A Hospital-based Approach to Achieving Better Health Outcomes in Heart Failure
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Faculty Disclosures

- Corey E. Tabit, MD, PhD, MBA, MPH, has no real or apparent conflicts of interest to report.
Utilize an evidence-based approach to the diagnosis and evaluation of patients with heart failure (HF) that is consistent with current guideline recommendations

Summarize current clinical evidence regarding the efficacy and safety of new pharmacologic therapies for the treatment of heart failure with reduced ejection fraction (HFrEF)

Implement guideline-directed medical therapy for patients with HF

Identify transitional care strategies to prevent disease progression and future hospitalizations among patients with HF
Definition of HF

- Complex, progressive, clinical syndrome
- Caused by structural or functional impairment of ventricular filling or contractility
- Major clinical manifestations*:
  - Dyspnea and fatigue
  - Fluid retention
- Not synonymous with cardiomyopathy or LV dysfunction, which describe possible structural or functional bases for development of HF

*Patient presentation varies.
LV, left ventricular.
Heart Failure in the Hospital Setting
Trends in Primary HF Admissions and In-hospital Mortality (2001-2014)

Δ in trend in 2005 = -2.4 (95% CI: -4.4, -0.39); P=0.02

Δ in trend in 2009 = -1.0 (95% CI: -2.3, 0.30); P=0.14

Δ in trend in 2005 = 0.41 (95% CI: -1.3, 2.1); P=0.64

Δ in trend in 2009 = 3.2 (95% CI: 1.9, 5.4); P=0.002

Despite recent decreases, a significant percentage (22%) of patients hospitalized with HF are readmitted within 30 days.
While 30-day readmission rates have improved for HF, 30-day HF mortality rates have increased at more than half of US hospitals since the advent of Centers for CMS readmission penalties.

Opportunities to Improve Patient Outcomes: Principles for Successful HF Treatment

Implement GDMT
I. Initiate and switch treatment as appropriate
II. Titration to optimal dose

Address Specific Care Challenges
I. Referral
II. Care coordination
III. Adherence
IV. Specific patient cohorts
V. Cost of care

Manage Other Aspects of HF
I. Increasing complexity of disease
II. Comorbidities
III. Palliative/hospice care

GDMT, guideline-directed medical therapy.
Patient Evaluation
A careful **history** and **physical examination** remain the cornerstones of assessment

Patient History

- **Risk factors**
  - Family history
  - Other conditions (eg, HTN, CAD/MI, thyroid disease, & diabetes)

- **Duration of illness**

- **Symptoms**
  - Type
  - Severity

- **Recent/frequent prior hospitalizations for HF**

- **Diet**
  - Sodium intake

- **Medication**
  - Discontinuation or nonadherence
  - Agents that may exacerbate HF

- **De novo HF indicators**
  - Inadequate BP control
  - New-onset or poorly controlled AF
  - New ischemia
  - Metabolic, respiratory, & other stressors

Symptoms of HF

- Shortness of breath
- Chronic coughing/wheezing
- Edema
- Fatigue/lightheadedness
- Nausea/lack of appetite
- Confusion/impaired thinking
- Elevated HR

HR, heart rate.

Available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/WarningSignsforHeartFailure/Warning-Signs-of-Heart-Failure_UCM_002045_Article.jsp#.V7YfgFsrL4Z.
Physical Examination

- Weight loss or gain
- BP (supine and upright)
- Pulse
- JVP at rest (sitting or standing) and/or positive Kussmaul’s sign
- Presence of extra heart sounds and murmurs
- Size and location of PMI
- Presence of RV heave
- Pulmonary status: RR and pleural effusion
- Hepatomegaly and/or ascites
- Peripheral edema
- Presence of cool lower extremities

JVP, jugular venous pressure; PMI, point of maximal impulse; RV, right ventricular; RR, respiratory rate.

