Questions and Answers from

*State of Get With The Guidelines-Heart Failure 2019*

*Recorded live, February 11, 2019*

1. Many rural areas don't have access to heart failure clinics and cardiac rehab. Do you have recommendations to help ameliorate this disparity; especially if we can't get the health system to participate?
   1. This is a very important question. Telehealth-telemonitoring programs are increasingly being offered by some heart failure specialty programs and covered by some insurers. Home based cardiac rehabilitation has been evaluated in studies suggesting benefits and is an evolving option. Nevertheless, there are still many challenges and barriers. For patients without access, taking advantage of educational and self-care resources that are available may be a pragmatic approach.

This is a link to a telehealth statement from the AHA in 2017 <https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000475>

1. Adherence is difficult with multiple doses of medications. For those of us who are still working outside the home, trying to be active in the world, and busy with families and community, most medications don't fit with the lifestyle. Patient centered studies are crucial to identify what if effective, doable and guideline directed.
   1. Yes, adherence will always be difficult as it must be individualized. One plan will never work for all. Since some medications are multi-dose and others are not, it is important for providers to discuss medication timing with patients. Some medications can be given at bedtime to decrease potential symptoms (ie.., dizziness) or the burden of taking during the day. Also, when once-daily options are available, that is always a plus.
2. Do we know that women who are at risk for HFpEF have had diagnostics to identify the HFpEF?
   1. When patients have signs or symptoms that mimic HF or in assessment, have a family history that places them at high risk for HF, at minimum, an echocardiogram should be obtained so that we can learn about chamber dimensions and function, pressures, and valve function as a starting point.
3. Will GWTG-HF be updated to include quality of life data elements?
   1. GWTG-HF collects health status including KCCQ as part of the optional 30-day post discharge follow-up forms. In addition, the optional fields can be utilized to record health status measures for the hospital forms. Addition of health status fields for the hospital form will be further considered.
4. It acceptable to refer patients to outpatient CHF clinic to switch to ARNI?
   1. It has been shown to be safe, well-tolerated to initiate ARNI (whether switching from ACEI/ARB or denovo initiation) during hospitalization after 24 hours from admission in stabilized patients (with SBP 100 mm Hg or greater and no contraindications). This approach resulted in lower risk of death or rehospitalization over 8 weeks in PIONEER-HF\*. Further, multiple studies have shown when GDMT are initiated in-hospital there are vastly superior treatment rates as well as short-term, intermediate-term, and long-term adherence to therapy, then post discharge initiation of clinician discretion. Access issues including formulary, prior-authorization, and copayments are additional considerations that need to be taken into account.

Nevertheless, there may be very select patients with lower SBP or other reasons where some additional period of clinical stability is thought to be necessary and post-discharge initiation/switching may be appropriate, recognizing that the clinical benefits of ARNI vs ACEI were observed within the first 1-3 weeks. While any clinician involved in the care of HF patients should be able to initiate/switch patients to ARNI, if for some reason there is concern, this can be done in the outpatient HF program setting.

1. Do you feel as though palliative care is appropriate to initiate at diagnosis or onset of symptoms?
   1. A discussion about the trajectory of heart failure and how that impacts wellness, quality of life and even length of life is important as patients need to understand the seriousness of heart failure, even when they have minimal or no symptoms; however, there is no need to discuss palliative care among patients who are being assertively managed and may not have end stage symptoms/advanced heart failure.
2. What is the recommendation for initiating ARNI during the hospitalization for a patient admitted with decompensated heart failure?
   1. Based on PIONEER-HF\*, patients should be considered after they have been hospitalized for 24 hours, if they are stable and have a systolic BP of 100 mmHg or higher. To learn the definition of stability as set forth in the trial and also, to learn non-stability inclusion and exclusion criteria, please refer to the paper that was published in November 2018.
3. During the presentation, discussion was had around using the KCCQ. Our hospital uses the KCCQ for our TAVR patients. However, we understand that if we want to use it for patients where they are not associated with a registry that CMS requires, we must pay to get the rights to use this.

Do you have any information on how other places are getting around this issue? Would be great if the KCCQ was free to use for all patients, and no issue around getting it placed into our EPIC system for use.

* 1. The tool owner has a website that you can go to. You should communicate that you wish to use the tool for clinical practice, not for research. It may be that you would only pay an administrative fee to use the tool.

1. What strategies have you seen successfully used to increase compliance with GDMT, specifically reaching target does?
   1. Very good question. There are many strategies that may work (i.e., standing order sets, algorithms...); but a foundation of leadership, quality monitoring and team discussion of cases that are outside of the parameters of care expectations are an ideal mix of strategies to ensure that the team is following GDMT expectations when patients make themselves available for care.
2. My question is regarding the use of hydralazine and nitrates in the self-described African-American patient population. The science supports the use of isosorbide dinitrate along with hydralazine. Is there support for substituting isosorbide mononitrate (IMDUR) with hydralazine? Are the benefits of treatment the same?
   1. There is one paper available in the literature on fixed dose (Bi-Dil) versus other combinations. Researchers learned that fixed dose was more effective than other combinations of hydralazine/nitrate administration and of the 2 options, short acting nitrates given with hydralazine was more effective in 1 year survival than long-acting nitrate administration. (Adv Ther. 2017;34(8):1976-1988).
3. What is Dr. Nancy M. Albert’s preferred tool for evaluation of Quality of Life of Heart failure patients.
   1. Of the tools, the Minnesota Living w HF tool and Kansas City Cardiomyopathy Questionnaires (1) are HF-specific, and (2) have been extensively used and have metrics that not only show statistical significance of changes over time, but also, clinical significance. Having stated that, the right tool should be used based on the purpose of using a tool. Some tools measure different aspects of quality of life. The tool should match the intended purpose of the project or goals of assessment.

\* We highly encourage you to read the publication on the PIONEER-HF trial in its eternity for more information on the trial scope, objectives and findings at the link below.

* + *Angiotensin–Neprilysin Inhibition in Acute Decompensated Heart Failure,* Eric J. Velazquez, M.D., et. al. <https://www.nejm.org/doi/full/10.1056/NEJMoa1409077>
* Join us for our upcoming webinar, ***PIONEER-HF Trial: Findings and Significance for the Treatment of HF***, Presented by Gregg C. Fonarow, MD, FACC, FAHA, FHFSA on Feb 26, 2019 at 12:00 PM CST.

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Questions from *State of Get With The Guidelines-Heart Failure 2019*, recorded live February 11, 2019. For more information, please contact [liz.olson@heart.org](mailto:liz.olson@heart.org).

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