**Operator:**

It is now my pleasure to turn today's program over to Steve Dentel with the American Heart Association. The floor is yours.

**Steve Dentel:**

Thank you so much, Ginneen. And good afternoon and welcome to the American Heart Association's Get With The Guidelines national webinar: 2017 Updates to Target: Heart Failure. My name is Steve Dentel, and I'm the national director of Field Programs and Integration for the American Heart Association. On today's webinar, we will hear from Dr. Gregg Fonarow on the updates on the Target: Heart Failure program, and updates to our evidence-based strategies, tools and resources, and new tools to help you deliver patient care.

I'd like to introduce Dr. Fonarow at this point. Dr. Fonarow is the Eliot Corday Professor of Cardiovascular Medicine and Science at UCLA. He serves as director of the Ahmanson-UCLA Cardiomyopathy Center, co-director of UCLA's Preventive Cardiology Program, and clinical co-chief of Cardiology, UCLA division of Cardiology. Attained the rank of Professor of Medicine, Geffen School of Medicine at UCLA in 2003. His research interests center on acute and chronic heart failure, preventive cardiology, quality of care, outcomes and implementing treatment systems to improve clinical outcomes. Dr. Fonarow has published over 600 research studies in clinical trials in heart failure, disease management, preventative cardiology and outcomes research. New therapies and management strategies for advanced heart failure and research into the pathophysiology of this disease are conducted at UCLA under his direction. He also has developed and successfully implemented a comprehensive atherosclerosis treatment program at the UCLA Medical Center, which served as the model for the American Heart Association's Get With The Guidelines program. I'll now turn the presentation over to Dr. Gregg Fonarow. Thanks, Dr. Fonarow.

**Gregg Fonarow, MD:**

Thanks so much, Steve. Really appreciate it. Appreciate all of you joining us. These are my disclosures related to this presentation today, so please keep that in mind. I want to provide you with, over the course of this presentation, an overview and background on Target: Heart Failure, where we stand with some of the metrics, and then most importantly, highlight some of the exciting updates that are going to be available now or very shortly and some revisions to the recognition criteria that will be taking place next year. Then importantly, we'll answer any questions that you have.

I really want to start off with thanking all of you that are participating in Get With The Guidelines-Heart Failure and Target: Heart Failure and your care and dedication to improve the quality of care and outcomes for patients with heart failure. As you know, patients who are hospitalized with heart failure are highly vulnerable patient population, they face a very high readmission rate, not just in the first 30 days but over the course of the year. The national statistics suggest when a patient is hospitalized with heart failure, you know, fully one in three patients will not survive the full year. And this is true among patients with heart failure, with reduced ejection fraction heart failure, with borderline or so called mid-range ejection fraction, and patients with heart failure with preserved ejection fraction.

So as this slide highlights, what is overview of Target: Heart Failure, it was launched by the American Heart Association in 2011 as intended to be a national initiative done in conjunction with Get With Guidelines-Heart Failure but specifically targeting the ability to help clinicians with patients hospitalized with heart failure around the transitions of care and really with a heart failure focus, not just on general reductions and 30-day readmissions but to really provide the actionable tools, content-rich resources, all based on the evidence and guidelines to really help improve the care of this patient population, but also the broader range and goal of Target: Heart Failure was to recognize all aspects of heart failure to provide professionals with knowledge about abilities of preventing heart failure, the national scope of heart failure, how heart failure is common, costly, and deadly. So designed also to help advance heart failure awareness, heart failure prevention, which is so important given that we have the tools that can prevent heart failure and the best treatment for heart failure is, in fact, preventing it in the first place, as well as for those individuals that have developed heart failure, advancing treatment.

Now with regards to the Target: Heart Failure mission, there were three patient-centered care domains with very well established evidence base with regards to improving transitions of care for patients and done in conjunction with Get With The Guidelines-Heart Failure. Some medication optimization, particularly for those with heart failure with reduced EF where we have life-prolonging medications that reduce not only hospitalizations but improve quality of life, longevity of life, are highly cost-effective, provide for early follow-up and care coordination because Get With The Guidelines=-Heart Failure data itself had shown that patients with an early physician follow-up, within seven days, and with better care coordination, had a lower 30-day readmission rates and trends for even better survival, as well as enhancing patient education. Importantly with regards to the need to adhere to evidence-based medications, the lifestyle modifications, the worsening signs of heart failure and what to do if they occur, the education of not just patients but also their caregivers, family members. So these were the three domains of kind of the targeted initiative but overall Target: Heart Failure, the awareness, prevention and treatment of heart failure itself being central to this mission of Target: Heart Failure and the overall mission of the American Heart Association.