## Recommendations for the Use of Biomarkers in the Evaluation of Patients with HF

<table>
<thead>
<tr>
<th>Biomarker, Application</th>
<th>Setting</th>
<th>COR</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Natriuretic peptides</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis or exclusion of HF</td>
<td>Ambulatory, Acute</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Prognosis of HF</td>
<td>Ambulatory, Acute</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Achieve GDMT</td>
<td>Ambulatory</td>
<td>Ila</td>
<td>B</td>
</tr>
<tr>
<td>Guidance for ADHF therapy</td>
<td>Acute</td>
<td>IIb</td>
<td>C</td>
</tr>
<tr>
<td><strong>Biomarkers of myocardial injury</strong></td>
<td></td>
<td></td>
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<tr>
<td>Additive risk stratification</td>
<td>Acute, Ambulatory</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td><strong>Biomarkers of myocardial fibrosis</strong></td>
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<tr>
<td>Additive risk stratification</td>
<td>Ambulatory</td>
<td>IIb</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Acute</td>
<td>IIb</td>
<td>A</td>
</tr>
</tbody>
</table>

NT-proBNP Reduction Lowers the Rate of CV Death or HF-related Hospitalization

Risk of Primary Endpoint After 1 Month

Did not achieve NT-proBNP ≤1000 pg/mL

Achieved NT-proBNP ≤1000 pg/mL

## ACCF/AHA Stages and NYHA Functional Classes of HF

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Class</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Significant risk factors for HF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No known structural heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No signs or symptoms of HF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Structural heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No signs or symptoms of HF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>I, II, III, IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Structural heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prior or current symptoms of HF</td>
<td></td>
<td></td>
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<tr>
<td>D</td>
<td></td>
<td>IV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Refractory HF requiring specialized interventions (eg, transplant, VAD, palliative care/hospice, and experimental therapies)</td>
<td></td>
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</tr>
</tbody>
</table>

ACCF/AHA, American College of Cardiology Foundation/American Heart Association; VAD, ventricular assist device; ADLs, activities of daily living.

Stage vs Class

- ACCF/AHA stages emphasize the development and progression of disease
- NYHA classification underscores exercise capacity and symptom status
- Stage and class provide complementary information about the presence and severity of disease

NYHA, New York Heart Association.
HF Type by Ejection Fraction

*HFrEF has been defined across different guidelines by left ventricular ejection fraction 35%, <40%, and 40%.

EF, ejection fraction; HFpEF, heart failure with preserved ejection fraction.
Treatment Options for HFrEF
## Conventional Guideline-recommended Pharmacologic Treatments

<table>
<thead>
<tr>
<th>Therapy</th>
<th>NYHA Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>ACE inhibitors, ARBs</td>
<td>✓</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>(✓)</td>
</tr>
<tr>
<td>Aldosterone antagonists</td>
<td>(✓)</td>
</tr>
<tr>
<td>Diuretics</td>
<td>(✓)</td>
</tr>
<tr>
<td>Digoxin</td>
<td></td>
</tr>
<tr>
<td>Hydralazine and isosorbide dinitrate</td>
<td>(✓)</td>
</tr>
</tbody>
</table>

(✓) For select patients.

# Newer Therapies for the Treatment of HF

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Mechanism of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ivabradine</strong></td>
<td>• Selective inhibition of sinus node $I_f$ channel (decreases HR)</td>
</tr>
<tr>
<td></td>
<td>• Does <strong>not</strong> affect cardiac ionotropy and can be used with a beta blocker</td>
</tr>
<tr>
<td><strong>Angiotensin Receptor–Neprilysin Inhibitor (ARNI)</strong></td>
<td>• Angiotensin receptor blockade + inhibition of neprilysin* (inhibits RAAS and augmenting NP activity)</td>
</tr>
</tbody>
</table>

*The metallopeptidase neprilysin hydrolyzes natriuretic peptides.
RAAS, renin-angiotensin-aldosterone system; NP, natriuretic peptide.
Impact of Ivabradine Treatment on CV Death or Hospital Admission for Worsening HF


CV, cardiovascular; HR, hazard ratio; CI, confidence interval.

