

# The New Heart Failure Guidelines: Impact on the Patient Journey – The Healthcare Professional Perspective

ADAPTED FROM:

2022 AHA/ACC/HFSA  
Guideline for Heart Failure



American  
Heart  
Association.

# The New Guidelines: Unique Characteristics & Heart Failure Stages A & B

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Her research interests include factors contributing to exercise intolerance and debilitation in heart failure patients, particularly with advancing age. She is also interested in disparities in heart failure therapy access, utilization, and outcomes in diverse and aging populations.





# Disclosures

- Dr. Sabra Lewsey – No disclosures



# Epidemiology of Heart Failure in the United States



Increase in HF related deaths from 2009 to 2014.



Increase in HF hospitalizations from 2013 to 2017.



Decline in overall HF incidence from 2011 to 2014 with declining incidence of HFrEF but increasing

## Racial and ethnic disparities in HF burden, hospitalization, and death persist.

### Age-adjusted mortality rates per 100,000 for HF:

<i>145.5 for non-Hispanic (NH) Black men</i>	<i>102.9 for non-Hispanic (NH) Black women</i>
<i>124.1 for NH White men</i>	<i>87.5 for NH White women</i>
<i>119 for NH American Indian/Alaskan Native men</i>	<i>80.7 for NH American Indian/Alaskan Native women</i>
<i>82 for Hispanic men</i>	<i>57.2 for Hispanic women</i>
<i>54.8 for NH Asian or PI men</i>	<i>37.8 for NH Asian or PI women</i>

## Research, evidenced-based interventions, and health and social policy reforms are warranted to address racial and ethnic disparities in HF outcomes.



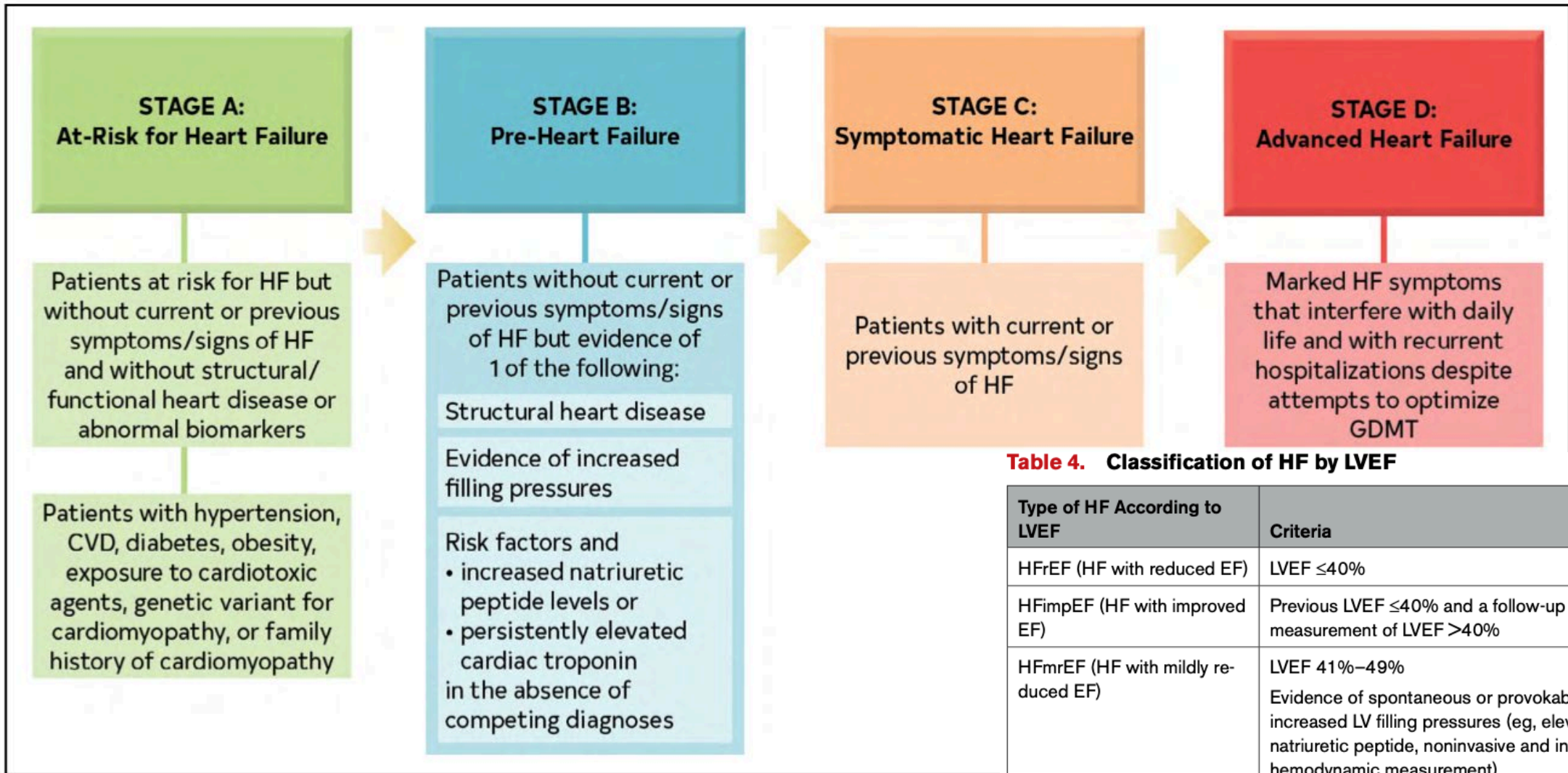
Abbreviations: HF indicates heart failure; HFpEF, heart failure with preserved ejection fraction; and HFrEF, heart failure with reduced ejection fraction.



# 2022 HF Guidelines Overview:

- *A Common Framework to Improve Care*
  - *Staging and Severity: New emphasis on primary prevention of HF*
  - *Universal Classification by LVEF and Common Diagnostics/ Diagnostic Aids (HFpEF\*)*
- *The “-rEF to -pEF” spectrum of HF medical therapies*
  - *Quadruple-Based Guideline Directed Medical Therapy for HFrEF*
  - *New GDMT Arsenal for HFpEF and HFmrEF*
- Minimize Interruptions in GDMT
- Address Social Determinants of Health & HF Disparities
- *Value-Based* Assertions regarding HF Therapeutics
- Addressing Goals of Care & Timely Referral for Advanced Therapies
- Considerations in Special Populations\* & the Need of Multi-Disciplinary Care:
  - HF in Pregnancy
  - Recognition and Rx of Cardiac Amyloidosis
- Treat the whole patient: co-morbidity management