So as this slide shows, a little bit of a background and overview of Get With The Guidelines-Heart Failure, this launched in 2005, grew out of the Optimize HF initiative that had launched in 2003. Get With The Guidelines-Heart Failure focused on those patients hospitalized with heart failure, the in-hospital initiation of guideline-directed medical therapies and other components of heart failure care to improve care and outcomes, not just in the short term during the hospitalization and care transition, but in the long term. There are four achievement measures, 10 quality measures, a whole variety of reporting metrics. In fact, Get With The Guidelines-Heart Failure is the most complete and comprehensive way of assessing quality of care and outcomes for patients with heart failure. Hospitals have several opportunities for recognition, the performance achievement awards and at the national events, and the "U.S. News & World Report" recognition. As of June 2017, there have been 87 Get With The Guidelines-Heart Failure manuscripts in publications in the peer reviewed literature. You can actually -- these are reviewable online so this is also beyond its main mission of improving quality of care and outcomes and assisting hospitals, the data that you all collect has been assembled and been able to lead to peer reviewed publications, some on the impact of Get With The Guidelines in improving care and outcomes but others better understand our disease state, seminal publication that we talked about, identifying that early follow-up is associated with lower 30-day readmission rates and heart failure patients that ultimately led to revisions in the guidelines.

Currently, there are 684 hospitals enrolled in the program. If your hospital is not currently involved, we'd love to have you join. There's strong data to support the improvement in care and outcomes with participation. And overall, there have been 1.5 million patient heart failure hospitalization episodes entered into the Patient Management Tool, so this program has truly benefited a large number of individuals hospitalized with heart failure to help hospitals in the improvement of their quality of care and clinical outcomes. And in fact, Target: Heart Failure is conducted in conjunction with Get With The Guidelines-Heart Failure using the Get With The Guidelines Patient Management Tool and platform regarding the data aggregation and the metrics, as well as really being aligned for honor roll recognition, already have recognition as a performance achievement award winning hospital.

Now, with regards to the metrics that are following, these really are comprehensive rather than focusing just on a few measures. Get With The Guidelines provides hospitals really a comprehensive set of measures by which to measure, track and improve the quality of care for patients with heart failure. So, the current achievement measure, ACEI inhibitor, ARB, or angiotensin receptor, neprilysin inhibitor in eligible patients, heart failure reduced injection fraction at discharge, and the absence of contraindications. One of the three Guideline recommended evidence-based specific beta blockers at discharge, measurement of the LV function, so left ventricular ejection fraction previously or during the hospitalization for heart failure is recommended in the Guidelines, and a post-discharge appointment for heart failure patients with date, time and location all documented. The quality measures for eligible patients who already have established heart failure and meet the class I recommendations for having been switched to angiotensin receptor neprilysin inhibitor at discharge, and aldosterone antagonist in eligible patients at discharge and a whole variety of device and ancillary medical therapy, vaccination, which is increasingly important in heart failure patients, all captured in our quality measures, and then a whole variety of reporting metrics. So hospitals can really track a whole variety of metrics over time with regards to the care that's being provided. Additional reporting metrics are shown here. In addition, there are descriptive measures shown here in the slide so you can track this. There are composite measures, and the defect-free measures, Joint Commission version of the measures, the Target: Heart Failure measures that are being tracked, and then also tracking of in-hospital mortality with the risk-adjusted mortality ratio, and for those that are utilizing the 30, 60 and 90-day readmission forms, the ability to track re-admission frequencies and rate, though recognizing this is different than what's publicly reported from CMS, or that is only fee for service Medicare patients but based on no matter where a patient may have been rehospitalized, whereas for utilizing Get With The Guidelines and entering these forms, not all hospitals have access to data on readmissions that are occurring in other facilities. So really a very comprehensive measure set that has really greatly enabled hospitals participating in Get With The Guidelines over time to improve care on multiple measures in a sustained clinically relevant fashion that is ultimately translated to better clinical outcomes.

