2017 Get With The Guidelines-Heart Failure Measure Updates

Thursday January 26, 2017
11:00am – 12:00pm CT

Presenters:
Gregg C. Fonarow, MD, FACC, FAHA, FHFSA
Christina Sterzing, RHIA
Meet Our Presenters:

Gregg C. Fonarow, MD, FACC, FAHA
The Eliot Corday Professor of Cardiovascular Medicine and Science
Co-Chief of Clinical Cardiology UCLA Division of Cardiology
Director, Ahmanson-UCLA Cardiomyopathy Center
Co-Director, UCLA Preventative Cardiology Program

Christina Sterzing, RHIA
Quality & Health IT
American Heart Association, National Center
christina.sterzing@heart.org
Core Principles of Get With The Guidelines

• Focus is on quality improvement
• Success is in translating guidelines into clinical practice in the hospital setting
• Capitalizing on the ‘teachable moment’ for both patient and family
• Data drives change- moving from simply collecting data to driving process and system improvements by measuring trends in compliance in real time
• Celebrating success of improved compliance within one hospital, in a region, and across the country!
• Best Practice sharing within the network of hospitals
• Evaluation through analytics to highlight key insights as well as consider future efforts
GWTG-HF Webinar Overview

• Update on GWTG-HF scope
• Current achievement and quality measure performance and awards
• Highlights of GWTG-HF research
• PMT Update and revised/new measures
• Update on Target: Heart Failure and Rise Above Heart Failure
• New developments in Hospital Accreditation and Certification
• Questions
GWTG-HF: Data Submission

Number of records

- July 2015: 116,958
- October 2015: 122,405
- January 2016: 125,054
- April 2016: 130,102
- July 2016: 134,321
- October 2016: 138,174

October 2016
### GWTG-HF: Achievement Measures

**Baseline** = Admissions Jan2005 – Dec2005  
**Current** = Overall

<table>
<thead>
<tr>
<th>Compliance Measurement</th>
<th>Baseline</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV Function Measurement</td>
<td>90.10%</td>
<td>98.64%</td>
</tr>
<tr>
<td>ACEI or ARB at D/C for LV SD</td>
<td>81.20%</td>
<td>91.68%</td>
</tr>
<tr>
<td>Evidence-Based Beta Blocker at D/C for LVSD</td>
<td>61.00%</td>
<td>92.60%</td>
</tr>
<tr>
<td>Beta Blocker Discharge</td>
<td>87.30%</td>
<td>97.90%</td>
</tr>
<tr>
<td>Post Discharge Appointment for HF patients</td>
<td>39.30%</td>
<td>74.64%</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>69.70%</td>
<td>95.42%</td>
</tr>
<tr>
<td>Composite Performance Measure*</td>
<td>80.30%</td>
<td>96.68%</td>
</tr>
<tr>
<td>100% Compliance Measure*</td>
<td>62.10%</td>
<td>92.52%</td>
</tr>
</tbody>
</table>

* Modified to include Beta Blocker at Discharge and Discharge Instructions rather than Evidence-Based Beta Blocker at D/C and Post Discharge Appointment  
Baseline = Admissions Jan2005 – Dec2005  
Current = Overall  
October 2016  
Achievement Measure
GWTG-HF: Quality Measures (1)

Baseline = Admissions Jan2005 – Dec2005

October 2016

Current = Overall

- Warfarin at D/C: Baseline = 57.30%, Current = 84.61%
- Aldosterone antagonist at D/C for LVSD: Baseline = 19.90%, Current = 39.62%
- Hydralazine/Isosorbide at D/C for AA: Baseline = 10.80%, Current = 29.14%
- ICD Counseling or ICD placed or prescribed at D/C: Baseline = 10.80%, Current = 31.30%
- ICD Counseling or ICD placed or prescribed at D/C: Baseline = 31.30%, Current = 54.10%

Quality Measure
GWTG-HF: Quality Measures (2)

Baseline = Admissions Jan2009 – Dec2009
Current = Overall

- Pneumococcal Vaccine
  - Baseline: 22.90%
  - Current: 67.50%

- Influenza Vaccine
  - Baseline: 17.70%
  - Current: 78.00%

- Follow-up visit within 7 days
  - Baseline: 61.90%
  - Current: 79.03%

- DVT Management
  - Baseline: 25.40%
  - Current: 85.42%

- CRT placed or prescribed at discharge
  - Baseline: 39.90%
  - Current: 49.78%

Baseline = Admissions Jan2009 – Dec2009
October 2016
Current = Overall
GWTG-Heart Failure Awards