**Figure 1. ACC/AHA Stages of HF.**

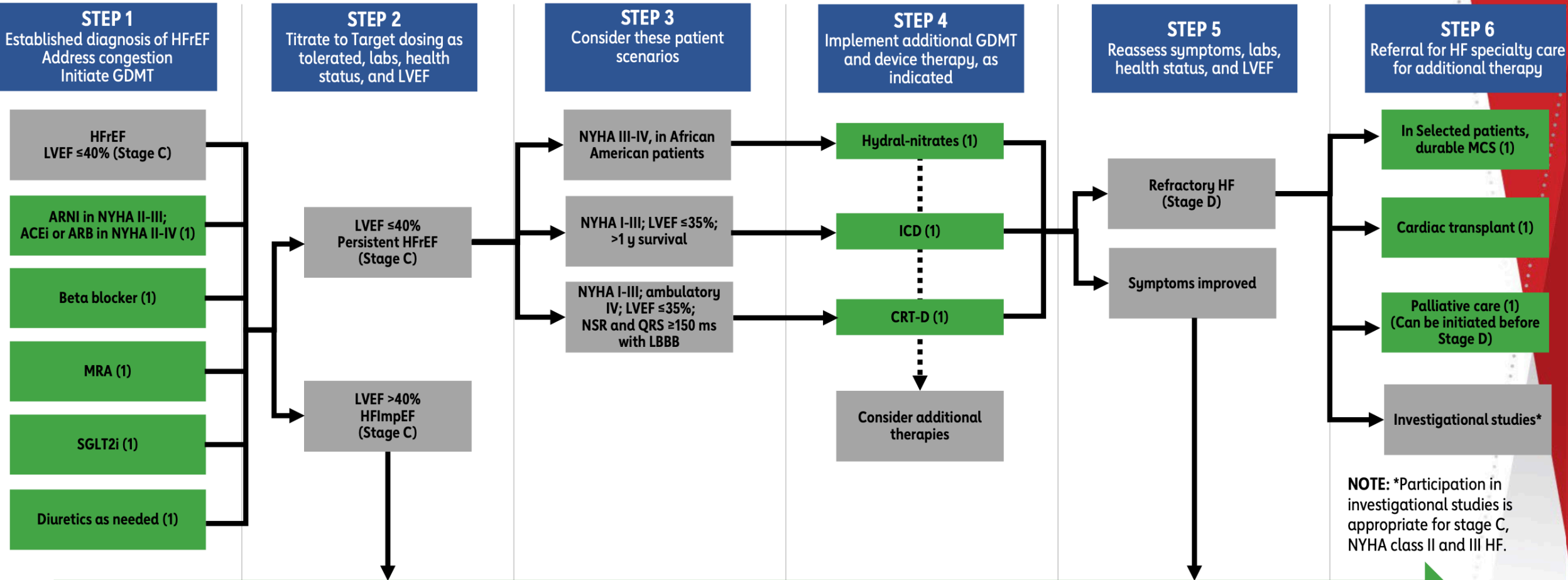
**Table 4. Classification of HF by LVEF**

Type of HF According to LVEF	Criteria
HFrEF (HF with reduced EF)	LVEF $\leq 40\%$
HFimpEF (HF with improved EF)	Previous LVEF $\leq 40\%$ and a follow-up measurement of LVEF $> 40\%$
HFmrEF (HF with mildly reduced EF)	LVEF 41%–49% Evidence of spontaneous or provokable increased LV filling pressures (eg, elevated natriuretic peptide, noninvasive and invasive hemodynamic measurement)
HFpEF (HF with preserved EF)	LVEF $\geq 50\%$ Evidence of spontaneous or provokable increased LV filling pressures (eg, elevated natriuretic peptide, noninvasive and invasive hemodynamic measurement)

# Recommendations for Patients with Symptomatic (Stage C) HFrEF



New Onset/De Novo HF: Resolution of Symptoms: Persistent HF: Worsening HF:



Continue GDMT with serial reassessment and optimize dosing, adherence and patient education, address goals of care

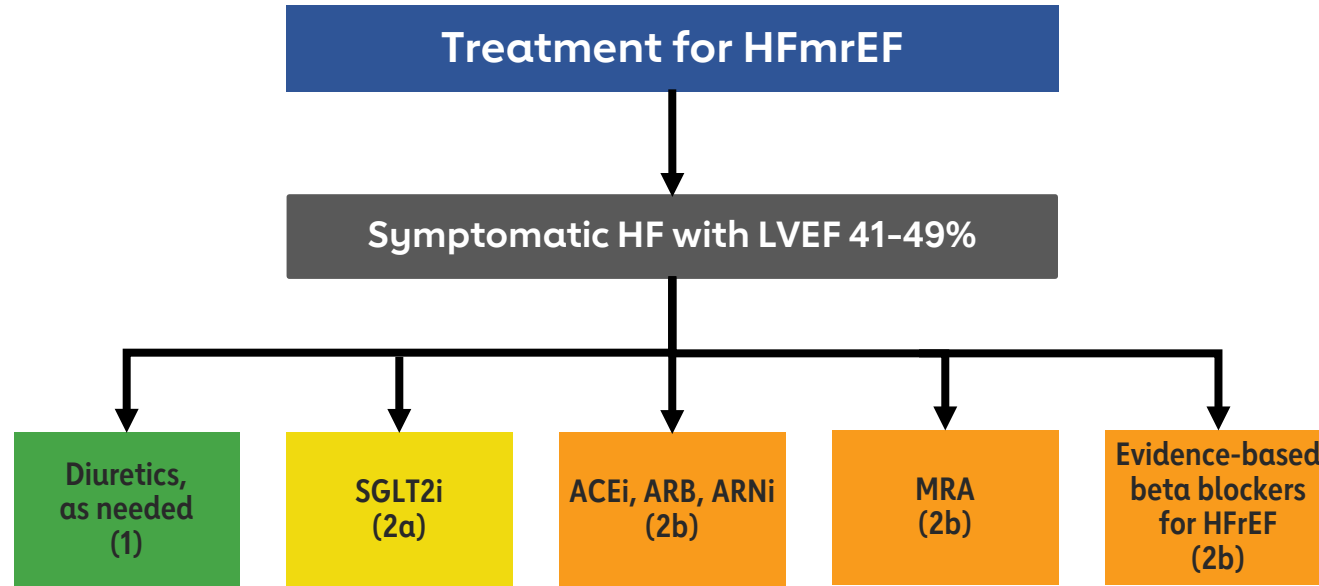
**NOTE:** \*Participation in investigational studies is appropriate for stage C, NYHA class II and III HF.