So with regards to the Target: Heart Failure award recognition measures, so this involves the use of the key evidence-based therapies for heart failure with reduced EFs, so discharge use of ACE inhibitor, ARB, or angiotensin receptor neprilysin inhibitor, all class 1 recommended in the Guidelines, use of the one of the three evidence-based beta-blockers and in eligible patients, use of Aldosterone antagonist. Again, all these are in the absence of contraindications or intolerance in document patient or system reasons for not utilizing the therapy. In addition, beyond the three core evidence-based cornerstones of heart failure reduced ejection fraction medications, early post-discharge follow-up visit or phone call scheduled to occur within seven days of a hospital discharge, enhanced patient education or referral to a heart failure disease management program or provision of at least 60 minutes of heart failure education by a qualified heart failure educator or a provision at the AHA interactive workbook. Now what will be new going forward, a referral to an outpatient cardiac rehab program will allow for fulfillment of this third component of the recognition criteria. And so starting with Patient Management Tool update in spring 2018, given the evidence supporting cardiac rehab for heart failure and coverage for this, at least for heart failure with reduced EF, this will be an additional means for fulfilling this third criteria. So these are the recognition criteria as they exist for Target: Heart Failure. The three major components, the evidence-based medications, early follow-up, and the enhanced education or disease management or interactive workbook or referral to cardiac rehab that will be phased in with the next PMT update. So you can see all of these really are essential elements of ensuring a safe, effective transition of care. Certainly while these core elements are really essential components, there are obviously other components that go into safe and effective transitions of care and optimized outcomes for our patients with heart failure, and Get With The Guidelines-Heart Failure and the Patient Management Tool allows you to track all of those elements of care, lifestyle modification, counseling, follow-up, being provided for a much more comprehensive component. But for Target: Heart Failure award recognition, these are the measures that are utilized.

Now the honorable recognition requires all three care components meeting at least 50% or greater compliance for eligible patients. Hospitals must also have met the Get With The Guidelines performance achievement award criteria, which means 85% conformity with each of the measures as part of the performance achievement award criteria, the achievement measure components must also be met. So if all these elements are met, Target: Heart Failure honor roll recognition is met. So these are worthwhile, meaningful recognition goals. This is a high bar for hospitals to meet when you think about all of the elements that need to be met without potentially failure in over half the patients as well as the bar of being a Get With The Guidelines performance achievement award winning hospital as well.

So if we look at the number of hospitals so far that have achieved Target: Heart Failure honor roll, 192 hospitals and 438 awards have been given out by the American Heart Association to date. So this is excellent progress and success. You see that among the Get With The Guidelines-Heart Failure participating hospitals, this is still a pretty high bar, that just 192 of the close to, during this time period, 800 hospitals that have been participating and been able to meet the Target: Heart Failure honor roll at some point. So we really recognize that this requires a significant amount of effort and focus on the transition of care but meaningful that these awards can be achieved and hospitals getting the well-deserved recognition. So this shows that clearly over time, there's been growth there, and we hope with the updated tools and resources that we're going to tell you about that will allow even a greater proportion of hospitals to achieve success and meet the Target: Heart Failure honor roll criteria.

Let me now take you through where we stand with some of the performance achievement award measures. So you can see the challenge, these bars represent the Get With The Guidelines-Heart Failure participating hospitals for the performance and achievement measures. 100% is the ideal that we're aiming for. Remember, patients with contraindications or intolerance are removed from the denominator. So this first set of bars is showing evidence-based beta-blockers for those with heart failure with reduced ejection fraction use at discharge. And you can see that really there was a pretty remarkable increase that occurred around the 2011-2012 timeframe and has now gotten well above 90% in recent years. So that's really excellent. There's obviously been with measurement of LV function having been a Joint Commission CMS core measure, high conformity rates have grown to where approaching 100% and being maintained over time.

If we look at use of ACE inhibitor, ARB, and then most recently ARNI at discharge being integrated here, we do see getting to a high level, above 90%. I will say in the last year or two, since this is no longer a joint -- a reported core measure being publicly reported, there has been this little down tick. We're hoping that with further efforts, that we'll be able to reverse that but still above 90%. With regards to post-discharge appointment, this is difference than the six components of the patient instructions. This requires not just a patient to follow up in two weeks but a date, time, and location for the appointment. So RCRA's documentation of the post-discharge appointment., and you can see this has been improving, but still just a little below 80%, so we've got some additional work for our hospitals in meeting this criteria. A lot of this centers around documentation. There's the additional quality metric and of course the Get With The Guidelines Target: Heart Failure honorable recognition criteria of meeting that early post discharge follow-up appointment. So not just having the appointment but it being within seven days or less.

This slide shows the composite performance measures, so the achievement measures in composite form. You can see that in the mid-90% range has been achieved and maintained in recent years, so a few little percentages remaining to get to really 100% care. And with the all or none, or so called defect-free composite measure, this started off at only 60% and is now well above 90%. So really remarkable improvement, notice the number of years that this has been sustained. With most quality improvement programs, you often see this little improvement for a year or two and then people move on to other things and a back sliding in performance but yet here among participating hospitals Get With The Guidelines is really remarkably sustained, high level performance over time, really showing the power of the platform to improve care and outcomes.