<table>
<thead>
<tr>
<th>Year</th>
<th>Bronze</th>
<th>Silver</th>
<th>Silver Plus</th>
<th>Gold</th>
<th>Gold Plus</th>
<th>Target: HF Honor Roll</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>74</td>
<td>77</td>
<td>6</td>
<td>145</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>2011</td>
<td>81</td>
<td>87</td>
<td>14</td>
<td>168</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>43</td>
<td>60</td>
<td>22</td>
<td>164</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>31</td>
<td>26</td>
<td>23</td>
<td>131</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>35</td>
<td>28</td>
<td>48</td>
<td>62</td>
<td>48</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>23</td>
<td>30</td>
<td>30</td>
<td>65</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>48</td>
<td>80</td>
<td>42</td>
<td>111</td>
<td>17</td>
<td>0</td>
</tr>
</tbody>
</table>
Most Comprehensive and Up to Date HF Quality Measure Set

<table>
<thead>
<tr>
<th>Achievement Measures</th>
<th>Quality Measures</th>
<th>Reporting Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACEI/ARB/ARNI at Discharge <strong>(Updated)</strong></td>
<td>• ARNI at Discharge <strong>(New)</strong></td>
<td>• ICD Placed or Prescribed at Discharge</td>
</tr>
<tr>
<td>• Evidence-Based Specific Beta Blockers</td>
<td>• Aldosterone Antagonist at Discharge</td>
<td>• Advanced Care Plan</td>
</tr>
<tr>
<td>• Measure LV Function</td>
<td>• Anticoagulation for Atrial Fibrillation and Atrial Flutter</td>
<td>• QRS Duration Documented</td>
</tr>
<tr>
<td>• Post-Discharge Appointment for Heart Failure Patients</td>
<td>• Hydralazine Nitrate at Discharge</td>
<td>• HF Disease Management Program Referral</td>
</tr>
<tr>
<td></td>
<td>• DVT Prophylaxis</td>
<td>• Follow-Up Visit or Contact Within 48 Hours of Discharge Scheduled</td>
</tr>
<tr>
<td></td>
<td>• CRT-D or CRT-P Placed or Prescribed at Discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ICD Counseling Provided or Prescribed or Placed at Discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Influenza Vaccination During Flu Season</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal Vaccination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Follow-Up Visit Scheduled Within 7 Days or Less</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ivabradine at Discharge <strong>(New)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Blood Pressure Control at Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Beta Blocker at Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Beta Blocker Medication at Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lipid-Lowering Medications at Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Omega-3 Fatty Acid Supplement Use at Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diabetes Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diabetes Teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Smoking Cessation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discharge Instructions</td>
</tr>
</tbody>
</table>
GWTG Heart Failure Publications
86 Total (through 12/8/16)
2016 GWTG-HF Publications


• Frizzell, Jarrod D. Prediction of 30-day All-Cause Readmissions in Patients Hospitalized for Heart Failure: Comparison of Machine-Learning and Other Statistical Approaches. JAMA Cardiology (In Press) *AHA Young Investigator Database Seed Grant Awardee


• Pandey, Ambarish. Association of 30-day Readmission Metric for Heart Failure under the Hospital Readmissions Reduction Program with Quality of Care and Outcomes. JACC HF (in press) simultaneous publication in JACC HF with AHA Scientific Sessions 2016 abstract- November 15, 2016 *AHA Young Investigator Database Seed Grant Awardee


2016 GWTG-HF Publications (continued)


Scope of Recent PMT Updates

ACE/ARB or ARNI at Discharge Measure Update (Achievement)

New ARNI at Discharge Measure (Quality 2017)

New Ivabradine at Discharge (Reporting 2017)
Updated Achievement Measure

- ACE/ARB/ARNI at Discharge (Achievement)

- Background:
  - ARNI was approved for use in Summer 2015
  - ARNI was added to ACE/ARB or ARNI measure for inclusion in the denominator

