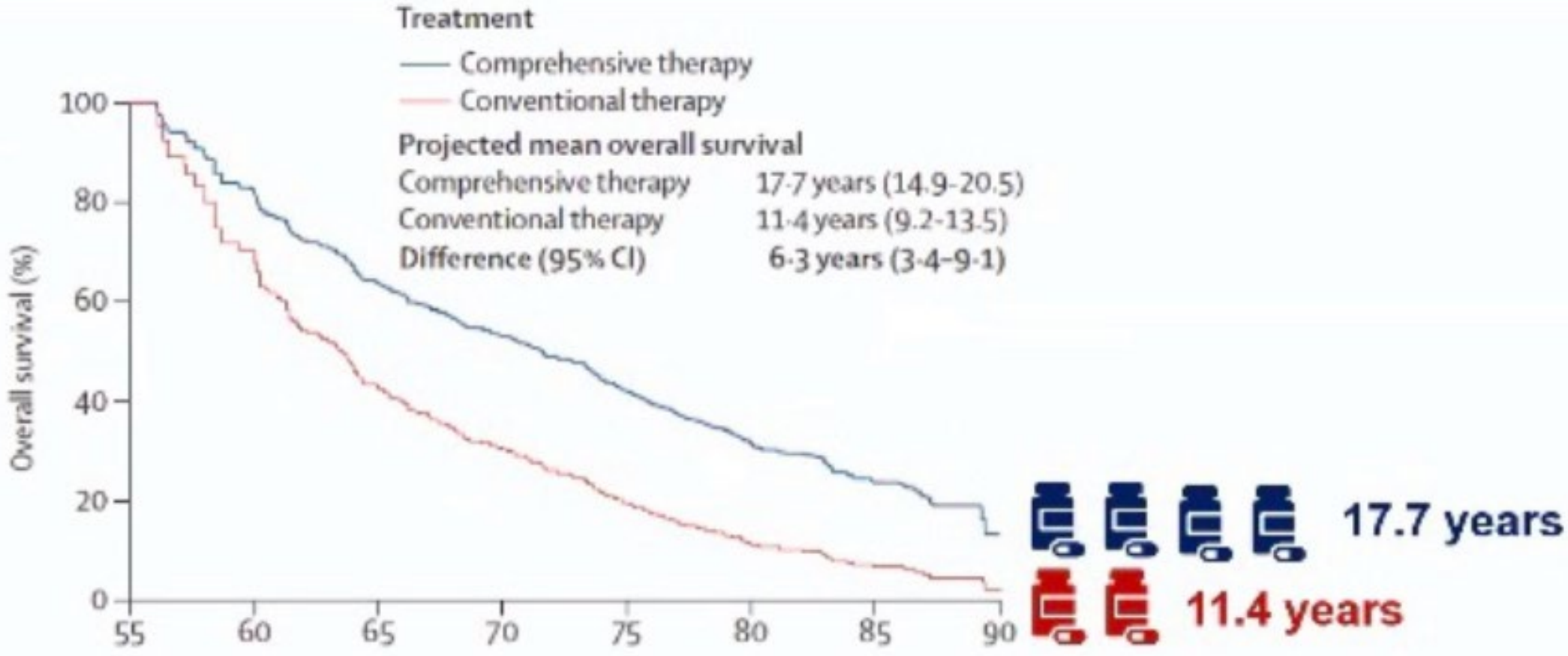
Case #2

- 46 year old female with prior myocarditis
  - EF 38%, stable and doing well
  - Ramipril 5mg daily, bisoprolol 5 mg daily
  - No concerns



What would you do next?

- Nothing. She is doing great
- Increase ramipril/bisoprolol
- Start spironolactone or SGLT2 inhibitor
- Refer her for ICD



6.3 additional years of overall survival

Vaduganathan M et al. *Lancet* 2020

Case #3

- 89 year old male
  - HTN, DM, CKD (eGFR 35), Afib
  - 1 week history of abdominal bloating, palpitations, LE edema
  - Unable to sleep in bed, lying down in recliner, feels tired and dizzy
  - Prior LVEF 55%, moderate TR
- Vitals: 90/60 mmHg, pulse 130 bpm
- What would you do next?

What would you do next?

- Start spironolactone
- Start SGLT2 inhibitor (dapagliflozin 10 mg daily)
- Start diltiazem 120 mg daily and DC home
- Start metoprolol 25mg BID and send home
- Send to hospital

A word on BNP

B-type Natriuretic Peptide (BNP) or NT-proBNP, if available

- **BNP***
  - < 100 pg/ml - HF unlikely
  - = 100-400 pg/ml - HF possible but other diagnoses need to be considered
  - > 400 pg/ml - HF likely
- **NT-proBNP***
  - < 300 pg/ml - HF unlikely
  - = 300-900 pg/ml - HF possible, but other diagnoses need to be considered (age 50-75)
  - = 300-1800 pg/ml - HF possible, but other diagnoses need to be considered (age > 75)
  - > 900 pg/ml - HF likely (age 50-75)
  - > 1800 pg/ml - HF likely (age > 75)

*Values correspond to decompensated heart failure and do not apply for diagnosis of stable heart failure.