If we look at aldosterone antagonist use, a low baseline use that concerns about hyperkalemia, but there's persistent underuse but has been gradual increase in most recent year, in 2016, the highest level that has been reported to date, yet there remains further opportunity to improve care and outcomes within appropriate patients with appropriate dosing with appropriate monitoring for hyperkalemia and the use of this agent.

If we look at anticoagulation for AFib, that has gone up to a very high rate but there's still some opportunity for providing anticoagulation for AFib and heart failure without contraindications. This is remarkable, many other performance improvement registries including, for example, Pinnacle reporting treatment rates of below 50% in patients with atrial fibrillation in CHA2DS2-VASc scores of two or higher. So this is good performance but could further improve.

With regards to hydralazine nitrates for African-American patients, this is a class I recommended therapy but relatively low rates of use, so needs further efforts to improve performance. ICD placement in eligible patients, we've seen very significant improvements in some early publications from Get With The Guidelines highlighted the treatment gap but further opportunities. Likewise for CRT therapy. We see DVT prophylaxis, very remarkable improvement. This was down at 25%. It’s now well above 80% over time. That's great. Influenza vaccination during flu season, also remarkable improvement. There’s evidence showing the association with better heart failure outcomes by avoiding influenza. Same thing with pneumococcal infection with vaccinations. So we see really significant improvement in these quality measures. Here's pneumococcal vaccination.

And if we look at follow-up within seven days, this has been hovering around the 80% range but still some opportunity to provide early post-discharge follow-up, which, as I alluded to, is associated with better outcomes, at least with 30 day re-hospitalization and some other metrics. And the other thing, of course, this is part of the component for Target: Heart Failure, so the opportunity.

So let's now turn to some program updates with regards to Target: Heart Failure. So although we've had comprehensive clinical tools that reflected the 2013 Guidelines in the initial version of Target: Heart Failure, now with new Guideline updates in 2016 and 2017, the clinical tools have been updated to be reflective of the most current guidelines. We're now launching an OnTarget monthly newsletter featuring clinical resources and key program elements, so all participating hospitals and clinicians will be able to receive the OnTarget monthly newsletter. Hope you will find that helpful with valuable content. There will be an update to the main website with not only the look and feel changing but rich content that we think you will find helpful. And then we're also very excited to announce the launch of the Target: Heart Failure app that will bring key clinical resources to your mobile device. This will be available entirely free of charge, rich resources, and I'll tell you more detail about that. But so at the point of care on your mobile device, you will be able to access this information as well as valuable clinical decision support tools.

Regarding taking action, National Heart Failure Clinical Work Group members work to review and re-assess the program and the direction to go, conducted a review of all existing materials and provided updates to make them aligned with the national guidelines as well as providing additional well validated and utilized tools. All the tools in Target: Heart Failure and Get With The Guidelines-Heart Failure go through a thorough AHA science review to make sure they're consistent with evidence and guidelines. And importantly, the newest guideline updates were integrated into the materials to make sure really everything is up to date and consistent with the best evidence and importantly, the ACC/AHA/Heart Failure Society of America guidelines and recommendations.

Some additional highlights, so certainly the guideline recommendations regarding the angiotensin receptor neprilysin inhibitors were integrated in the performance measures, integrated into the different algorithms and tools and materials, also the heart rate lowering agent ivabradine which can lower rehospitalization in hospitalization rates in patients with heart failure with reduced ejection fraction and sinus rhythm have been integrated. There's been a lot of interest in risk scores. We have developed a Get With The Guidelines-Heart Failure risk score. An additional risk score that has proven to be useful is the LACE risk score and the more recent version, the LACE+ risk score. So this has been integrated as additional clinical tool and into the app. The updated Target: Heart Failure composite measure, including cardiac rehab that I highlighted for you, updated patient readmission risk factor, medication adherence and cardiac rehab referral tools, and then the readmission factors that can play a really important role now include highlighting some of the things that have emerged in recent literature regarding frailty, cognition, memory, social support, language barriers are now better addressed in the tools for Target: Heart Failure.

So this slide shows the update to the composite measures, so the details regarding this that now beyond the prior components that referred outpatient cardiac rehab will fulfill the numerator for this measure. Of course those with exclusions for cardiac rehab can come out of the denominator, and with regards to when this will go live again, that will be in spring of 2018 but I did want to highlight this to you. And we do already collect data on referral to cardiac rehab, and again, there's evidence and guideline recommendations and Medicare coverage for cardiac rehab.

