Initial and Subsequent Office Visit Templates

	Initial Visit (confirm diagnosis, etiology, and initiate appropriate therapy)
Provider History	• Duration of illness • NYHA Class (I-IV) • Weight gain/loss, new or worsening edema, orthopnea, and dyspnea • Assessment of comorbidities including obesity, prior CAD, atrial fibrillation, DM, HLD, and smoking • Potential clues suggesting etiology of heart failure if unknown *(ischemic vs. non-ischemic).* • Assess, if indicated, for any known or suspected anemia, valvular, lung, liver, thyroid, renal, or rheumatologic diseases, pulmonary hypertension, sleep apnea, HIV infection, recent pregnancies, relevant travel, or symptoms of pheochromocytoma • Complete medication review, including OTC medications • PHQ 2 and if positive, PHQ 9. • Current/past alcohol use • Prior drug abuse, including IVDA • Diet and fluid intake • Family history • Inquire if Healthcare Proxy form has been completed • Previous COVID-19 infection and antibody status

Provider Physical	• Blood pressure, pulse, weight, BMI, possibly 02 sat
	• Assessment of volume status
	• Cardiovascular exam (especially JVD, hepatojugular reflex, and presence of S3)
	  • Telemedicine consideration:
	  o "edema check": ("PLACE YOUR FINGERS WHERE YOU HAVE SWELLING ON YOUR LOWER LEG, PUSH DOWN HARD AND REMOVE, DO YOU SEE AN INDENTATION? IF YES, HOW DEEP IS THAT INDENTATION

Diagnostic Studies	**1. Lab work** • CBC with diff • BMP, magnesium • Lipid profile • BNP or NT-proBNP *(if no prior documentation)* • Troponin (*risk marker)* • Digoxin level, if signs or symptoms of toxicity or recent addition of interacting drug • PT/INR (Every patient on warfarin should be enrolled in an anticoagulation clinic or have his/her PT/INR followed closely by a designated provider.) **2. Consider the following in appropriate patients if the etiology of HF is unknown** • TSH • LFTs • HIV Ab (if not recently documented) • Anemia panel and Hemochromatosis screen *(transferrin sat, ferritin)* • Rheumatologic evaluation • Evaluation for amyloidosis, if red flags present • Others as indicated **3. Procedures** • 12-lead EKG; document QRS duration • Echo with Doppler flow studies; document EF • Chest X-ray: PA & Lat • Ischemic workup in appropriate patients