Ivabradine Added on to Standard of Care Therapy Reduces the Risk of Hospitalizations for HF


<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>Ivabradine (N=3241)</th>
<th>Placebo (N=3264)</th>
<th>HR (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>514 (16%)</td>
<td>672 (21%)</td>
<td>0.75 (0.65–0.87)</td>
<td>P&lt;.001</td>
</tr>
<tr>
<td>Second</td>
<td>189 (6%)</td>
<td>283 (9%)</td>
<td>0.66 (0.55–0.79)</td>
<td>P&lt;.001</td>
</tr>
<tr>
<td>Third</td>
<td>90 (3%)</td>
<td>128 (4%)</td>
<td>0.71 (0.54–0.93)</td>
<td>P&lt;.012</td>
</tr>
</tbody>
</table>
Effect of ARNI Treatment on the Risk of Death or First-time Hospitalization for HF

ARNI Treatment Reduces the Incidence of Hospital Readmissions

ARNI Treatment Reduces CV Death and HF Hospitalization Across the LVEF Spectrum

LVEF, left ventricular ejection fraction.
How Should Newer Therapies Be Incorporated into GDMT?

HFrEF Stage C Treatment

ACEI / ARB AND beta blocker with diuretic as needed

For patients with persistent volume overload, NYHA class II-IV
- Titrate Diuretics

For persistently symptomatic African Americans, NYHA class III-IV
- Add Hydralazine + isosorbide dinitrate

For patients stable on ACEI/ARB, NYHA class II-III
- Switch ARNI

For patients with eGFR ≥30 mL/min/1.72 m², K⁺ <5.0 mEq/dL, NYHA class II-IV
- Add Aldosterone Antagonist

For patients with resting HR ≥70, on maximally tolerated beta blocker dose in sinus rhythm, NYHA class II-III
- Add Ivabradine

Multi-center, patient-level, randomized, open-label study

Patient population (N=~450)
- Reduced LVEF of 35%
- HR 70 bpm
- Discharged following stabilization from acute HF

Predischarge initiation of ivabradine or usual care

Post-discharge follow-up at 7-14 days, 6 weeks, and 180 days

HR, systolic BP, and quality of life to be assessed

Available at: https://clinicaltrials.gov/ct2/show/NCT02827500
Testing and Medication Titration for Patients with HFrEF

- Consider initial evaluation studies*
  - Intensification 2-4 months (1-4 week cycles)
  - Serial evaluation and titration of medications
  - Lack of response/instability
  - End-intensification/maintenance
  - Assess response to therapy and cardiac remodeling
  - Referral for advanced care

*BNP/NT-proBNP, complete blood count, basic metabolic panel, liver function tests, iron and thyroid studies, HbA1c, x-ray, echocardiogram, coronary angiogram, cardiac MRI, biopsy, other imaging.

When to Refer Patients for Advanced HF Care: I-NEED-HELP

**I**V inotropes

**N**YHA IIIb/IV or persistently elevated natriuretic peptides

**E**nd-organ dysfunction

**E**jection fraction ≤35%

**D**efibrillator shocks

**H**ospitalizations >1

**E**dema despite escalating diuretics

**L**ow blood pressure, high heart rate

**P**rognostic medication - progressive intolerance or down-titration of GDMT

Therapies for HFrEF Under Investigation
Effects of Omecamtiv Mecarbil on Cardiac Function and Structure