- New with this release:
  - ARNI contraindications were added to measure exclusion criteria in October 2016
PARADIGM-HF: Primary Endpoint of CV Death or Heart Failure Hospitalization

Number needed to treat = 21

HR 0.80 (95% CI, 0.73–0.87), p<0.001

Cumulative Probability

Days since Randomization 0 180 360 540 720 900 1080 1260

Enalapril
1117 events (26.5%)

Sac/Val
914 events (21.8%)

Number at Risk

<table>
<thead>
<tr>
<th>Days</th>
<th>Enalapril</th>
<th>Sac/Val</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4187</td>
<td>4212</td>
</tr>
<tr>
<td>180</td>
<td>3922</td>
<td>3883</td>
</tr>
<tr>
<td>360</td>
<td>3663</td>
<td>3579</td>
</tr>
<tr>
<td>540</td>
<td>3018</td>
<td>2922</td>
</tr>
<tr>
<td>720</td>
<td>2257</td>
<td>2123</td>
</tr>
<tr>
<td>900</td>
<td>1544</td>
<td>1488</td>
</tr>
<tr>
<td>1080</td>
<td>896</td>
<td>853</td>
</tr>
<tr>
<td>1260</td>
<td>249</td>
<td>236</td>
</tr>
</tbody>
</table>

Sac/Val = Sacubitril/Valsartan.
<table>
<thead>
<tr>
<th><strong>Sacubitril/Valsartan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand name</strong></td>
</tr>
<tr>
<td><strong>Indication</strong></td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
</tr>
<tr>
<td><strong>Renal/hepatic impairment</strong></td>
</tr>
<tr>
<td><strong>Switching from an ACE inhibitor</strong></td>
</tr>
<tr>
<td><strong>Contraindications</strong></td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
</tr>
</tbody>
</table>

7.3.2. Pharmacological Treatment for Stage C HF With Reduced Ejection Fraction: Recommendations

7.3.2.10. Renin-Angiotensin System Inhibition With Angiotensin-Converting Enzyme Inhibitor or Angiotensin Receptor Blocker or ARNI: Recommendations

See the Online Data Supplement (http://jaccjacc.acc.org/Clinical_Document/2016_HF_Focused_Update_Data_Supplement_New_Therapy_Only_S5.pdf) for evidence supporting these recommendations.

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>ACE: A</td>
<td>The clinical strategy of inhibition of the renin-angiotensin system with ACE inhibitors (Level of Evidence: A) (9-14), OR ARBs (Level of Evidence: A) (15-18), OR ARNI (Level of Evidence: B-R) (19) in conjunction with evidence-based beta blockers (20-22), and aldosterone antagonists in selected patients (23, 24), is recommended for patients with chronic HFrEF to reduce morbidity and mortality.</td>
</tr>
<tr>
<td></td>
<td>ARB: A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ARNI: B-R</td>
<td></td>
</tr>
</tbody>
</table>
## ACE-I & ARB- 2016

### ACE: A

The use of ACE inhibitors is beneficial for patients with prior or current symptoms of chronic HFrEF to reduce morbidity and mortality (9-14, 25).

ACE inhibitors have been shown in large RCTs to reduce morbidity and mortality in patients with HFrEF with mild, moderate, or severe symptoms of HF, with or without coronary artery disease (9-14). Data suggest that there are no differences among available ACE inhibitors in their effects on symptoms or survival (25). ACE inhibitors should be started at low doses and titrated upward to doses shown to reduce the risk of cardiovascular events in clinical trials. ACE inhibitors can produce angioedema and should be given with caution to patients with low systemic blood pressures, renal insufficiency, or elevated serum potassium (>5.0 mEq/L). Angioedema occurs in <1% of patients who take an ACE inhibitor, but it occurs more frequently in blacks and women (26). Patients should not be given ACE inhibitors if they are pregnant or plan to become pregnant. ACE inhibitors also inhibit kininase and increase levels of bradykinin, which can induce cough in up to 20% of patients but also may contribute to beneficial vasodilation. If maximal doses are not tolerated, intermediate doses should be tried; abrupt withdrawal of ACE inhibition can lead to clinical deterioration and should be avoided.

Although the use of an ARNI in lieu of an ACE inhibitor for HFrEF has been found to be superior, for those patients for whom ARNI is not appropriate, continued use of an ACE inhibitor for all classes of HFrEF remains strongly advised.

