The CCS Heart Failure Companion: Bridging Guidelines to your Practice

Looking for practical answers concerning optimal heart failure care? The CCS Heart Failure Guidelines Companion can help.
The CCS HF Guidelines Companion has been developed in response to key practical questions brought forth by HF practitioners. For the first time, we articulate how soon and how often patients with HF should be seen, when they should be reassessed, how new therapies should be incorporated into treatment algorithms and many other important questions. The HF Companion provides a pathway to achieving optimal treatment and encourages integration of the CCS HF guidelines into daily practice.

We adopted a question and answer approach with the main HF provider in mind, indicating where published evidence, randomized controlled trials, and expert consensus informed the responses. Graphics, tables and lists have been incorporated throughout both the online and print versions to ensure the busy clinician may conveniently use this tool.

1. How soon should I see a newly referred heart failure patient, how often should my heart failure patient be seen, and when can a patient be discharged from a heart failure clinic?
2. How quickly and in what order should standard heart failure therapy be titrated for most patients?
3. When should I measure electrolytes, serum Creatinine and BUN and how should I manage abnormal potassium or rising creatinine levels?
4. Should I treat my heart failure patients to a specific heart rate or blood pressure and how often should I measure left ventricular EF?
5. Can I ever stop heart failure medications?
6. When should I refer my patient to a heart surgeon?
7. How should I manage gout in my patient?
8. In what way do I care differently for frail older patients with heart failure?
9. How do I teach self-care to my patients?

Find it Online A full version of the HF Companion is available online in the Canadian Journal of Cardiology at www.onlinecjc.ca and at CCS.CA in the Guidelines Library.
Recommended Initial Referral
Wait Time and Follow-up Frequency

Routine, Elective Referral
- Chronic HF disease management, NYHA II
- NYHA I - minimal or no symptoms

Semi-Urgent, Intermediate Risk
- New diagnosis of HF, stable, compensated
- NYHA II/III
- Worsening HF on therapy
- Mild symptoms with valvular or renal disease or hypotension

Urgent
- New diagnosis of HF, not improving on therapy (unstable, decompensated)
- Progression to NYHA IV HF
- Post-hospitalization or ER visit for HF
- Severe HF with valvular or renal disease or hypotension
- Post myocardial infarction HF

Emergent
- Acute severe myocarditis
- Rapidly progressive HF/cardiogenic shock
- HF with ACS or MI
- Transplant and device evaluation of unstable patients
- New-onset acute pulmonary edema

High Risk Individual
- NYHA IIIb or IV symptoms
- Recent HF hospitalization
- During titration of HF medications
- New onset heart failure
- Complications of HF therapy (rising creatinine, hypotension)
- Need to down-titrate or discontinue beta-blockers or ACEi/ARB
- Severe concomitant and active illness (e.g. COPD, frailty)
- Frequent ICD firings (1 month)

Intermediate Risk Individual
- No clear features of high or low risk

Low Risk Individual
- NYHA I or II
- No hospitalizations in past year
- No recent changes in medications
- Receiving optimal medical/device HF therapies

Follow-up every 6-12 months

* Visit frequency may increase during medication titration

Follow-up every 1-4 weeks or as clinically indicated (remote monitoring possible for some titrations)

Follow-up every 1-6 months

Follow-up within 24 hrs

Follow-up within 4 weeks, ideally within 2

Follow-up within 12 weeks, ideally within 6

Follow-up within less than 2 weeks

Follow-up every 1-4 weeks or as clinically indicated

* Visit frequency may increase during medication titration

Make inactive or consider for discharge from HF clinic if a minimum of 2 of the following characteristics are present:

- Stable NYHA I or II for 6-12 months
- On optimal therapies
- Reversible causes of HF fully controlled
- Having access to General Practitioner with expertise in management of HF

- Stable adherence to optimal HF therapy
- No hospitalizations for >1 year
- LVEF >35% (consistently shown if more than one recent EF measurement)
- Primary care provider has access to urgent specialist reassessment
**Therapeutic Approach to Patients with Heart Failure and Reduced Ejection Fraction**

**Patient with LVEF <40%**

**Triple Therapy**
ACEi (or ARB if ACEi intolerant), BB, MRA
Titrate to target doses or maximum tolerated evidence-based dose

**ADD Ivabradine and SWITCH ACEi or ARB to LCZ696 for eligible patients**

**NYHA II-IV: SR, HR ≥ 70 bpm**
ADD Ivabradine* and SWITCH ACEi or ARB to LCZ696 for eligible patients**

**NYHA II-IV: SR with HR <70 bpm or AF or pacemaker**
SWITCH ACEi or ARB to LCZ696 for eligible patients**

**Reassess Symptoms**

**NYHA I**
Continue triple therapy

**NYHA I or LVEF >35%**
Continue present management

**NYHA I-III and LVEF ≤ 35%**
Refer to ICD/CRT algorithm

**NYHA IV**
Consider:
- Hydralazine/nitrates
- Referral for advanced HF therapy (mechanical circulatory support/transplant)
- Advanced HF referral

**Reassess Symptoms and LVEF**

**Reassess every 1-3 years or with clinical status change†**

**Consider LVEF reassessment every 1-5 years**

**Reassess as needed according to clinical status‡**

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* Pending Health Canada approval
† Ivabradine may be added when available in Canada
‡ LCZ696, when available in Canada, will replace ACEi or ARB in patients with elevated NP or recent hospitalization (BNP > 150 pg/ml or NT-pro-BNP > 600 pg/ml)
‡ Refer to Table 4 (in companion document)
Other CCS Tools and Resources

Access these clinical tools and additional educational resources at CCS.CA

- Pocket Guides
- Slide Decks
- Library of Guidelines (HF, AF, Lipids & more)
- HF Compendium
- Mobile Apps: Med-hf, iCCS