Target doses

Drug Class	Specific Agent	Start Dose	Target Dose
ARNI	Sacubitril-valsartan	50-100 mg BID (dose rounded)	200 mg BID (dose rounded)
ACE inhibitor	Enalapril Lisinopril Perindopril Ramipri Trandalopril	1.25-2.5 mg BID 2.5-5 mg daily 2-4 mg daily 1.25-2.5 mg BID 1-2 mg daily	10 mg BID/20 mg BID in NYHA IV 20-35 mg daily 4-8 mg daily 5 mg BID 4 mg daily
ARB	Candesartan Valsartan	4-8 mg daily 40 mg BID	32 mg daily 160 mg BID
Beta-blocker	Carvedilol Bisoprolol Metoprolol (CR/XL)	3.125 mg BID 1.25 mg daily 12.2-25 mg daily	25 mg BID/50 mg BID (>85 kg) 10 mg daily 200 mg daily
MRA	Spironolactone Eplerenone	12.5 mg daily 25 mg daily	25-50 mg daily 50 mg daily
SGLT2 inhibitor	Dapagliflozin Empagliflozin Canagliflozin	10 mg daily 10 mg daily 100 mg daily	10 mg daily 10-25 mg daily 100-300 mg daily
Sinus node inhibitor (If inhibitors)	Ivabradine	2.5-5 mg BID	7.5 mg BID
sGC stimulator	Vericiguat	2.5 mg daily	10 mg daily
Vasodilator	Hydralazine/ Isosorbide dinitrate	10-37.5 mg TID/ 10-20 mg TID	75-100 mg TID or QID/ 40 mg TID
Cardiac glycosides	Digoxin	0.0625-0.125mg daily	N/A: monitor for toxicity

fraserhealth

HEART FUNCTION CLINIC REFERRAL

☐ ARH ☐ BH ☐ JPOCSC ☐ LMH ☐ RCH ☐ RMH

Form ID: MSXX104940C Rev: Feb 20/2020 Page: 1 of 1

*Patient	*Referring Provider
Name: _____	Name: _____
City, Province: _____	Phone: _____
Postal Code: _____	Fax #: _____
Contact #: _____	MSP #: _____
PHN#: _____	☐ GP ☐ NP ☐ ED ☐ In patient
DOB: _____	☐ Specialist, Specify: _____

Referral Criteria:

1. Established heart failure of any etiology with an LVEF < 40%
2. LVEF > 40% with sign's and/or symptoms of heart failure, with an elevated BNP or NT-PRO-BNP.

***Primary Community Cardiologist:**

BNP Reference:

Age	*NT Pro BNP*
<50 YRS	> 450
50-75 YRS	> 900
> 75 YRS	> 1800

Indicative of HF	*BNP*
Does not support HF	*<100*
Borderline Zone	100-250
Supports HF	250-400
Strongly supports HF	>400

***Reason for Referral:** Wait times are allocated within published benchmarks as listed below.

☐ **Emergent referral - speak with on-call Cardiologist**	**Emergent heart failure consultation is for cardiogenic shock, inotrope/vaso pressor requirements or respiratory distress.**
☐ New diagnosis of heart failure and UNSTABLE **OR** Post MI heart failure **OR** Post hospitalization HF **OR** Progressively worsening HF	**Appointment within 2 weeks**
☐ Heart Failure with symptoms but NOT decompensated, **OR** New diagnosis of heart failure and STABLE	**Appointment within 4 weeks**
☐ Chronic heart failure management **OR** Asymptomatic LV dysfunction	**Appointment within 6 weeks**

Every effort is made to maintain benchmark times however timing may vary due to volume of referrals.

***Care Management:** *all options will be invited to HF Group Education*

- ☐ Shared care (for 6 months or until discharge criteria met)
- ☐ HF Medication Optimization (Titrations done by Pharmacist, Cardiologist or NP)
- ☐ Education only
- ☐ Advice only (consultation but no changes) Specific question referring provider would like answered?

Please attach a list of current medications, relevant history and investigations.

*Primary Language Spoken, if not English, please ensure there is someone with the patient who can speak English

* Referring Physician/ NP: _____ Date: _____ # of pages faxed _____

* Fax: ☐ ARH: 604-851-4782 ☐ BH: 604-412-6189 ☐ JPOCSC: 604-582-3783 ☐ LMH: 604-514-6012 ☐ RCH: 604-528-5067 ☐ RMH: 604-463-1887

To expedite care PLEASE ensure ALL aspects of this form are completed

Thank You!