This slide shows some of the appearance, what the tools will look like, the Heart Failure 30-day Risk Calculator tool, the facts about heart failure, some of the clinical decision support tools, the checklists, again, having all been updated to be consistent with the current evidence and guidelines. So there will be updates and refresh and nice appearance for all of these tools that you can utilize for your patients, your hospitals, modify as you see fit, so all of these can be customized and personalized to support the local quality improvement efforts. In addition, we really wanted to hear from you, those who have been participating in Target: Heart Failure. So in depth telephone interviews were conducted, qualitative discussion, focusing on challenges that you face, awareness around Target: Heart Failure, the resources that were available and feedback on what could we do to improve the program that would be helpful to you and how can we better communicate the elements in Target: Heart Failure and what directions should we really take the program. And this valuable feedback was integrated in redesign. Also, assessed hospital needs for resources to support their efforts in heart failure in general, and for Target: Heart Failure specifically, identified potential gaps, or limited availability of different resources and how we could potentially fill those gaps and assess, really, the program communication efforts, marketing efforts and ways that things could be improved.

So here's some insights on the metrics provided. So the general consensus was the metrics are in a good place and they're helpful in keeping the focus on the patient rather than just hospital systems, per se. The most frequently discussed metrics were the evidence-based beta-blockers, the in-hospital education, and the details of how to fulfill that, and really the documentation part of scheduling follow-up appointments and some of the challenges of really not just scheduling an appointment within seven days of discharge but actually helping to ensure that it actually occurs. There's also a discussion, could there be more powerful data mining software available to kind of help with data extraction and analysis, as well as recommendations, or the ways to have better electronic health record information automatically flow into Get With The Guidelines so that less time could be spent on chart extractions and more time spent on actually implementation improving care and outcomes.

The OnTarget newsletter series, so you can see a screen shot and look and feel here. This will be emailed monthly, highlighting key topics, feature clinical tools or resources, updates to evidence and guidelines. And if you're at all interested in receiving the OnTarget newsletter, Liz Olson’s email is right here. Email her, she'll add you to the listserv and make sure you get a copy, and any colleagues you want to refer, please share this email widely and we'd love to expand the audience that receives the OnTarget newsletter as wide as possible because we really do think this is a helpful way of communicating about the program.

Regarding the website updates, these are highlighted here; you can see some of the graphics and look and feel. So this will be at heart.org/targethf. The new look will be launching in the coming months, so stay tuned for that. We hope the navigation will be even easier for you to access key program materials to research, patient education resources, but we'd love to hear from you. So once this launches, if you're struggling to find things that you previously could find easily, you know, please give us any feedback, any suggestions on how to improve the website, how to improve Target: Heart Failure. We’d love to hear from you because we really do want this to be a meaningful program that serves your best needs and the best needs of patients with heart failure.

Now, we're very excited about the Target: Heart Failure app. This is using actually pretty advanced technology, Progressive Web App. That means you can directly download it. It does not have to go through an app store. This is an interactive mobile site that's designed for mobile use. There will be a dedicated link to it, but what it allows us to do is rapidly update content. You'll be able to save it to your home screen or elsewhere on your mobile device, it’s adaptable for phones, tablet use, accessible also from computers. It integrates the variety of risk scores to where can you calculate them right there at the bedside, online, the Yale Risk Score Calculator utilized by CMS, the LACE+ calculator, Get With The Guidelines-Heart Failure Risk Calculator, you can input the data directly from your phone or tablet, get the risk score back for that patient. There are also the key clinical topics of heart failure featured in the media area, there are editable PDF clinical tools that you can look up on the mobile device or download from the mobile device. They’re actually editable within the app, and so a whole variety of tools where really right there at the point of care, wherever you are, whatever device with access to the Internet, you'll be able to actually utilize this, and once downloaded, have a variety of things at your fingertips wherever you are, even in the clinical care arena. So we really look forward to this rolling out and we’ll appreciate any feedback you have on further improving the heart failure app.

So let me show you what the home screen looks like here. Can you see the risk calculators, the measures, links to tools, some further menu navigation shown here, we'll be having additional content as things evolve so it's really going to be a dynamic, not a static application with regards to helping you. So easy navigation no matter what device or computer you’re utilizing to get everything at your fingertips and make the Target: Heart Failure rich tools available to you.

So all the clinical tools are updated with the latest science, and as new science comes out, new guideline updates can be rapidly updated. So there's fast and easy access. The documents are available in both English and Spanish, new resources for patient education regarding cardiac rehab, net adherence and more, the links to the Rise Above Heart Failure initiative, updated interactive workbook, My Heart Failure Guide is actually now accessible from the app, on the phone and tablet. So this is really going to be a valuable application that can be utilized to improve the care of patients with heart failure.

