Chronic HFrEF (age ≤ 65 years)*
Out-Patient Referral

PRE-REFERRAL WEEKS / MONTHS / YEARS***

New Diagnosis HFeEF
Stabilize & Initiate & Update GDMT (community /hospital/clinic)
Specific cardiac management (eg revasc/rhythm/valvular disease) as indicated
Device Therapy per Guidelines
Treat any comorbidities/risk factors including **
Stop Smoking
BMI < 30
Minimize/stop alcohol and other substances
Optimize Diabetic Control if desirable

Regular Local /HF Clinic Follow-Up
Active Management
(as indicated)
GDMT
CRT
Revascularisation
Valvular therapies
Rhythm control

CONSIDERING REFERRAL

Still Persistent NYHA ≥ 2 Symptoms AND no or minimal improvement in EF despite the above

Is there Limiting Comorbidity causing life expectancy < 1 year or chronic non-cardiac condition causing significant reduced QoL?
(eg PVD / neurological disease / cancer /COPD)

YES

C/t mx local HF clinic ± Subspecialty Service
Contact Adv Hf Centre to discuss if ?s
Consider palliative care referral

NO / NOT YET

NO

Stopped / Non -smoker > 6/12?
Stopped alcohol / other substances?
BMI <30?

YES

"I NEED HELP" Criteria*
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TIME OF REFERRAL

DO THEY HAVE 1≥ **"I NEED HELP"** Criteria*

I	Inotropes	Previous / ongoing requirement for any inotrope
N	NYHA Class / Natriuretic peptide	Persisting NYHA class 111-IV / persistent high BNP?Ntpro-BNP
E	End-organ dysfunction	Worsening renal or liver dysfunction in the setting of HF
E	Ejection fraction	Very low ejection fraction <20%
D	Defibrillator shocks	Recurrent appropriate defibrillator shocks
H	Hospitalization / Hyponatremia	> 1HF hospitalization past 12 months / Serum NA <133mEq/L
E	Edema / Escalating diurectics	Persisting fluid overload and / or increasing diuretic need
L	Low blood pressure	Consistently low BP with systolic <90-100mmHg
P	Prognostic medications	Inability to uptitrate (or need to decrease / stop RAASi/ARNi?BB/MRA

Lab abnormality cut-offs: NT-proBNP>1000pg/ml; Creatinine >160umol/L, Liver dysfunction: any (due to HF)

YES

Refer to MMUH Advanced HF Centre Consultant Only Referral

Complete Heart Transplant / LVAD referral form, email to:
heartransplantandvadreferrals@mater.ie
If ability / feasibility for CPET, please order and send with results

FOOTNOTES

* selected patients 65 – 69 with already established chronic advanced may be considered on case by case basis; this algorithm is for those starting out at <65

** as well as needing to treat them to improve HF symptoms in general, these are common reasons that patients down the line are not candidates for or cannot be evaluated for transplant – need to target upfront!

*** Timing of thinking about referral for advanced HF therapies varies for everyone. Most often, for the majority of these pathway patients, it will be after years of HFrEF. However, there are a subset of patients in whom assessing whether or not they may need to be referred will be much shorter, and may even be weeks to months after initial diagnosis. Key is to consider them still and go through the algorithm - if they have persistent symptoms and no improvement in EF and 1 or more I NEED HELP criterion – refer, even if only weeks!

**** if any doubt as to limiting nature of a comorbidity or condition please reach out to Advanced HF service to discuss

Other Notes

Active smoking is an Absolute contraindications to Tx.

Additionally, in a chronic/stable outpatient referral BMI should be <30. Unfortunately services too limited to spend time at Adv HF clinic pushing smoking cessation, or weight loss, when these patients are already established with cardiology clinics/HF services.

Similarly, alcohol MUST be minimized in those with HFrEF.

Other substances includes vaping, cannabis

If urgent referral/new diagnosis but worried that already advanced, and are active smokers/BMI >30, please discuss with Advanced HF team.