**Table 2:** Heart Function Clinical Referral Recommendations and Criteria in Current Practice Guidelines and Policy Documents

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| Author / organization | Document Title | Key Referral criteria  |
| Ezekowitz et al., 2017 Canadian Cardiovascular Society | Guidelines for the diagnosis and management of HF | “Practical tip: Patients with persistence of HF symptoms or ventricular dysfunction should be followed in a multidisciplinary HF/function clinic.”“Patients with RHF secondary to congenital heart disease or secondary to PH should be referred early to specialized clinics for investigations and management”“We recommend that all patients with recurrent HF hospitalizations, irrespective of age, multimorbidity, or frailty, should be referred to a HF disease management program (*Strong Recommendation; High-Quality Evidence*).” |
| Ponikowski et al., 2016 European Society of Cardiology | Guidelines for the diagnosis andtreatment of acute and chronic HF | “It is recommended that patients with HF are enrolled in a multidisciplinary care management programme to reduce the risk of HF hospitalization and mortality. *(Class I, level A).”*  |
| Health Quality Ontario (Health Quality Ontario, 2018)  | Quality Standards;HF care in the community for adults | “People with newly diagnosed heart failure, those who have been recently hospitalized or treated in the emergency for heart failure, and those with advanced heart failure (NYHA III-IV) are offered a referral to specialized multidisciplinary care for heart failure” |
| Yancy et al., 2013†American College of Cardiology Foundation/American Heart Association / Heart Failure Society of America§ | Guideline for the Managementof HF | “Multidisciplinary HF disease-management programs are recommended for patients at high risk for hospital readmission, to facilitate the implementation of GDMT, to address different barriers to behavioral change, and to reduce the risk of subsequent rehospitalization for HF *(Class I, Level B)”* |
| Yancy et al., 2018 American College of Cardiology Task Force on Expert Consensus Decision Pathways | 2017 ACC Expert Consensus Decision Pathway for Optimization of HF Treatment | I-NEED-HELP: IV inotropes; NYHA IIIB/IV or persistently elevated natriuretic peptides; End-organ dysfunction; Ejection fraction ≤35; Defibrillator shocks; Hospitalization >1; Edema despite escalating diuretics; Low blood pressure, high heart rate; Prognostic medication – progressive intolerance or down-titration of GDMT |

†2017 comprehensive update does not address HF clinics, Pg 1381, Under situational wait time benchmark, it has the type ( description of patients being referred and wait time recommendations – from routine to emergent. Semi urgent and urgent referral being considered as intermediet risk patient and and emergent as high risk individuals.

§2006 HFSA guideline (Adams et al., 2006) suggested the following as candidates for HF clinics: patients recently hospitalized for HF, other “high-risk” patients (i.e., renal insufficiency, diabetes, chronic obstructive pulmonary disease), persistent NYHA class III or IV symptoms, frequent hospitalizations for any cause, elderly patients and other patients with multiple active comorbidities, as well as a history of depression, cognitive impairment, persistent non-adherence to therapeutic regimens, or inadequate social or economic support.

GDMT: Guideline-directed medical therapy; HF: Heart failure; LVEF: Left ventricular ejection fraction; NYHA: New York Heart Association; PH: Pulmonary hypertension; RHF: Right heart failure; RV: Right ventricle