# Recommendations for Patients with (Stage C) Mildly Reduced LVEF

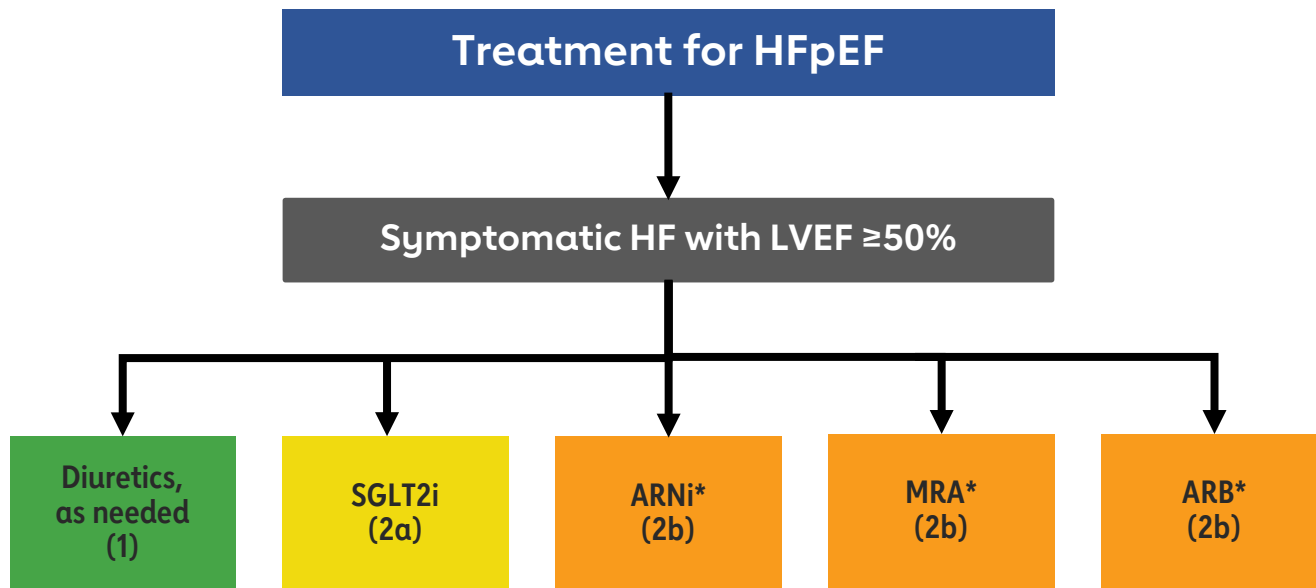


## Patients With HFimpEF

COR	RECOMMENDATIONS
1	1. In patients with HFimpEF after treatment, GDMT should be continued to prevent relapse of HF and LV dysfunction, even in patients who may become asymptomatic. (1)



# Recommendations for Patients with (Stage C) Preserved LVEF



NOTE: \*Greater benefit in patients with LVEF closer to 50%

1	C-LD	1. Patients with HFpEF and hypertension should have medication titrated to attain blood pressure targets in accordance with published clinical practice guidelines to prevent morbidity. <sup>1-3</sup>
2a	B-R	2. In patients with HFpEF, SGLT2i can be beneficial in decreasing HF hospitalizations and cardiovascular mortality. <sup>4</sup>
2a	C-EO	3. In patients with HFpEF, management of AF can be useful to improve symptoms.
2b	B-R	4. In selected patients with HFpEF, MRAs may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum. <sup>5-7</sup>
2b	B-R	5. In selected patients with HFpEF, the use of ARB may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum. <sup>8,9</sup>
2b	B-R	6. In selected patients with HFpEF, ARNi may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum. <sup>10,11</sup>
3: No-Benefit	B-R	7. In patients with HFpEF, routine use of nitrates or phosphodiesterase-5 inhibitors to increase activity or QOL is ineffective. <sup>12,13</sup>



**Abbreviations:** ACEi indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor-neprilysin inhibitor; HFimpEF, heart failure with improved ejection fraction; HFmrEF, heart failure with mildly reduced ejection fraction; HFrefEF, heart failure with reduced ejection fraction; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; and SGLT2i, sodium-glucose cotransporter 2 inhibitor.

Heidenreich, P. A. et al. (2022). 2022 AHA/ACC/HFSA Guideline for Heart Failure. *Circulation*.



# Recommendations for Addressing SDOH and Disparities in Vulnerable Populations



COR	RECOMMENDATIONS
1	Evidence of health disparities should be monitored and addressed at the clinical practice and the health care system levels.

COR	RECOMMENDATIONS
1	In vulnerable patient populations at risk for health disparities, HF risk assessments and multidisciplinary management strategies should target both known risks for CVD and social determinants of health, as a means toward elimination of disparate HF outcomes.

COR	RECOMMENDATIONS
1	In patients presenting with HF, a thorough history and physical examination should be obtained and performed to identify cardiac and noncardiac disorders, lifestyle and behavioral factors, and social determinants of health that might cause or accelerate the development or progression of HF.

**Take Home Point:**  
 Class I recommendation to assess, monitor, and address SDOH and disparities impacting HF patients with multidisciplinary management, across phases of care.

# Social Barriers

## Take Home Point:

Class I recommendation to assess, monitor, and address SDOH and disparities impacting HF patients with multidisciplinary management, across phases of care.



Financial Burden

Unsafe Environments

Food Insecurity

Language Barriers

Low Health Literacy

Housing Insecurity

Transportation Issues

Low Social Support

Intervene





# Value Statements for GDMT for HFrEF



## Take Home Point:

Class 1 recommended medical therapies for HFrEF have very high economic value (low cost).

## In patients:

With previous or current symptoms of chronic HFrEF, in whom ARNi is not feasible, tx with ACEi or ARB provides high economic value.

Value Statement:  
High Value (A)

With chronic symptomatic HFrEF, tx with an ARNi instead of an ACEi provides high economic value.

Value Statement:  
High Value (A)

With HFrEF and NYHA class II to IV symptoms, MRA therapy provides high economic value.

Value Statement:  
High Value (A)

With HFrEF, with current or previous symptoms, beta-blocker therapy provides high economic value.

Value Statement:  
High Value (A)

With symptomatic chronic HFrEF, SGLT2i therapy provides intermediate economic value.

Value Statement:  
Intermediate Value (A)

Self-identified African American patients with NYHA class III to IV HFrEF who are receiving optimal medical therapy with ACEi or ARB, beta blockers, and MRA, the combination of hydralazine and isosorbide dinitrate provides high economic value.

Value Statement: High Value (B-NR)

**Abbreviations:** ACEi indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor-neprilysin inhibitor; HFrEF, heart failure with reduced ejection fraction; MRA, mineralocorticoid receptor antagonist; SGLT2i, NR, non-randomized; sodium-glucose cotransporter 2 inhibitor; and tx, treatment.

# Value Statements for Device Therapy



A transvenous ICD provides high economic value in the primary prevention of SCD particularly when the patient's risk of death caused by ventricular arrhythmia is deemed high and the risk of nonarrhythmic death (either cardiac or noncardiac) is deemed low based on the patient's burden of comorbidities & functional status.

*Value Statement: High Value (A)*

For patients who have LVEF  $\leq 35\%$ , sinus rhythm, LBBB with a QRS duration of  $\geq 150$  ms, and NYHA class II, III, or ambulatory IV symptoms on GDMT, CRT implantation provides high economic value.

*Value Statement: High Value (B-NR)*

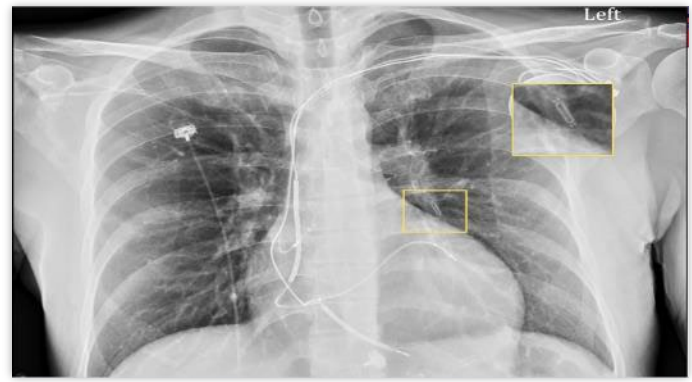
**Take Home Point:** Class 1 recommended medical devices for specifically selected HFrEF patients have very high economic value (low cost).