COSMIC-HF

A. Change in Systolic Ejection Time (ms)
- Placebo: P=0.0007
- 25 mg Fixed Dose Study Group: P=0.0001

B. Change in Stroke Volume (ml)
- Placebo: P=0.0036
- 25 mg Fixed Dose Study Group: P=0.0217

C. Change in LVESD (mm)
- Placebo: P=0.1732
- 25 mg Fixed Dose Study Group: P=0.0027

D. Change in LVEDD (mm)
- Placebo: P=0.1899
- 25 mg Fixed Dose Study Group: P=0.0128

E. Change in Heart Rate (beats per min)
- Placebo: P=0.2177
- 25 mg Fixed Dose Study Group: P=0.0070

F. Change in NT-proBNP Concentration (ng/L)
- Placebo: P=0.0205
- 25 mg Fixed Dose Study Group: P=0.0069

Effect of Vericiguat Treatment in Patients with Worsening HFrEF

SOCRATES-REDUCED

Ratio of Geometric Means for Change from Baseline of NT-proBNP Level

<table>
<thead>
<tr>
<th>Vericiguat Group</th>
<th>0.5</th>
<th>0.6</th>
<th>0.7</th>
<th>0.8</th>
<th>0.9</th>
<th>1.0</th>
<th>1.1</th>
<th>1.2</th>
<th>1.3</th>
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<tbody>
<tr>
<td>1.25 mg</td>
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<tr>
<td>2.5 mg</td>
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<tr>
<td>2.5 to 5 mg</td>
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<tr>
<td>2.5 to 10 mg</td>
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<tr>
<td>Pooled 2.5/5/10 mg</td>
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</tbody>
</table>

P<.02

P<.05

Proportion of Patients Experiencing the Composite of CV Death and HF Hospitalization

Day

0 28 56 84
Treatment of HFpEF
Significance of HFpEF

- Increasing incidence
- Frequent in elderly female patients
- Comorbidities include obesity, CAD, DM, AF, and hyperlipidemia
- HTN is the most important cause (60%-89% prevalence)
- Represents a growing proportion of patients with HF requiring hospitalization

DM, diabetes mellitus.

ARNI for the Treatment of Patients with HFpEF: PARAGON-HF

**Sequential Single-Blind Run-In Period**
Eligible patients who meet tolerability criteria at each safety/tolerability check visit are switched to the next study period.

-2 weeks

**Screening period**

1-4 weeks*

Valsartan single-blind run-in

Safety/tolerability check

2-4 weeks†

Sacubitril/Valsartan single-blind run-in

Safety/tolerability check and randomizations (if eligible)

**Randomized Double-Blind Long-Term Follow-Up Period**
Follow-up visits occurred at 4, 16, 32, and 48 weeks and every 12 weeks thereafter. All patients are followed until target number of primary composite (CV deaths and total HF hospitalizations) occur or 26 months after randomization of the last patient elapse, whichever occurs last.

Sacubitril/Valsartan at a target dose of 97/103 mg bid

N~4800

Valsartan at a target dose of 160 mg bid

---

*Eligible patients are exposed to valsartan 80 mg bid for 1 to 2 weeks. Patients on low pre-study angiotensin converting enzyme inhibitors or angiotensin receptor blocker doses or those with tolerability concerns are first started on valsartan 40 mg bid 1 to 2 weeks and then up-titrated to valsartan 80 mg bid for 1 to 2 weeks.

†Patients tolerating valsartan 80 mg bid for 1 to 2 weeks are switched to sacubitril/valsartan 49/51 mg bid for 2 to 4 weeks.

Management of Comorbidities
Management of Hypertension in Patients with HF

- Target an optimal BP of <130/80 mm Hg in those with HTN and at increased risk (stage A HF)
- Titration of GDMT to attain SBP <130 mm Hg in patients with HFrEF and HTN
- Titration of GDMT to attain SBP <130 mm Hg in patients with HFpEF and persistent HTN after management of volume overload

BP, blood pressure; SBP, systolic blood pressure.