### ARB: A

The use of ARBs to reduce morbidity and mortality is recommended in patients with prior or current symptoms of chronic HFrEF who are intolerant to ACE inhibitors because of cough or angioedema (15-18, 27, 28).
### I ARNI: B-R

| Benefits of ACE inhibitors with regard to decreasing HF progression, hospitalizations, and mortality rate have been shown consistently for patients across the clinical spectrum, from asymptomatic to severely symptomatic HF. Similar benefits have been shown for ARBs in populations with mild-to-moderate HF who are unable to tolerate ACE inhibitors. In patients with mild-to-moderate HF (characterized by either 1) mildly elevated natriuretic peptide levels, BNP [B-type natriuretic peptide] ≥ 150 pg/mL or NT-proBNP [N-terminal pro-B-type natriuretic peptide] ≥ 600 pg/mL; or 2) BNP ≥ 100 pg/mL or NT-proBNP ≥ 400 pg/mL with a prior hospitalization in the preceding 12 months) who were able to tolerate both a target dose of enalapril (10 mg twice daily) and then subsequently an ARNI (valsartan/sacubitril; 200 mg twice daily, with the ARB component equivalent to valsartan 160 mg), hospitalizations and mortality were significantly decreased with the valsartan/sacubitril compound compared with enalapril. The target dose of the ACE inhibitor was consistent with that known to improve outcomes in previous landmark clinical trials (10). |

See Online Data Supplements: 1 and 18.
<table>
<thead>
<tr>
<th>III: Harm</th>
<th>B-R</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARNI</strong> should not be administered concomitantly with ACE inhibitors or within 36 hours of the last dose of an ACE inhibitor (31, 32).</td>
<td></td>
</tr>
<tr>
<td>Oral neprilysin inhibitors, used in combination with ACE inhibitors can lead to angioedema and concomitant use is contraindicated and should be avoided. A medication that represented both a neprilysin inhibitor and an ACE inhibitor,</td>
<td></td>
</tr>
</tbody>
</table>

*See Online Data Supplement 3.*
Patients who have contraindications to both ACEI and ARB or ARNI are now excluded from the measure.

**Discharge Status** = 02 (Dsch/Trans to a short term general hospital for inpatient care) **OR** = 05 (Discharged/transferred to a Designated Cancer Center or Children’s Hospital) **OR** = 07 (Left against medical advice or discontinued care) **OR** = 20 (Expired) **OR** = 41 [Exp in medical facility (ie. SNF, ICF, Hospice)] **OR** = 43 (Dsch/Trans to a federal health care facility) **OR** = 50 (Hospice-home) **OR** = 51 [Hospice - medical facility (certified providing hospice level of care)] **OR** = 66 [Discharged/transferred to a Critical Access Hospital (CAH)]

**Discharge Disposition** = 2 (Hospice – Home) **OR** = 3 (Hospice – Health Care Facility) **OR** = 4 (Acute Care Facility) **OR** = 6 (Expired) **OR** = 7 (Left Against Medical Advice/AMA)

**Contraindications to ACEI at discharge** = AND
**Contraindication to ARB at discharge** = Yes
**Contraindication to ARNI at discharge** = Yes

**Is there physician/APN/PA documentation of comfort measures only during the hospital stay?** = Yes OR
**When is the earliest physician/APN/PA documentation of comfort measures only?** = Day 0 or 1 **OR** = Day 2 or after **OR** = 3 Timing unclear
ACE/ARB/ARNI at Discharge (Rationale)

Rationale

Benefits of ACE inhibitors with regard to decreasing HF progression, hospitalizations, and mortality rate have been shown consistently for patients across the clinical spectrum, from asymptomatic to severely symptomatic HF. ACE inhibitors reduce morbidity and mortality in heart failure with reduced ejection fraction (HFrEF). RCTs clearly establish the benefits of ACE inhibition in patients with mild, moderate, or severe symptoms of HF and in patients with or without coronary artery disease. ARBs have been shown to reduce mortality and HF hospitalizations in patients with HFrEF in large RCTs. Patients intolerant to ACE inhibitors because of cough or angioedema should be started on ARBs; patients already tolerating ARBs for other indications may be continued on ARBs if they subsequently develop HF. An ARNI has recently been approved for patients with symptomatic HFrEF and is intended to be substituted for ACE inhibitors or ARBs. In an RCT that compared the first approved ARNI, valsartan/sacubitril, with enalapril in symptomatic patients with HFrEF tolerating an adequate dose of either ACE inhibitor or ARB, the ARNI reduced the composite endpoint of cardiovascular death or HF hospitalization significantly, by 20%. The benefit was seen to a similar extent for both death and HF hospitalization and was consistent across subgroups. One of these three medications should be prescribed at discharge for patients with HFrEF.