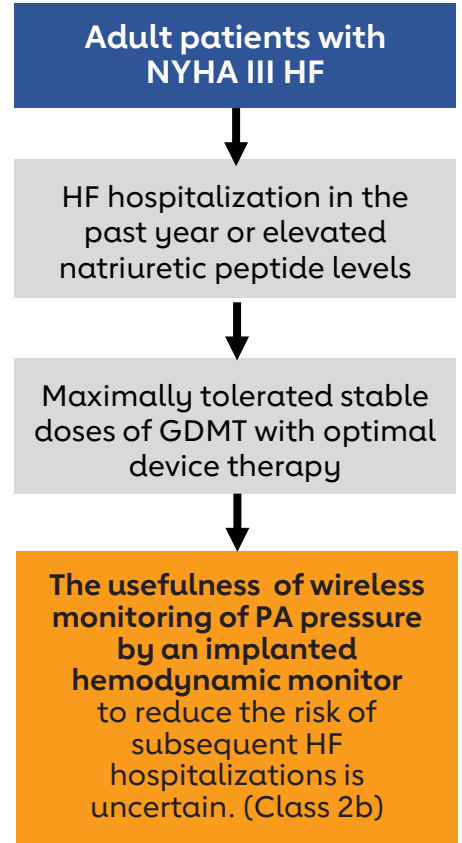


# Initial & Serial Evaluation

## Wearables & Remote Monitoring



Source: Pennmedicine.org



**In patients with NYHA class III HF with a HF hospitalization within the previous year, wireless monitoring of the PA pressure by an implanted hemodynamic monitor provides uncertain value.**

*Value Statement: Uncertain Value (B-NR)*

## Exercise & Functional Capacity Testing

COR	RECOMMENDATIONS
<b>1</b>	1. In patients with HF, assessment and documentation of NYHA functional classification are recommended to <b>determine eligibility for treatments</b>
<b>1</b>	2. In selected ambulatory patients with HF, CPET is recommended to <b>determine appropriateness of advanced treatments</b> (e.g., LVAD, heart transplant)
<b>2a</b>	3. In ambulatory patients with HF, performing a CPET or 6- minute walk test is reasonable to <b>assess functional capacity</b>
<b>2a</b>	4. In ambulatory patients with unexplained dyspnea, CPET is reasonable to <b>evaluate the cause of dyspnea</b>



Abbreviations: CPET indicates cardiopulmonary exercise testing; GDMT, guideline-directed medical therapy; HF, heart failure; LVAD, left ventricular assist device; NYHA, New York Heart Association; and PA, pulmonary artery.

Heidenreich, P. A. et al. (2022). 2022 AHA/ACC/HFSA Guideline for Heart Failure. *Circulation*.



# Goals of Care

COR	RECOMMENDATIONS
1	1. For all patients with HF, palliative and supportive care—including high quality communication, conveyance of prognosis, clarifying goals of care, shared decision-making, symptom management, and caregiver support—should be provided to improve QOL and relieve suffering.
1	2. For patients with HF being considered for, or treated with, life-extending therapies, the option for discontinuation should be anticipated and discussed through the continuum of care, including at the time of initiation, and reassessed with changing medical conditions and shifting goals of care.
2a	3. For patients with HF, execution of advance care directives can be useful to improve documentation of treatment preference, delivery of patient-centered care, and dying in preferred place.
2a	4. For patients with HF— particularly stage D HF patients being evaluated for advanced therapies, patients requiring inotropic support or temporary mechanical support, patients experiencing uncontrolled symptoms, major medical decisions, or multimorbidity, frailty, and cognitive impairment – specialist palliative care consultation can be useful to improve QOL and relieve suffering.
2a	5. In patients with advanced HF with expected survival <6 months, timely referral to hospice can be useful to improve QOL.

# Recommendations for HF and Pregnancy: Multi-disciplinary Care



In women with a history of HF or cardiomyopathy, including previous peripartum cardiomyopathy, patient-centered counseling regarding contraception and the risks of cardiovascular deterioration during pregnancy should be provided (1)

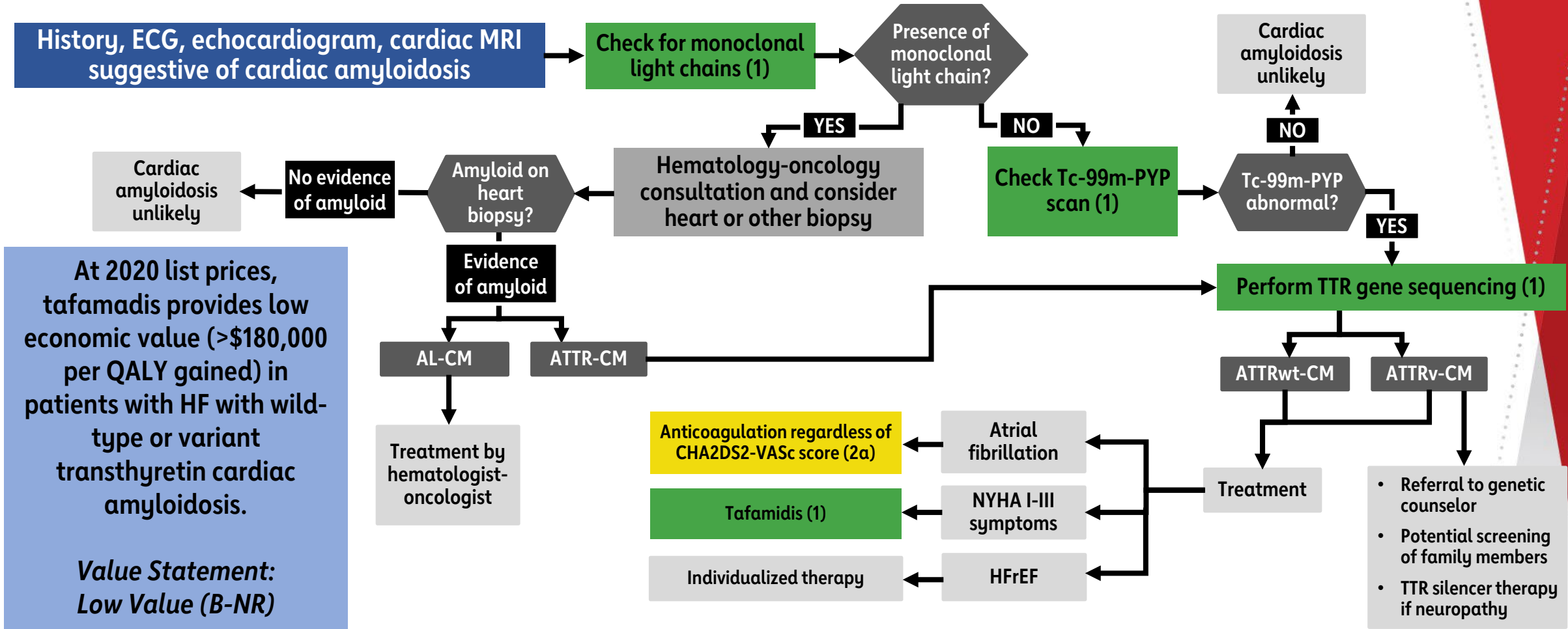
In women with acute HF caused by peripartum cardiomyopathy and LVEF <30%, anticoagulation may be reasonable at diagnosis, until 6 to 8 weeks postpartum, although the efficacy and safety are uncertain (2b)