Use of Intravenous Iron for Patients with Symptomatic HF and Iron Deficiency

Odds Ratio (95% CI)

Weeks Since Randomization

Placebo better

Better FCM

Self-reported Patients Global Assessment

P = .29

P = .035

P = .047

P = .001

P = .001

NYHA Functional Class

Odds Ratio (95% CI)

Weeks Since Randomization

Placebo better

Better FCM

P = .093

P = .067

P = .004

P < .001

P < .001

Impact of Intravenous Iron Therapy on Hospitalization Due to Worsening HF


Log-rank test

\[ P = 0.009 \]
Improving Outcomes Through Effective Transitional Care
Obstacles to Effective Transitions of Care in HF

**Medical Management**
- Reconciliation issues
- Unclear instructions
- Transportation issues

**Follow-up Appointment**
- No appointment scheduled within 7 days
- Lack of transportation
- HCP failure to follow GDMT
- Patient unsure of location
- Patient unaware

**HCP Communication**
- Poor handoff among HCPs
- Insufficient patient education

**Non-medication signs/symptoms (S/S) Management**
- Nonadherence to diet, activity, exercise, & fluid management
- Not recognizing S/S requiring medical attention
- Primary HCP is unclear about who to contact for assistance

## Systematic Review of Transitional Care Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Impact</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-visiting programs and multidisciplinary HF (MDS-HF) clinic interventions</td>
<td>↓ All-cause 3 to 6 months readmission</td>
<td>High</td>
</tr>
<tr>
<td>Structured telephone support (STS) interventions</td>
<td>↓ HF-specific and all-cause readmissions</td>
<td>High (HF-specific) Moderate (all-cause)</td>
</tr>
<tr>
<td>Home-visiting programs</td>
<td>↓ HF-specific readmission and composite end point*</td>
<td>Moderate</td>
</tr>
<tr>
<td>Home-visiting programs, MDS-HF clinics, and STS interventions</td>
<td>↓ Mortality</td>
<td>Moderate</td>
</tr>
<tr>
<td>High-intensity home-visiting program</td>
<td>↓ All-cause 30 day readmission and composite end point* at 30 days</td>
<td>Low</td>
</tr>
<tr>
<td>Telemonitoring and primarily educational interventions</td>
<td>Did NOT reduce readmissions or mortality</td>
<td>Low</td>
</tr>
</tbody>
</table>

*All-cause readmission or death

## Systematic Review of Transitional Care Interventions Cont’d

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Impact</th>
<th>Evidence</th>
</tr>
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<tbody>
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</tr>
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<td>Did <strong>NOT</strong> reduce readmissions or mortality</td>
<td>Low</td>
</tr>
</tbody>
</table>
AHA Recommended Strategies for Improving Transitional Care in HF

- Patient education
- Phone follow-up (48-72 hours)
- Early post-discharge follow-up visit (7-10 days)
- Early assessment after admission
- Medication reconciliation
- Caregiver inclusion
- Home visits
- Handoff communication to post-hospital providers

Enhanced HF Patient Education: What Domains Should Be Covered?

- Recognition of escalating symptoms/concrete plan for response
- Activity/exercise
- Indications, use, and need for medication adherence
- Daily weight monitoring
- Modification of risk factors for HF progression
- Diet
- End-of-life considerations
- Follow-up
- Discharge instructions

Available at: http://www.heart.org/idc/groups/heart-public/@private/@wcm/@hcm/@gwtg/documents/downloadable/ucm_428949.pdf
## Risk of 30-Day Readmission by Post-discharge Follow-up Contact

<table>
<thead>
<tr>
<th>Type of First Contact</th>
<th>Number of Contacts</th>
<th>Time to First Contact</th>
<th>Unadjusted Risk of 30-Day Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>&gt; 2 Contacts</td>
<td>8-30 Days</td>
<td>12.1%</td>
</tr>
<tr>
<td></td>
<td>1 or 2 Contacts</td>
<td>8-30 Days</td>
<td>10.7%</td>
</tr>
<tr>
<td>Clinic</td>
<td>&gt; 2 Contacts</td>
<td>8-30 Days</td>
<td>7.3%</td>
</tr>
<tr>
<td></td>
<td>1 or 2 Contacts</td>
<td>8-30 Days</td>
<td>13.1%</td>
</tr>
<tr>
<td></td>
<td>No Contact</td>
<td>8-30 Days</td>
<td>29.3%</td>
</tr>
</tbody>
</table>