ARNI reduces CV death or HF hospitalization by 20%
Supporting Guideline Recommendations or Other Evidence

Class I
The clinical strategy of inhibition of the renin-angiotensin system with ACE inhibitors *(Level of Evidence: A)* OR ARBs *(Level of Evidence: A)* OR ARNI *(Level of Evidence: B-R)* in conjunction with evidence-based beta blockers (20-22), and aldosterone antagonists in selected patients, is recommended for patients with chronic HFpEF to reduce morbidity and mortality.

Class I
The use of ACE inhibitors is beneficial for patients with prior or current symptoms of chronic HFpEF to reduce morbidity and mortality *(Level of Evidence: A)*.

Class I
The use of ARBs to reduce morbidity and mortality is recommended in patients with prior or current symptoms of chronic HFpEF who are intolerant to ACE inhibitors because of cough or angioedema *(Level of Evidence: A)*.

Class I
In patients with chronic symptomatic HFpEF NYHA class II or III who tolerate an ACE inhibitor or ARB, replacement by an ARNI is recommended to further reduce morbidity and mortality *(Level of Evidence: B-R)*.

ARNI shows as Class I recommendation
New Quality Measure

- ARNI at Discharge (Quality)
- Key Points
  - ARNI reduces CV death or HF hospitalization by 20%
  - Adding the Quality measure is the first step in tracking patients who receive ARNI or over ACE or ARB alone
  - This measure will be tested and validated, and may graduate to an achievement measure in the future
ARNI at Discharge Measure Description

Denominator:
• All patients in the Initial Patient Population
• Patients who have a documented ejection fraction of < 40% or a narrative description of LVF consistent with moderate or severe systolic dysfunction

Exclusions:
• Patients who left against medical advice; patients who expired; patients who expired in medical facility; patients discharged/transferred to a federal healthcare hospital; patients discharged to hospice; patients discharged/transferred to a critical access hospital (CAH)
• Patients with contraindications or other reasons for not prescribing ARNI
• Patients with contraindications to ARB
• Comfort Measures Only

Numerator
• Patients who were prescribed ARNI at discharge
ARNI is recommended to replace ACE or ARB in certain patients

**Rationale**
An ARNI has recently been approved for patients with symptomatic HFrEF and is intended to be substituted for ACE inhibitors or ARBs. In an RCT that compared the first approved ARNI, valsartan/sacubitril, with enalapril in symptomatic patients with HFrEF tolerating an adequate dose of either ACE inhibitor or ARB, the ARNI reduced the composite endpoint of cardiovascular death or HF hospitalization significantly, by 20%. The benefit was seen to a similar extent for both death and HF hospitalization and was consistent across subgroups.

**Supporting Guideline Recommendations or Other Evidence**

**Class I**
In patients with chronic symptomatic HFrEF NYHA class II or III who tolerate an ACE inhibitor or ARB, replacement by an ARNI is recommended to further reduce morbidity and mortality (Level of Evidence: B-R).

**Class III (Harm)**
ARNI should not be administered concomitantly with ACE inhibitors or within 36 hours of the last dose of an ACE inhibitor (Level of Evidence: B-R).