In women with HF or cardiomyopathy who are pregnant or currently planning for pregnancy, ACEi, ARB, ARNi, MRA, SGLT2i, ivabradine, and vericiguat should *not* be administered because of significant risks of fetal harm (3 – Harm)





# Diagnosis and Treatment of Transthyretin Cardiac Amyloidosis



At 2020 list prices, tafamadis provides low economic value (>\$180,000 per QALY gained) in patients with HF with wild-type or variant transthyretin cardiac amyloidosis.

**Value Statement:  
Low Value (B-NR)**

**Abbreviations:** AF indicates atrial fibrillation; AL-CM, AL amyloid cardiomyopathy; ATTR-CM, transthyretin amyloid cardiomyopathy; ATTRV, variant transthyretin amyloidosis; ATTRwt, wild-type transthyretin amyloidosis; CHA<sub>2</sub>DS<sub>2</sub>-VASc, congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, stroke or transient ischemic attack (TIA), vascular disease, age 65 to 74 years, sex category; ECG, electrocardiogram; H/CL, heart to contralateral chest; HFrEF, heart failure with reduced ejection fraction; IFE, immunofixation electrophoresis; MRI, magnetic resonance imaging; NYHA, New York Heart Association; PYP, pyrophosphate: Tc. technetium: and TTR. Transthyretin.





Age 45  
Woman,  
Hypertension,  
Diabetes &  
High Cholesterol

# LAYLA



## **STAGE A:** At-Risk for Heart Failure

Patients at risk for HF but without current or previous symptoms/signs of HF and without structural/functional heart disease or abnormal biomarkers.

Patients with HTN, CVD, diabetes, obesity, exposure to cardiotoxic agents, genetic variant for cardiomyopathy, or family history of cardiomyopathy.



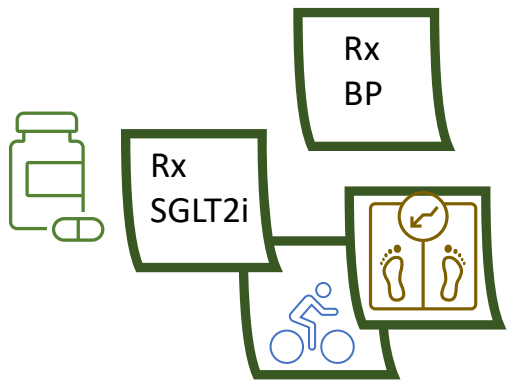


# Recommendations for Patients at Risk of HF: Stage A

## STAGE A: At-Risk for Heart Failure

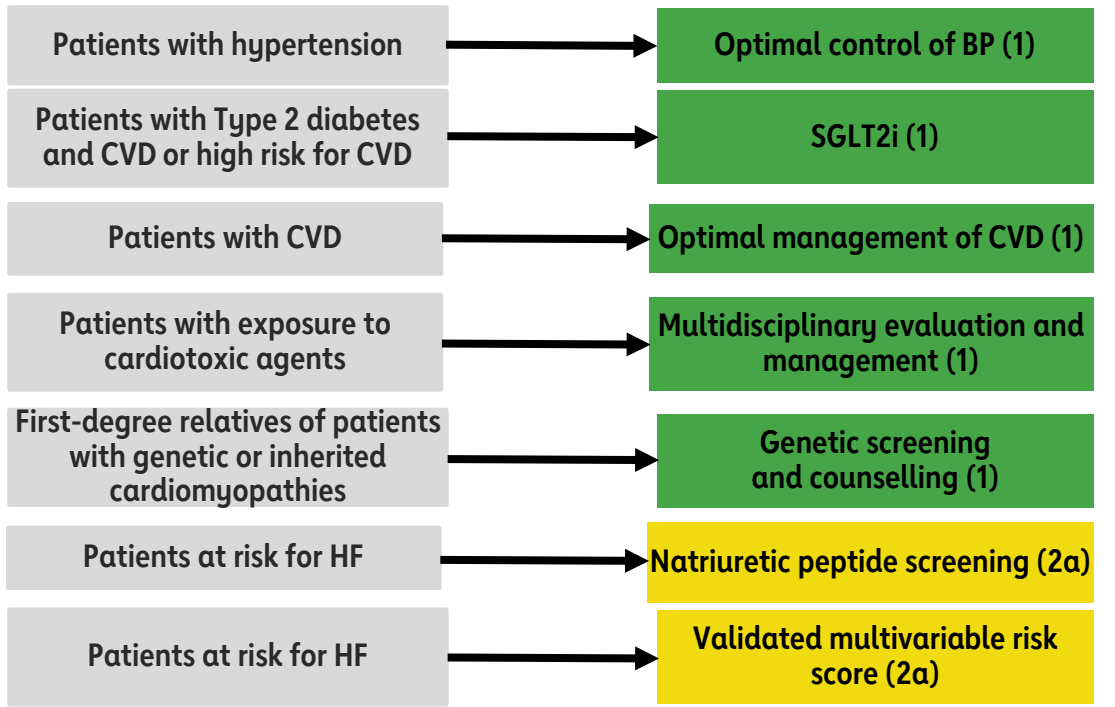
Patients at risk for HF but without current or previous symptoms/signs of HF and without structural/functional heart disease or abnormal biomarkers.

Patients with HTN, CVD, diabetes, obesity, exposure to cardiotoxic agents, genetic variant for cardiomyopathy, or family history of cardiomyopathy.



## At Risk for HF (Stage A)

### Primary Prevention



Continue Lifestyle modification and management strategies implemented in Stage A, through Stage B

Abbreviations: ACEi indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; BP, blood pressure; CVD, cardiovascular disease; HF, heart failure; ICD, implantable cardioverter-defibrillator; LVEF, left ventricular ejection fraction; MI, myocardial infarction; and SGLT2i, sodium glucose cotransporter 2 inhibitor.