There will be important topics on the management of heart failure that we’ll be able to push out through the apps. The archives of the national Get With The Guidelines-Heart Failure and Target: Heart Failure webinars, including this one, will actually be able to be accessible and viewable on your app, your mobile target tablet and device. So basically you'll have that at your fingertips. So what was covered two months ago when Dr. Yancy was on about the Guideline update, you can rapidly tune back into that, those slides and that content. And future updates will include bonus videos, audio content, and even some things that are not currently available in the heart.org. So really we would encourage you to download and utilize this heart failure, really intensive application for Target: Heart Failure that I think will really be helpful to you.

This screen shot shows the LACE calculator that will be available right there at the point of care. With a couple clicks, can enter this information and allow you to determine your patient's LACE+ index and then handy reference to what level of 30-day rehospitalization risk this can be associated with based on the LACE+ score and can thus, can target the most intensive efforts to those that are highest risk for rehospitalization. Some hospitals have had significant success utilizing LACE+ index for essentially risk stratifying patients regarding their rehospitalization risk.

So with that, that covers our really exciting updates for Target: Heart Failure. We do want to give special thanks to the Target: Heart Failure sponsor, which is Novartis Pharmaceuticals and their national sponsorship has helped make some of these updates available and we really appreciate that.

So important context to learn more, so Steve Dentel, our national director, his email is here. For Get With the Guidelines-Heart Failure, Tanya Lane Truitt can be emailed. And then covered Liz Olson, who is program manager For Get With The Guidelines-Heart Failure, and can also get you on the newsletter to stay informed on the latest updates, you can sign up for the Focus on Quality e-Communications along with our OnTarget newsletter. So we're really excited about these enhanced ways of communicating with you, we're really excited about the ongoing participation in Get With The Guidelines-Heart Failure in this update to target heart failure. We really think we’re going to help participating hospitals, clinicians really make a meaningful difference for our patients with heart failure that are being cared for. So heart failure is common, costly, deadly, but fortunately we do have the tools that can improve clinical outcome if they're effectively implemented. I hope that Target: Heart Failure together with Get With The Guidelines-Heart Failure are helping you with this regard.

So with that, let me thank you for your participation in Get With The Guidelines-Heart Failure and Target: Heart Failure, and with that, open this up for any questions you may have.

**Steve Dentel:**

Operator, can you remind everybody how to ask a question? Thank you.

**Operator:**

Thank you. As a reminder, if you'd like to ask a question, please click on the green “Q&A” button in the lower left of your screen, type your question in the open area, and click “Submit.” And I'll turn it back for your Q&A session.

**Steve Dentel:**

Thank you, Ginneen. We have a lot of questions that have rolled in, Dr. Fonarow. We'll start with this one from Houston Methodist Hospital. “Are end stage heart failure patients, should they be included in the Get With The Guidelines-Heart Failure registry like those patients-- [inaudible]? Thanks.”

**Gregg Fonarow, MD:**

Yeah, so it's a great question. So Get With The Guidelines-Heart Failure is intended for those patients who are hospitalized primarily for heart failure, and that includes patients with advanced heart failure. So those that are being hospitalized with heart failure and being considered for heart transplantation or even undergo heart transplantation during that hospitalization or patients that were hospitalized for their severe advanced heart failure required ventricular assist device support. Now, for those patients who have now received a heart transplant and are subsequently being admitted for, say, transplant rejection or a patient with heart failure with a LVAD in place, now hospitalized with a complication of the LVAD or need for anticoagulation, those patients, since they're not being hospitalized for primarily heart failure, per se, they would not be entered in to Get With The Guidelines-Heart Failure. There are other registries and tracking for patients with LVADs. There's tracking the patients post-transplant so their care and outcome can be captured through those other means. So the key distinguishment in Get With The Guidelines-Heart Failure being focused on those hospitalized with heart failure. Now, I do recognize for coding purposes, you've had transplant but yet codes are being utilized where they have heart failure but a patient post-transplantation on subsequent hospitalizations should not be entered into the Get With The Guidelines-Heart Failure.

**Steve Dentel:**

Great. Next question, “Will Get With The Guidelines-Heart Failure be updated to coincide with the 2017 focus update to the 2013 Guidelines? “

**Gregg Fonarow, MD:**

Yes, so absolutely. And in fact, for the most part, because the medications for heart failure with reduced ejection fraction were already part of the 2016 update, that in fact that has really occurred. There are discussions, though, around some of the updates in the 2017 guidelines regarding a 2V recommend for heart failure with preserved ejection fraction, for example, whether reporting metrics would be appropriate. So yes, there will be some updates to Get With The Guidelines-Heart Failure in that regard, but they're going to be pretty minor because right now Get With The Guidelines-Heart Failure really is fully aligned. It's covered here the Target: Heart Failure tools as their release will be aligned. So I think you'll find even now the major measures and metrics are all well aligned with the most current version of the ACC/AHA/HFSA guidelines.