**Class III**
ARNI should not be administered to patients with a history of angioedema. (Level of Evidence: C-EO)
ARNI at Discharge

New data element: Reasons for not switching to ARNI (excludes patient from the denominator)
New Reporting Measure

- Ivabradine at Discharge
- New data elements under Ivabradine for Medications at Discharge have been added
- Move Ivabradine option from the Other Medications at Discharge to Historic.
- For discharges on or after Jan 1, 2017
Ivabradine

- Acts by inhibiting the If channel, present in the cardiac SA node
- Reduces persistently elevated heart rate
- Evaluated as treatment of HFrEF who have a resting HR of at least 70 beats per minute, in sinus rhythm, and who are also taking the highest tolerable dose of a beta blocker

SHIFT Study: Primary Endpoint of CV Death or Hospitalization for Worsening HF

- Ivabradine (n=3241)
- Placebo (n=3264)

Placebo: 937 events (29%)
Ivabradine: 793 events (24%)

HR 0.82 (95% CI, 0.75–0.90)
p<0.0001
ARR = 5%, NNT = 20

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Ivabradine (n=3241)</th>
<th>Placebo (n=3264)</th>
<th>HR</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary endpoint</td>
<td>24%</td>
<td>29%</td>
<td>0.82</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>All-cause mortality</td>
<td>16%</td>
<td>17%</td>
<td>0.90</td>
<td>0.092</td>
</tr>
<tr>
<td>Death from HF</td>
<td>3%</td>
<td>5%</td>
<td>0.74</td>
<td>0.014</td>
</tr>
<tr>
<td>All-cause hospitalization</td>
<td>38%</td>
<td>42%</td>
<td>0.89</td>
<td>0.003</td>
</tr>
<tr>
<td>Any CV hospitalization</td>
<td>30%</td>
<td>34%</td>
<td>0.85</td>
<td>0.0002</td>
</tr>
<tr>
<td>CV death, hospitalization for worsening HF, or hospitalization for non-fatal MI</td>
<td>25%</td>
<td>30%</td>
<td>0.82</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Ivabradine at Discharge Measure Description

Denominator:

• All patients in the Initial Patient Population:
  • Who have a documented ejection fraction of ≤35% or a narrative description of LVF consistent with moderate or severe systolic dysfunction AND
  • Whose heart rate closest to discharge is greater than or equal to 70 bpm AND
  • Who were either prescribed a beta-blocker at discharge or had a documented contraindication to beta-blocker
Measure Description (cont.)

Exclusions:

- Patients who left against medical advice; patients who expired; patients who expired in medical facility; patients discharged/转移到 a federal healthcare hospital; patients discharged to hospice; patients discharged/transferred to a critical access hospital (CAH)
- Patients with contraindications to Ivabradine
- History or current finding of Atrial Fibrillation or Atrial Flutter
- Comfort Measures Only

Numerator
- Ivabradine at Discharge
Rationale

Ivabradine selectively inhibits the I_{f} current in the sinoatrial node, providing heart rate reduction. One RCT demonstrated the efficacy of ivabradine in reducing the composite endpoint of cardiovascular death or HF hospitalization. Given the well-proven mortality benefits of beta-blocker therapy, it is important to initiate and up titrate these agents to target doses, as tolerated, before assessing the resting heart rate for consideration of ivabradine initiation. The introduction of an angiotensin receptor-neprilysin inhibitor (ARNI) (valsartan/sacubitril) and a sinoatrial node modulator (ivabradine), when applied judiciously, complements established pharmacological and device-based therapies.

Supporting Guideline Recommendations or Other Evidence

Class IIa

Ivabradine can be beneficial to reduce HF hospitalization for patients with symptomatic (NYHA class II-III) stable chronic HFREF (LVEF ≤35%) who are receiving GDEM*, including a beta blocker at maximum tolerated dose, and who are in sinus rhythm with a heart rate of 70 bpm or greater at rest (Level of Evidence: B-R).

*Guideline-directed evaluation and management.
Ivabradine (Other Medications at Discharge)

New data element to capture Ivabradine
### 7.3.2.11. Ivabradine: Recommendation

See the Online Data Supplement

(http://jaccjacc.acc.org/Clinical_Document/2016_HF_Focused_Update_Data_Supplement_Ne
w_Treatment_Only_S5.pdf) for evidence supporting this recommendation.

<table>
<thead>
<tr>
<th>Recommendation for Ivabradine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COR</strong></td>
</tr>
<tr>
<td>IIa</td>
</tr>
</tbody>
</table>

See Online Data Supplement 4.