Age 68  
Recent Heart  
Attack  
LV Ejection  
Fraction is 38%

# DONNA



## STAGE B: Pre-Heart Failure

Patients without current or previous symptoms/signs of HF but evidence of 1 of the following: structural heart disease, increased filling pressures, or risk factors and increased natriuretic peptide levels or cardiac troponin (in the absence of competing diagnosis)

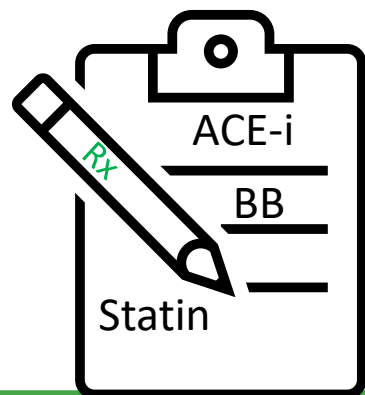


# Recommendations for Patients with Pre-HF : Stage B



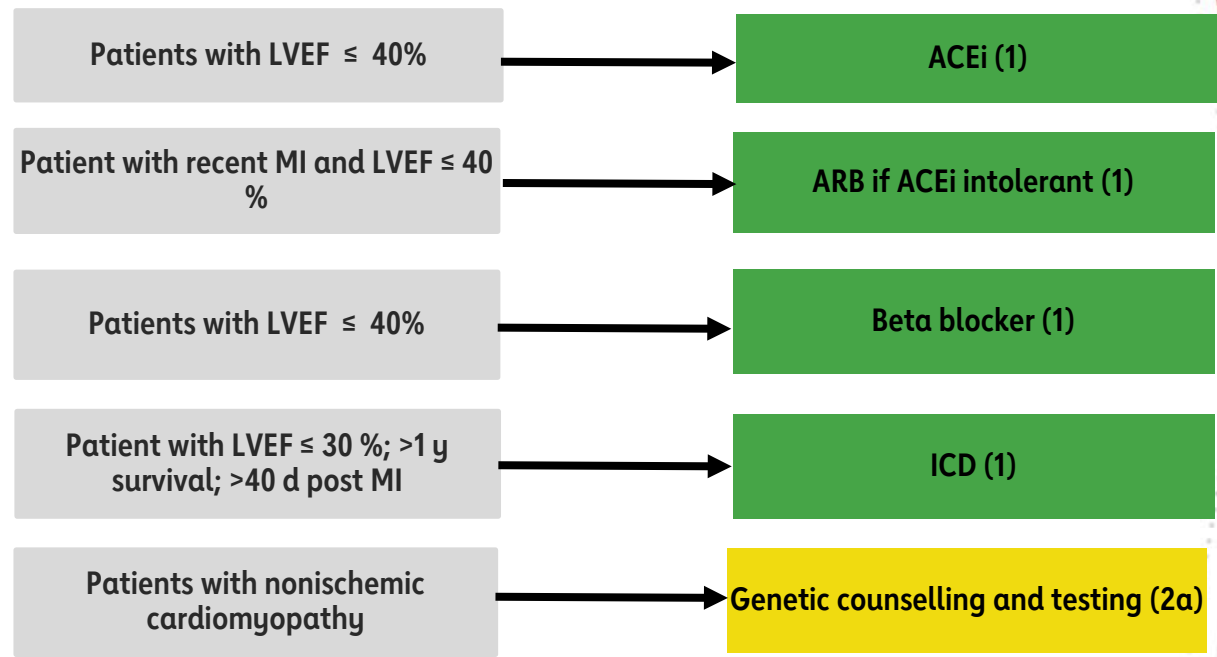
**STAGE B:**  
Pre-Heart Failure

Patients without current or previous symptoms/signs of HF but evidence of 1 of the following: structural heart disease, increased filling pressures, or risk factors and increased natriuretic peptide levels or cardiac troponin (in the absence of competing diagnosis)



## Pre-HF (Stage B)

### Preventing the Syndrome



**Continue Lifestyle modification and management strategies implemented in Stage A, through Stage B**

Abbreviations: ACEi indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; BP, blood pressure; CVD, cardiovascular disease; HF, heart failure; ICD, implantable cardioverter-defibrillator; LVEF, left ventricular ejection fraction; MI, myocardial infarction; and SGLT2i, sodium glucose cotransporter 2 inhibitor.





# Challenges & Barriers to GDMT (Stage A & B)

- Barriers to Screening for Risk Factors
- Barriers to Control, Despite Awareness, Treatment
- Disparities in Treatment Intensification to Target
- Barriers to Physical Activity, Walkability, and Food Access
- Barriers to Health Care & Medication Access & Affordability
- Social Barriers to Effective GDMT Initiation & Maintenance
- Medical Barriers to Effective GDMT Initiation & Maintenance

# Stages C & D: Overcoming Barriers to Guideline Directed Medical Therapy (GDMT)

Leanne L. Lefler, PhD, Adult Clinical  
Nurse Specialist, Advanced Practice  
Registered Nurse  
FAHA, FAAN



American  
Heart  
Association.

# Leanne L. Lefler, PhD, ACNS-BS, APRN, FAHA, FAAN



Professor, Loewenberg  
College of Nursing  
University of Memphis

Dr. Leanne Lefler is a Professor and the Associate Dean for Research in the Loewenberg College of Nursing at the University of Memphis and holds the Loewenberg Endowed Chair of Excellence. Dr. Lefler obtained her PhD in Nursing Science from the University of Arkansas for Medical Sciences' and postdoctoral training from the John A Hartford Foundation. Prior to that, she worked 17 years in clinical practice caring for adults with cardiovascular disease.

She is a board-certified Advanced Practice Nurse and Adult Clinical Nurse Specialist. She holds Fellowships in the American Academy of Nursing and the American Heart Association where she serves on the Heart Failure System of Care Advisory Group. Dr. Lefler is nationally recognized for her research work in cardiovascular disease health promotion and heart failure self-management using technological advances.