**Steve Dentel:**

Great. Next question, “For patients that are new heart failure and cannot have a device implanted due to time limits, we send our patients with a wearable device. Where does this fall into the metrics or do we get credit for as prescribing a device?”

**Gregg Fonarow, MD:**

Yeah, that's a great question. So Get With The Guidelines does capture that with regards to the ICD. It's not just only placed but planned, and so a patient where there is a plan in place for ICD to be potentially re-assessed, the need, and that patient is discharged with a wearable, that would count. So it's not an implantable ICD, so you wouldn't say that it was placed, but that there is a plan in place, certainly counseling, the counseling measure would be fulfilled there as long as that had been discussed, the potential need for an ICD. So that is captured. We don't specifically capture the data on wearables at this point, but for fulfilling the metrics certainly does as far as ICD planned would capture that as well as having provided ICD counseling.

**Steve Dentel:**

“Does a phone call with screening questions count as a contact or does it post discharge?“

**Gregg Fonarow, MD:**

Yeah, so this is a really great question, and one that I think is really important. The essence of that phone call is actually that it needs to be the type of phone call where there's assessment of the signs and symptoms of heart failure worsening, medication reconciliation components, and an interaction with the clinician to where that discussion consideration in change in symptoms, communication back if change in meds are needed. So just an automated phone call asking patients whether they were satisfied with their hospitalization or some administrative personnel just going through a checklist, yes, no, yes, no and no follow-up, that would not constitute meaningful telephone contact and constitute what fulfills that metric. So it's really important and we put a number of specified criteria that are really necessary for that to be considered a meaningful telephone interaction that would be potentially equivalent or similar enough to a clinical visit that criteria could be fulfilled. So a simple kind of checklist by administrative personnel or automated phone call would absolutely not fulfill that criteria.

**Steve Dentel:**

I'm going to answer a couple questions. One question was, “Are the workbooks available in Spanish?” Not at this point.

Second question is, “Is the interactive workbook available as a printable version for those low income patients that do not have a computer, smartphone?” And it is printable for those patients.

On to the next question, “What constitutes a qualified heart failure educator? Are there specific credentials this person should have?”

**Gregg Fonarow, MD:**

Yeah, you know, that is a great question. So there are a number of different personnel that can be involved in educating heart failure patients, right? This can be Pharm.Ds, this can be advanced practice nurses, this can be physicians. So to come up with the full list of different types of certification, we felt that was somewhat beyond scope, but really felt that these needed to be individuals where there had been sufficient understanding and training. And so that is self-identified in the sense that each hospital needs to decide then what is the level of training, experience and understanding required for those that will be educating the patient. So we put a time on it, we expect that individual -- so having a care partner with no clinical experience, just talking to the patient out of some printed book without any ability to interact well with the patient or answer their questions, that really would not be fulfilling this criteria. But we did not specify exact for each kind of discipline that would be treating the patient, a minimum or certified-type requirement.

**Steve Dentel:**

There's a good question here about, “Medicare doesn't cover cardiac rehab for heart failure patients unless they have ejection fraction less than 35%. I don't see that as an exclusion to the denominator. Are hospitals expected to provide this at no cost to the hospital? Can we even do that without doing this for all patients?” Just trying to get some clarification.

**Gregg Fonarow, MD:**

It's a great question. And that's why the referral to cardiac rehab is not an "and," right? It's an "or." So for those who are eligible, where there can be reimbursement, that's one of the ways of fulfilling this metric. But all of those patients still can qualify for being referred to heart failure disease management program, the other component. So cardiac rehab is just an additional way. So if you've referred them to cardiac rehab, you wouldn't necessarily also have to refer to a heart failure disease management program. So any one of those components. If we were to exclude everyone from the denominator with heart failure preserved EF even though they’re candidates for heart failure disease management for all the other components, that's why it's constructed that way. So really important, this is an additional -- cardiac rehab is an additional way of fulfilling this criteria but not the only way. And so heart failure preserved EF patients, if they qualify because they had valve surgery, coronary artery disease, they may still be able to have cardiac rehab but for heart failure alone wouldn't be covered, but those patients, you can still fulfill the numerator through the other components. So that's a really great question, don't want to create the perception that every patient with heart failure must be referred to cardiac rehab. It is those where this is consideration a good option, that one of the ways that's fulfilling the third component for Target: Heart Failure but not the only way, and any of those remain options. So if your hospital doesn't have cardiac rehab, it's not for 100 miles, you know, that would not be a focus then for your Target: Heart Failure efforts but the other components to fulfill that third measure certainly can be utilized.