Ivabradine is a new therapeutic agent that selectively inhibits the \( I_f \) current in the sinoatrial node, providing heart rate reduction. One RCT demonstrated the efficacy of ivabradine in reducing the composite endpoint of cardiovascular death or HF hospitalization (38). The benefit of ivabradine was driven by a reduction in HF hospitalization. The study included patients with HFrEF (NYHA class II-IV, albeit with only a modest representation of NYHA class IV HF) and left ventricular ejection fraction (LVEF) \( \leq 35\% \), in sinus rhythm with a resting heart rate of \( \geq 70 \) beats per minute. Patients enrolled included a small number with paroxysmal atrial fibrillation (\(<40\% \) of the time) but otherwise in
Additional Webinars

For additional information, visit the Focus on Quality Webinars page:

http://www.heart.org/HEARTORG/General/Get-With-The-Guidelines-HFTarget-HF-Webinars_UCM_447069
Target: Heart Failure Program Update

Objectives:

- Re-launch the program including a comprehensive webinar outlining all program components and benefits
- Enhance the Get With The Guidelines-Heart Failure Clinical Tools Library and the Target: Heart Failure resources (Ex. Electronic tools, Heart Failure Care Plans, Interactive Workbook)
- Launch a monthly Target: Heart Failure Spotlight Series to focus on components of Target: Heart Failure to increase clinician knowledge base
- Launch localized innovative Target: Heart Failure initiatives from within AHA’s seven regional affiliates throughout the US.
- Increase hospitals enrolled and engagement
- Improved compliance in measures and number of awards
RISE ABOVE HEART FAILURE UPDATE

COMING UP IN 2017: A TARGETED OUTREACH TO PROVIDERS

Convene, Educate, Amplify and Measure

**Convene A Summit of thought leaders**

**Engage key AHA volunteer & RAHF Alliance Expertise to build and promote relevant CTA’s and tools**

**Build out tools for professional on facilitating the dialogue with the patient and implementing guideline based care**

**Through Target HF and GWTG HF measure uptake in care coordination**

**HF Summit on Feb. 10th 2017**

- Plan Summit with key volunteers
- Convene Summit
- Reinforce and engage participants through webinars
- Communicate through media outreach and channels
- Build strong CTA’s with summit participants
Interactive Patient Experience Tool

- Through evidence based, connected heart health HF content, Patients will be able to track and learn about their symptoms, health data and medication adherence
- They can set goals and measure their progress
- Through evaluations of lesson plans, track health literacy
- Connect with their peers on the Support Network
- Finally through an evaluation at the end, measure Quality of life

Timeline: soft launch in Feb; and full promotional launch in April 2017
ACC and AHA

Setting a New Standard for Hospital Accreditation *Together*
A New Collaboration Between ACC and AHA

- Will offer all hospitals and institutions a single, comprehensive source of state-of-the-art accreditation tools

- These tools will bridge gaps and integrate evidence-based science, quality initiatives, clinical best-practices and the latest ACC/AHA guidelines into cardiovascular care processes

- Leverages collective strengths, expertise and resources to identify and recognize high performing and complex cardiovascular service lines

- Provides unbiased, actionable and achievable benchmarks for all hospital and clinical leaders to use as they work to raise their own standards of clinical performance.

- Offers hospitals a single source for accreditation that ensures continuous and effective quality improvement in cardiovascular care.
Beginning in 2017...

• U.S. hospitals will have access to a **suite of co-branded accreditation services** focused on all aspects of cardiac care, including:
  • chest pain
  • cardiac catheterization
  • atrial fibrillation
  • heart failure
  • other cardiovascular conditions.

• The collaborative will develop a **multi-faceted cardiac accreditation program** to enable hospitals and health systems to achieve the highest standard of cardiac care for all patients.
Stay informed on accreditation

accreditation@heart.org

To receive further updates visit

www.cardiacaccreditation.org
Contact Us to Learn More

Steve Dentel BSN, RN, CPHQ
National Director, Field Programs and Integration
steve.dentel@heart.org

GWTG-Heart Failure
Tanya Lane Truitt, RN MS
Sr. Program Manager Quality Systems Improvement
tanya.truitt@heart.org

Liz Olson
Program Manager, Get With The Guidelines – Heart Failure
liz.olson@heart.org

Stay informed on the latest updates from all of the Get With The Guidelines programs.

Sign Up for Focus on Quality e-Communications
Thank you for your active participation and contributions to GWTG-HF!