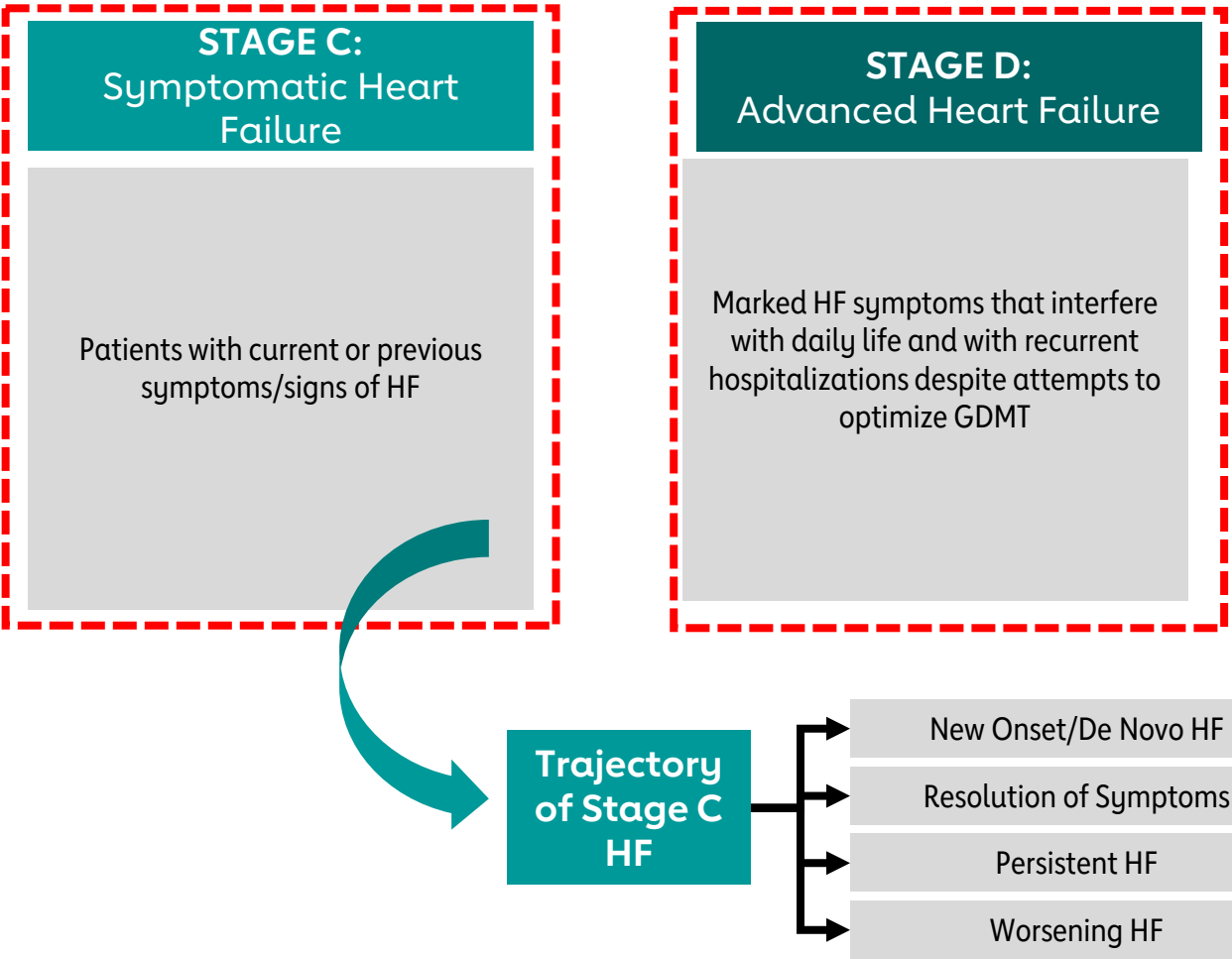
# Disclosures

- Dr. Leanne Lefler – No disclosures





# Revised Stages of Heart Failure



**Abbreviations:** CVD indicates cardiovascular disease; GDMT, guideline-directed medical therapy; HF, heart failure; HTN, hypertension; and NYHA, New York Heart Association.





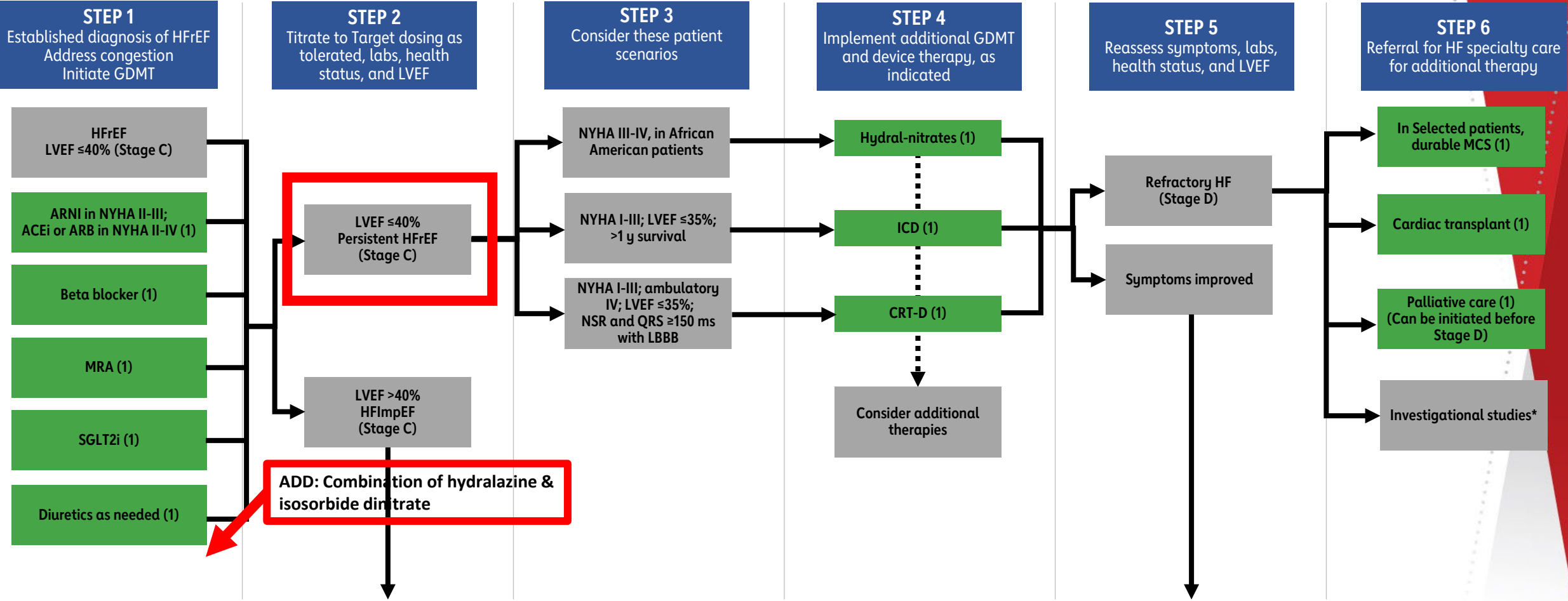
Age 63  
HF Diagnosis  
Confirmed  
EF 35  
Hospitalized w/  
Dyspnea

# ELIJAH





# Treatment of HFrEF Stages C and D



Continue GDMT with serial reassessment and optimize dosing, adherence and patient education, address goals of care





# Assessment of Patients Hospitalized With Decompensated HF



## Evaluation

COR	RECOMMENDATIONS
1	Address precipitating factors
1	Evaluate severity of congestion
1	Assess adequacy of perfusion



## Goals for GDMT

COR	RECOMMENDATIONS
1	Optimize volume status
1	Address reversible factors
1	Continue or initiate GDMT



## COMMON FACTORS PRECIPITATING HF HOSPITALIZATION

- Acute coronary syndrome
- Uncontrolled hypertension
- Atrial fibrillation and arrhythmias
- Additional cardiac disease
- Acute infections
- Non-adherence to medications or diet
- Anemia
- Hypo-/Hyperthyroidism
- Medications that increase sodium retention
- Medications with negative inotrope

