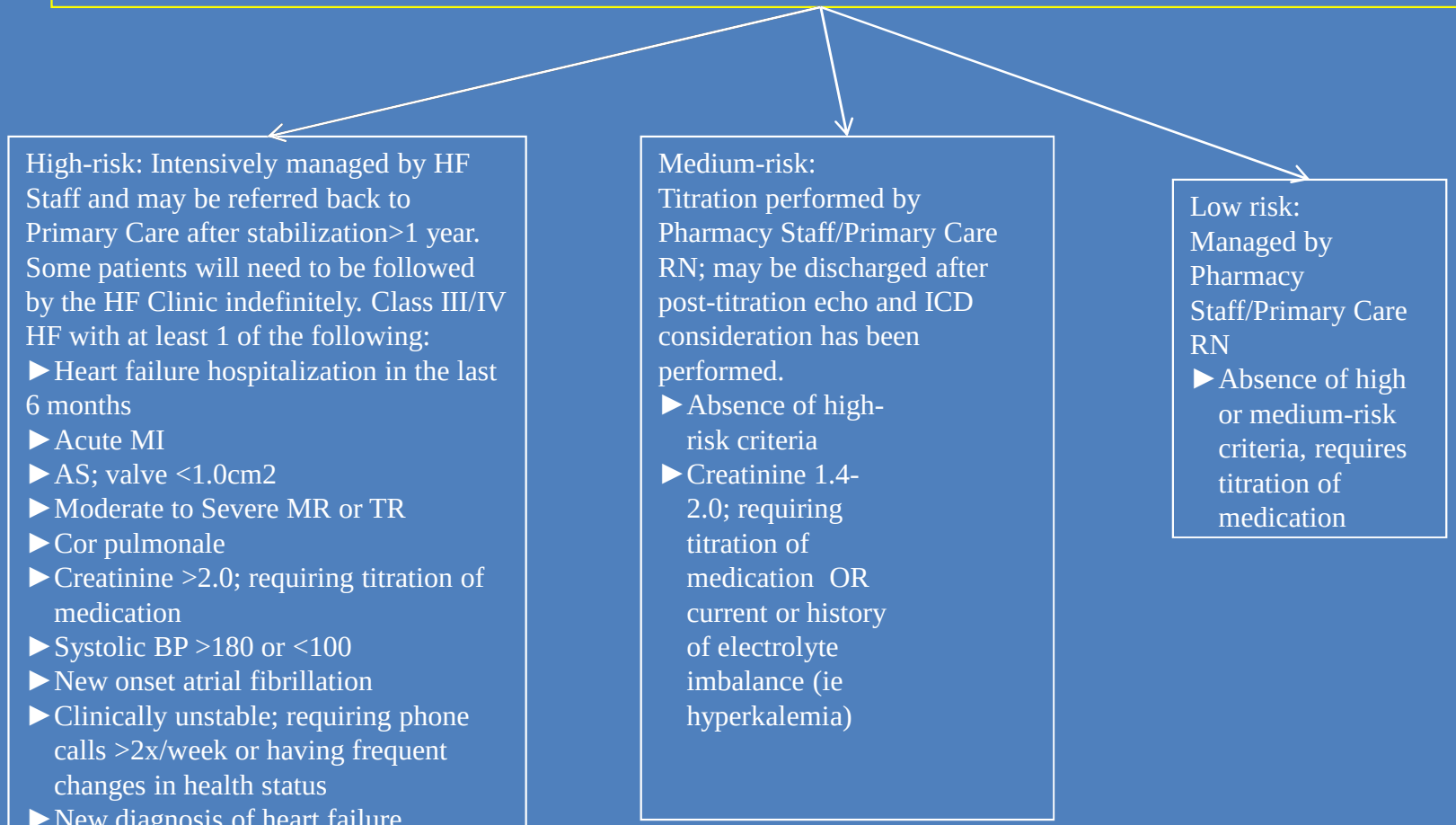
MINNEAPOLIS VAMC CHF AND PRIMARY CARE CONSULT TRIAGE ALGORITHM

1) Patients with or without LV dysfunction and/or diagnosis of heart failure are triaged by chart review and/or consult and categorized as high, medium, or low risk. Echos and PFTs ordered as indicated.
2) Patients are identified via echo as asymptomatic LV dysfunction



Minneapolis VAMC HF Telehealth Clinic

High risk

Meets criteria for Viterion 100 equipment

- Multiple hospitalizations or 1 admission with at least 1 UC/ER visits (either for CHF or ARF/dehydration); or requires daily monitoring/has failed telephone monitoring as clinically determined by heart failure staff
- Able to use equipment (cognitively, functionally, motivated, +family support for initial set-up and trouble-shooting if patient unable to do, patient or active family member able to give accurate assessment of heart failure, room for equipment in home, analog phone line).
- Will include self-management and CHF group classes

Do not meet above criteria for Viterion equipment, but meets criteria for telephone management

- Able to give accurate assessment of heart failure symptoms, stable heart failure, capable of using scale and blood pressure cuff, intended short-term nursing home placement, patient agreeable to being followed on phone.
- If patient meets criteria for Viterion 100 equipment with the exception of analog phone line, room for equipment, or functional ability (that can be overcome with using phone follow-up), may be placed on telephone management as well.
- Will include self-management and CHF group classes

Do not meet criteria for Viterion equipment or telephone follow-up →In-clinic visits

- Will include self-management and CHF group classes (involving NPs, RNs, dietician, pharmacist, exercise therapist)

Criteria for discharge back to primary care:

- Optimally titrated and stable heart failure for 12 months. Weaned to telephone or in-clinic visits as indicated.
- Some patients may need to be in a heart failure clinic indefinitely or referred to hospice.

Minneapolis VAMC HF Telehealth Clinic

Indications for Referral back to Heart Failure Staff.

Indication for Referral back to CDM Heart Failure Staff:

- Patients being followed in or co-managed with primary care who meet high-risk criteria or who the Primary Care Team identifies as needing more intensive management.
- Patients being followed in the General Heart Failure Clinic who have been hospitalized or have frequent ER visits, and are telehealth candidates.

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Refer to high-risk algorithm; will be intensively followed by CDM Heart Failure Staff.

Indication for Referral from HF Telehealth Clinic to General HF Clinic:

- Patients identified as requiring indefinite, in-clinic follow-up by a HF Clinic as determined by CDM Heart Failure Staff.

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CDM Heart Failure Staff will send consult to Heart Failure Clinic.

Note: *Patients who have a current or past history of medication or visit non-compliance will be followed closely by clinic staff for 6 weeks. If patient does not utilize the telehealth equipment, clinic staff are unable to reach patient by phone, or the patient "no-shows" twice, they will be discharged back to primary care. A notification will be sent to the primary care provider via e-mail, consult reply, or letter. Other exclusion criteria are those with cognitive deficits who are unable to make safe medication adjustments, hospice patients, and those on dialysis.*