	Telemedicine considerations • When possible, get blood tests done ~ 1 week prior to virtual visit, either at office, local phlebotomy center (Labcorp/Quest) or have blood drawn at home (Apex Lab) • Results of home cardiac rhythm (KardiaMobile) monitoring can be transmitted to practice in advance of visit • Patient should upload results of home monitoring into Epic or fax to office prior to visit • When available, staff can outreach to patient in advance of visit to collect needed information
Medical Therapy	**For patients with HFrEF** **Plan to initiate treatment in stepwise manner. Titrate to target dose as per GDMT.** If the patient is hemodynamically stable, it is generally acceptable to double the dose of the neurohormonal antagonist (Beta-blockers, ACE, ARB, ARNI mineralocorticoid antagonists (i.e. Spironolactone)) when increasing the dose. It is recommended that only one of these agents be increased each visit. Caution is advised if increasing more than one. **Document contraindications or intolerance** • ACEI/ARB: initiate/titrate to target dose, document contraindications/intolerance. • Use Subcutril/Valsartan (i.e. Entresto) instead of ACE/ARB for patients with NYHA class II-III and LVEF ≤ 35% who are stable an an ACEI/ARB. • Beta blocker: initiate/titrate using either carvedilol, sustained-release metoprolol succinate, or bisoprolol • Aldosterone antagonist: initiate/titrate if not contraindicated (GFR≥30ml/min,K <5.0 mEq/ml) and NYHA class II-IV HF with LVEF ≤ 35% *(NYHA Class II should have hx of prior CV hospitalization or elevated BNP*) or post-MI with LVEF ≤ 40% with symptoms of HF or who have DM • Hydralazine/isosorbide dinitrate: Initiate/titrate in African American patients NYHA class III-IV on standard medical therapy including ACEI/ARB or ARNI, and BB; consider in all patients who cannot tolerate an ACEI/ARB or ARNI unless contraindicated. • Diuretic: initiate/titrate in patients with fluid retention. • Ivabradine: if sinus rhythm, HR >70 bpm on maximally tolerated beta blocker, NYHA II-III, and no contraindications • Digoxin for NYHA III-IV symptoms despite optimal GMT and/or rate control for atrial fib. • Dapagliflozin (ie SGLT-2i) should be considered as adjunctive therapy, to reduce CV death and worsening HF, even in absence of Type 2 diabetes, unless contraindicated, and after considering potential incremental cost to patient • Anticoagulation indicated if atrial fibrillation present. Choice of agent should be individualized. Routine anticoagulation for heart failure without atrial fibrillation is not indicated. • Antiplatelet therapy: as indicated • Lipid-lowering therapy: as indicated **For patients with HFpEF:** • Focus on treating volume overload (diuretics, salt restriction) and effectively managing their comorbidities. • Mineralocorticocoid receptor antagonists may be helpful in HFpEF. • Consider use of SGLT-2i (GFR >30) or GLP-1 Agonists if SGLT-2i contraindicated. • Avoid nitrates.
Considerations for Patients with Co-existing Type 2 Diabetes	• **Metformin remains first line therapy for diabetes (if GFR > 30).** • **SGLT-2i (dapagliflozin, canaglifozin, empaglifozin) are preferred in HFrEF when additional therapy required, unless contraindicated/cautions {Type 1 DM, symptomatic hypotension or SBP <95 mmHg, GFR <30, prior/high risk for DKA, risk of foot amputation (ulcer, PVD, neuropathy, deformity), recurrent UTI's/genital mycotic infections}.** • **Thiazolidinendiones (pioglitazone, rosiglitazone) are contraindicated.** • GLP-1 receptor antagonists (exenatide, semaglutide,dulaglutide, liraglutide) can be used if SGLT-2 inhibitors are contraindicated. Contraindications to GLP-1 RA include personal/fam hx of medullary thyroid cancer, MEN Type 2, pancreatitis, gastroparesis, GFR <30. (perhaps remove) • DPP-4 inhibitors (linagliptin, sitagliptin, alogliptin) should be used cautiously in all patients who have diagnosis. Saxagliptin should not be used. (perhaps remove)
Immunizations	• Pneumococcal vaccination (PPSV-23 and possibly PV-13) and annual influenza vaccination in the absence of known contraindications. For telemedicine visits, can be ordered and subsequently administered in office or at local pharmacy.

Device Therapy	• Remote monitoring of BP, pulse, weight, possibly 02 sat. • Consider EP referral for primary ICD or CRT in patients with: o EF ≤ 35% for at least 90 days (or 40 days post MI) on chronic GDMT.
Escalation Pathway	• Primary Care: Every patient should have a primary care physician (Patients should be seen at least quarterly by PCP or Cardiologist.) • Cardiology: All new diagnoses of heart failure, assistance desired with GDMT, including replacement of ACEI/ARB w ARNI, and/or other significant co-existing cardiac disorders • Advanced Heart Failure: Refer patients if refractory symptoms or end stage heart failure, (acronym "I-NEED_HELP") • Cardiac Rehabilitation: If stable HFrEF, EF <35%, NYHA III-IV despite 6 weeks of HF therapy.
Other Referrals to Consider	• Sleep Medicine Referral if coexisting obstructive sleep apnea. • Care Management referral: frequent ED visits and hospitalizations, multiple no shows, non-adherence to treatment plan, complex psychosocial issues impacting care, difficulty accessing community resources • Pharmacist referral (if available): uncontrolled HF, non-adherence to medications, polypharmacy, poorly controlled comorbid diseases, med reconciliation • Home Health referral: particularly for recently discharged, vulnerable HF patients • Behavioral Health referral: active psychiatric disorders adversely impacting heart failure care, not manageable in primary care setting • Wellness Coaches (CDE): for patients with co-existing diabetes • Remote patient monitoring for select patients: Connected Hearts Program and Cardiomems • Palliative Care referral for NYHA III-IV with frequent admissions, significant anxiety and depression, and assistance with decision-making regarding advanced therapies (LVAD, transplant, home ionotropic therapy)
Patient Education	• Provide patient/family with the heart failure education booklet, "**Managing Your Heart Health"**, and other general information about heart failure. • Technique to measure and record blood pressure, pulse, weight, 02 sat at home • How to record and transmit cardiac rhythm, for those with afib/flutter. (KardiaMobile) • How to access mychart and any desired clinical apps
Diet/Fluids	• Limit salt intake to < 3 grams/day • Other diets as indicated • Fluid restriction <2 L/day *(6-8 glasses)* for patients with moderate hyponatremia *(serum sodium <130 mEq/L)* and should be considered in other patients to assist in treatment of fluid overload