Case Evaluations
Case Evaluation #1: Patient Description

Judy is a 68-year-old woman who presents to the ED for acute distress due to breathlessness and uncontrolled coughing. She reports that over the past 4 months, she has had some difficulty climbing stairs and breathing when lying down (having to sit back up to catch her breath). Judy’s medical history includes a remote history of smoking and alcohol consumption. She is dyslipidemic and moderately obese.
Case Evaluation #1: Question 1

Judy’s physical exam confirms dyspnea on exertion and reveals significant ankle edema. Her BP = 130/86 mm Hg, HR = 90 bpm, JVD 12 cm, and she has a positive Kussmaul sign. Which of the following tests would you order to further aid in your diagnosis?

A. Blood testing for BNP/NT-proBNP
B. Invasive hemodynamic monitoring
C. Endomyocardial biopsy
Case Evaluation #1: Question 2

Judy is diagnosed with NYHA III Stage C HFrEF. Following stabilization, she is initiated on a regimen that includes lisinopril and carvedilol. At her 3 month follow-up, clinical and laboratory assessments indicate that she is stable with her current treatment plan. Which of the following would you recommend for Judy?

A. Maintain current treatment regimen
B. Switch to ARNI
C. Switch to ivabradine
If you were to switch Judy to ARNI, how long would you wait before initiating ARNI after discontinuing lisinopril?

A. 12 hours  
B. 36 hours  
C. 3 days
Case Evaluation #2: Patient Description

Jim is a 73-year-old man who presents with breathlessness over the past 2 days. His history includes 3 prior hospital admissions for worsening HF over 2 years. He has difficulty with ADLs. Previous echocardiograms have shown moderate LV systolic dysfunction (EF 26%, PASP 55 mm Hg, EDD 6.7 cm). Physical exam reveals BP 98/78 mm Hg, HR 100 bpm, RR 25/min, S₄, and displaced point of maximal impulse. Jim’s EMR reveals that he has a history of iron deficiency as well. His current medications include aspirin, furosemide, enalapril, and carvedilol.
Case Evaluation #2: Question 1

Which of the following changes to Jim’s therapeutic regimen would you recommend for Jim?

A. Addition of ARNI to Jim’s current treatment regimen
B. Increase the dose of carvedilol
C. Switch Jim from enalapril to ivabradine

8 0% 0% 0%
A. B. C.
What type of intervention, if any, would you consider for the treatment of Jim’s iron deficiency?

A. Dietary iron supplementation
B. Intravenous iron therapy
C. Erythropoietin therapy
D. No therapy
Summary

- Despite recent progress in the reduction of HF-related readmission rates, the health outcomes of many patients with HF remain suboptimal.

- Optimal management of HF requires thorough and accurate patient evaluation along with the implementation of guideline-directed medical therapy to control symptoms and improve prognosis.

- New treatment options have expanded the range of strategies to achieve therapeutic goals and demonstrated the capacity to significantly improve patient outcomes over standard therapy.
For patients with symptoms of HF, apply a multifaceted evaluation approach to identify underlying causes and risk for disease progression

Implement guideline-directed medical therapy for all patients with HF

Consider treatment using a newer agent with a novel mechanism of action for any patients who remain symptomatic despite their current regimen as well as those who are stable but may benefit from a switch in therapy

Prior to discharge, evaluate patients’ clinical status, comorbid conditions, and current medication regimen, and adjust the care plan accordingly

Schedule timely follow-up and ensure adequate communication of the care plan to the nursing home team, home healthcare team, PCP, or family caregiver
Thank You!