**Steve Dentel:**

Kind of a follow-up question, “What is the recommended time for cardiac rehab?”

**Gregg Fonarow, MD:**

So it’s time is also when you refer, so for heart failure, this issue of it's not immediately after that, the hospital discharge to begin the cardiac rehab process, to wait a few weeks. As far as the duration of rehab, it is usually the 24-36 one-hour visits, though they can be longer. Patients can then graduate to home-based exercise that's unsupervised, and there are lots of different versions, they're more intensive versions of cardiac rehab that can also be utilized. But in general, we're talking about the kind of 36 one-hour visits spread out over four to six weeks with regards to the cardiac rehab program, but they vary a little bit, but there are some criteria and standards regarding the elements that should be included to be considered an effective and good cardiac rehab program. In fact, the ACC/AHA are in the process of developing cardiac rehab performance measures that should be available for public comment in the near future.

**Steve Dentel:**

So there's a ton of questions here; we’re not going to get to them all, and we'll make sure we follow up with you on these. “Our facility is starting a remote scale monitoring program for CHF patients. Our goal is to prevent an exasperation or admission to the hospital by monitoring daily weights ultimately by nurses. What patient criteria would you look for to qualify heart failure patients for such programs?”

**Gregg Fonarow, MD:**

Yeah, you know, that's a really great question. I will say, some single center studies have had a lot of success with that type of monitoring program. I will say some of the larger multi-centered trials like Kelly-HF and B-HF that we were actually a part of, you know, found less success. I think the type of patients that, you know, are most amenable for that where volume overload congestion is more of their problem than low output, I think each program has to decide kind of the criteria their bandwidth, are they targeting just the very high risk patients with something like the LACE+ index or others could be utilized or whether they have the bandwidth of enrolling all heart failure patients. I mean, if you look at anyone hospitalized with heart failure, is it high risk for readmission? I mean, one in four patients. If you look among patients that are chronic stable outpatients, then you would tend to those that have had prior hospitalizations, those who were more advanced in their symptoms, so New York heart class 3 or 4 would be the type of patients that you would target.

**Steve Dentel:**

So what is the expect -- here's a question about the beta-blockers. “What is the expectation for those patients with EF of less than 30% on Sotalol for AFib rate control? What contraindication is acceptable or is the position expected to switch the patient to an evidence-based beta-blocker?

**Gregg Fonarow, MD:**

Great question. So Sotalol absolutely does not protect heart failure patients from death. Sotalol does not improve their ejection fraction. Sotalol does not fulfill the beta-blocker criteria. Sotalol can be used for rhythm control and a little bit of rate control but it is not sufficient treatment for heart failure reduced EF. Those patients should be on an evidence-based beta-blocker. They can be treated, however, with an evidence-based beta blocker and Sotalol together. So it's not a contraindication, it’s not excuse not to treat, they need to be on bot. So no reason why Carvedilol or Metoprolol succinate cannot be used together. With Sotalol, you may need to adjust the dose downward with Sotalol. In many cases if you start the evidence-based beta-blocker, their EF is going to improve, their AFib may go away or get better. So Sotalol alone is not sufficient treatment for heart failure with reduced ejection fraction, it doesn’t fulfill the measures as in a contraindication and good care would dictate being on one of the three evidence-based beta-blockers together with Sotalol if indicated. But Sotalol is not an adequate substitute for one of the three evidence-based beta-blockers and the Guidelines are good clinical care.

**Steve Dentel:**

We're at the top of the hour, so there's a couple questions I'll just need to real quickly about the app. The app is intended for clinicians, it's not a patient app. There are resources on the app for patients. And the target to have it available is August. So this should be coming out really soon and we'll make sure we follow up with any questions that didn't get answered. Special thanks to all the participants and a special thanks to Dr. Fonarow, again, for taking time out, you know, and providing a lot about valuable insight to Target: Heart Failure and the Get With The Guidelines-Heart Failure program. Any closing words, Dr. Fonarow?

**Gregg Fonarow, MD:**

Just want to thank everybody again; really appreciate your participation today.

**Steve Dentel:**

Thanks, everyone.

**Operator:**

And again, thank you all for joining us today. We hope you found this presentation informative. This concludes the program, and you may all disconnect.