	Subsequent Follow-Up Visits
Provider History	• NYHA Class (I-IV) • Document etiology of heart failure • Interval history including recent ED visits, hospitalization, weight changes, new/worsening HF symptoms • Reassessment of status of medical comorbidities • Complete medication review and assessment of compliance • Determine if Healthcare Proxy form has been completed previously
Provider Physical	• BP, pulse,weight, BMI, possibly 02 sat • Assessment of volume status • Cardiac exam (especially JVD, hepatojugular reflex, and presence of S3)

	• Telemedicine consideration: "edema check": ("PLACE YOUR FINGERS WHERE YOU HAVE SWELLING ON YOUR LOWER LEG, PUSH DOWN HARD AND REMOVE, DO YOU SEE AN INDENTATION? IF YES, HOW DEEP IS THAT INDENTATION
Diagnostic Studies	**1. Lab work as necessary:** • BMP: check 1-2 weeks after dose titration of ACEI/ARB or spironolactone/eplerenone. • Magnesium: if on diuretic, check at same interval as BMP • BNP or NT-proBNP if volume status unclear • Digoxin level, if signs of toxicity or recent addition of interacting drug • PT/INR (Every patient on warfarin should be enrolled in an anticoagulation clinic or have their PT/INR followed closely by a designated provider) **2. Procedures:** • Repeat echo if significant change in clinical status, recent clinical event, on GDMT that may significantly affect cardiac function, or may be candidates for device therapy • Consider cardiac MRI if cause of HFpEF or RHF unclear Telemedicine consideration • When possible, get blood tests done ~ 1 week prior to virtual visit, either at office, local phlebotomy center (Labcorp/Quest) or have blood drawn at home (Apex Lab) • Results of home cardiac rhythm monitoring (KardiaMobile) can be transmitted to practice in advance of visit • Patient should upload results of home monitoring into Epic or fax to office prior to visit • When available, staff can outreach out to patient in advance of visit to collect needed information
Medical Therapy	**For patients with heart failure with HFrEF:** **Escalate treatment in stepwise manner. Titrate to target dose as per GDMT.** If the patient is hemodynamically stable, it is generally acceptable to double the dose of the neurohormonal antagonist (BB, ACEI/ARB, MRA, ARNI) when increasing the dose. It is recommended that only one neurohormonal antagonist be increased at each visit. Caution is advised if increasing more than one. **By end of Visit #2, each patient should be on both a beta-blocker and either an ACEI or an ARB. Document contraindications or intolerance** • ACEI/ARB: initiate/titrate to target dose, document contraindications/ intolerance. • Consider Entresto for patients with NYHA class II-III and LVEF ≤ 35% who are stable on an ACEI/ARB. • Beta blocker: initiate/titrate using either carvedilol, sustained-release metoprolol succinate, or bisoprolol • Aldosterone antagonist: initiate/titrate if not contraindicated (GFR ≥30ml/min ,K <5.0 mEq/ml) and NYHA class II-IV HF with LVEF ≤ 35% *(NYHA Class II should have hx of prior CV hospitalization or elevated BNP*) or post-MI with LVEF ≤40% with symptoms of HF or who have DM • Hydralazine/isosorbide dinitrate: Initiate/titrate in African American patients NYHA class III-IV on standard medical therapy including ACEI or ARNI, and BB; consider in all patients who cannot tolerate an ACEI/ARB or ARNI unless contraindicated. • Diuretic: initiate/titrate in patients with fluid retention. • Ivabradine: if sinus rhythm, HR >70 bpm on maximally tolerated beta blocker, NYHA II-III, and no contraindications • Digoxin for NYHA III-IV symptoms despite optimal GMT and/or rate control for atrial fib. • Dapagliflozin should be considered as adjunctive theapy, to reduce CV death and worsening HF, even in the absence of diabetes, unless contraindicated and after considering incremental cost to the patient. • Anticoagulation: For atrial fibrillation the choice of agent should be individualized. Routine anticoagulation for HF without atrial fibrillation is not indicated. • Antiplatelet therapy: as indicated • Lipid-lowering therapy: as indicated

	For Patients with HFpEF • Continue to treat any volume overload (diuretics, salt restriction) and optimize control of comorbid medical disorders • Consider the addition of MRA. • Consider use of SGLT-2i (GFR >30) or GLP-1 Agonists if SGLT-2i contraindicated. • Avoid nitrates.
Considerations for Patients with Co-existing Type 2 Diabetes	• **Metformin remains first line therapy for diabetes (if GFR > 30).** • **SGLT-2i's (dapagliflozin, canaglifozin, empaglifozin) are preferred in HFrEF when additional therapy required, unless contraindicated/cautions {Type 1 DM, symptomatic hypotension or SBP <95 mmHg, GFR <30, prior/high risk for DKA, risk of foot amputation (ulcer, PVD, neuropathy, deformity), recurrent UTI/genital mycotic infections}.** • **Thiazolidinendiones (pioglitazone, rosiglitazone) are contraindicated.** • GLP-1 receptor antagonists (exenatide, semaglutide, dulaglutide, liraglutide) can be used if SGLT-2i are contraindicated. Contraindications to GLP-1 RA include personal/fam hx of medullary thyroid cancer, MEN Type 2, pancreatitis, gastroparesis, GFR <30. • DPP-4 inhibitors (linagliptin, sitagliptin, alogliptin) should be used cautiously in all patients who have diagnosis. Saxagliptin should not be used.
Immunizations	• Pneumococcal vaccination (PV23 and possibly, PV 13) and annual influenza vaccination in the absence of known contraindications. For telemedicine visits, can be ordered and subsequently administered in office or at local pharmacy.
Device Therapy	• Remote monitoring of BP, pulse, weight, and possibly 02 sat • Consider EP referral for primary ICD or CRT in patients with: o EF ≤ 35% for at least 90 days (or 40 days post MI) on chronic GDMT.
Escalation Pathway	• Primary Care: Every patient should have a primary care physician (Patients should be seen at least quarterly by PCP or Cardiologist.) • Cardiology: All new diagnoses of heart failure, assistance desired with GDMT, including replacement of ACEI/ARB w ARNI, and/or other significant co-existing cardiac disorders • Advanced Heart Failure: Refer patients if refractory symptoms or end stage heart failure, acronym "I-NEED_HELP" • Cardiac Rehabilitation: If stable HFrEF, EF <35%, NYHA III-IV despite 6 weeks of HF therapy.
Other Referrals to Consider	• Sleep Medicine Referral for coexisting obstructive sleep apnea • Care Management referral: frequent ED visits and hospitalizations, multiple no shows, non-adherence to treatment plan, complex psychosocial issues impacting care, difficulty accessing community resources • Pharmacist referral (if available): uncontrolled HF, non-adherence to medications, polypharmacy, poorly controlled comorbid diseases, med reconciliation • Home Health referral: particularly for recently discharged, vulnerable HF patients • Behavioral Health referral: active psychiatric disorders adversely impacting heart failure care not manageable in primary care setting • Wellness Coaches (CDE): for patients with co-existing diabetes • Remote patient monitoring for select patients: Connected Hearts Program and Cardiomems • Palliative Care referral for NYHA III-IV with frequent admissions, significant anxiety and depression, and assistance with decision-making regarding advanced therapies (LVAD, transplant, home, ionotropic therapy)
Patient Education	• Review recommendations, assess knowledge, treatment adherence; identify/address barriers, needs of patient/ family • Reinforce technique to measure and record blood pressure, pulse, weight at home, 02 sat as indicated
Diet/Fluids	• Emphasize the importance of daily weights • Assess dietary compliance • Assess adherence to fluid restriction, as indicated