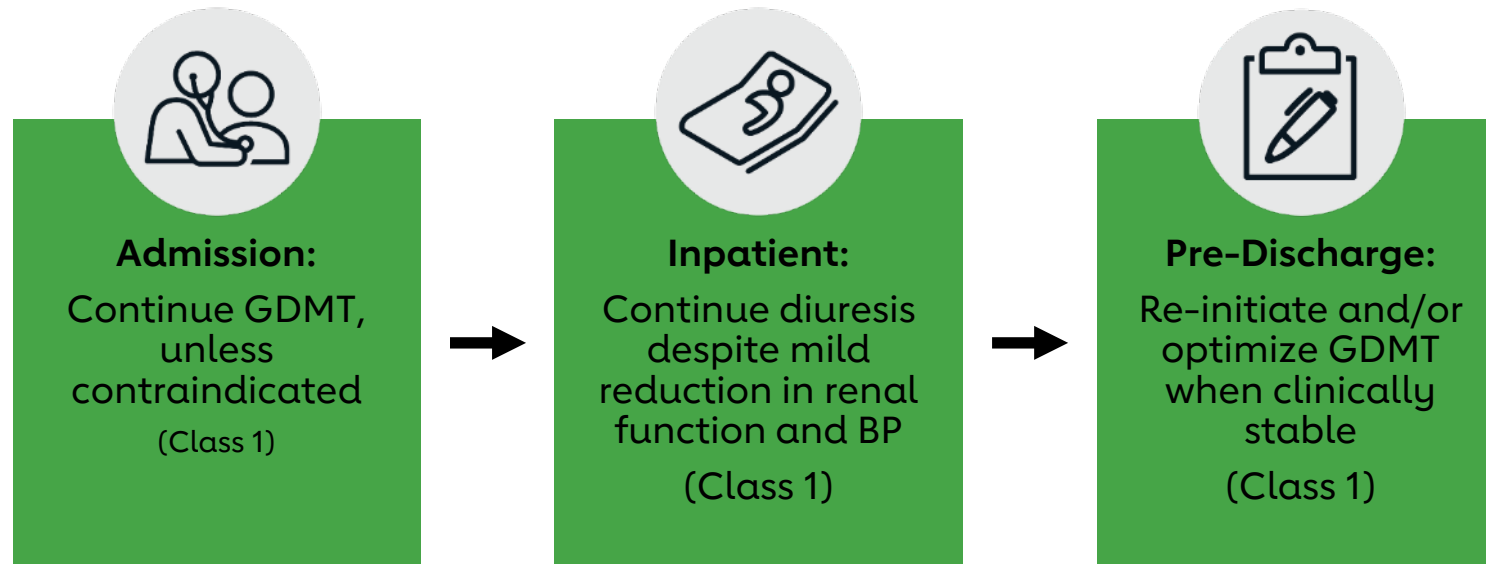
Abbreviation: GDMT indicates guideline-directed medical therapy.





# GDMT During Hospitalization

Oral GDMT should be continued and optimized on admission, as doing so is associated with lower post-discharge death and readmission.



## Special considerations

- Consider discontinuation of beta blockers in patients with low cardiac output, severe volume overload, advanced AV block or ACEi/ARNi with angioedema
- VTE prophylaxis is recommended in all hospitalized patients

Abbreviations: ACEi indicates angiotensin-converting enzyme inhibitor; ARNi, angiotensin receptor-neprilysin inhibitor; AV, atrioventricular; BP, blood pressure; GDMT, guideline-directed medical therapy; and VTE, venous thromboembolism.



# Recommendation for Specialty Referral to Advanced HF

COR	RECOMMENDATIONS
1	1. In patients with advanced HF, <i>when consistent with the patient's goals of care</i> , timely referral for HF specialty care is recommended to review HF management and assess suitability for advanced HF therapies (e.g., LVAD, cardiac transplantation, palliative care, and palliative inotropes).

## Consider if "I-Need-Help" to aid with recognition of patients with advanced HF:

- Complete assessment is not required before referral
- After patients develop end-organ dysfunction or cardiogenic shock, they may no longer qualify for advanced therapies



**I** Intravenous inotropes



**E** EF  $\leq$ 35%



**E** Edema despite escalating diuretics



**N** New York Heart Association class III/IV, or persistently elevated natriuretic peptides



**D** Defibrillator shocks



**L** Low systolic BP  $\leq$ 90mmHg



**E** End-organ dysfunction



**H** Hospitalizations  $>$ 1



**P** Prognostic medication; intolerance of GDMT

**Abbreviations:** BP indicates blood pressure; EF, ejection fraction; GDMT, guideline-directed medical therapy; and LVAD, left ventricular assist device.







# Challenges & Barriers to GDMT- (Stage C & D)

- Patients face different personal, disease-related, social determinate barriers to self-care, often precipitating hospitalization.

**MEDICAL BARRIERS:**  
 IMPAIRED COG.  
 DEPRESSION  
 SUBSTANCE USE  
 FRAILITY

**SOCIAL DETERMINATES BARRIERS**  
 FINANCIAL BURDEN  
 FOOD INSECURITY  
 HOME INSECURITY

**PERSONAL BARRIERS**  
 ENGLISH PROFECIENCY  
 HEALTH LITERACY  
 SOCIAL SUPPORT  
 TRANSPORTATION

**DOMESTIC BARRIERS**  
 ELDER ABUSE  
 PARTNER VIOLENCE

<b>Recommendations for Nonpharmacological Interventions: Self-Care Support in HF</b>		
Referenced studies that support the recommendations are summarized in the Online Data Supplements.		
<b>COR</b>	<b>LOE</b>	<b>RECOMMENDATIONS</b>
<b>1</b>	<b>A</b>	Patients with HF should receive care from multidisciplinary teams to facilitate the implementation of GDMT, address potential barriers to self-care, reduce the risk of subsequent rehospitalization for HF, and improve survival.



# Interventions to Overcome Self-Care Barriers

- Consider referral to case-management, social services, dietary counseling, palliative care to support tailored care
- Monitor for mental health needs, depression, cognitive impairment & refer
- Building therapeutic relationship with patient, increase engagement
- Including family/caregivers (if appropriate)
- Refer to education program, disease management program (HF, diabetes, etc), sensitive to culture
- Vouchers for transportation (improve access to care)
- Consider advocating to include SDH information in eHR
- Participation in GWTG reporting

# Transitions of Care: Overcoming Barriers to Guideline Directed Medical Therapy (GDMT)

Kyle G.Lavergne, DNP, APRN, FNP-bc  
Vice President Clinical Programs  
CenterWell Home Health



American  
Heart  
Association.



# Kyle G. Lavergne, DNP, APRN, FNP-BC



Vice President Clinical Programs  
CenterWell Home Health

Dr. Kyle G. Lavergne is Vice President of Clinical Programs at CenterWell Home Health. Originally from South Louisiana, he earned his bachelor's degree in nursing from The University of Louisiana at Lafayette. He earned his master's degree, with honors, as a family nurse practitioner after completing his studies at Northwestern State University. He then earned his Doctor of Nursing Practice from the University of Louisiana at Lafayette.

Dr. Lavergne is board certified as a Family Nurse Practitioner by the American Nurses Credentialing Center. He practiced as a nurse practitioner for six years in private family practice prior to working with a large group of cardiologists. He is a member of the American Academy of Nurse Practitioners, the Louisiana Association of Nurse Practitioners, where he is a board member and health policy co-chairman.





# Disclosures

- Kyle G. Lavergne, DNP, APRN, FNP-BC
  - No disclosures

Age 71

Recently  
hospitalized  
and being  
discharged

# MORRIS



Morris has a 5 year history of HF. Additionally has HTN, hypercholesterolemia, and afib. He resides by himself at home. He has had multiple hospital stays over the past 3 years for HF. He has had difficulty with his treatment regime in the past due to multiple medication changes.





# Transitions of Care



A transition of care plan should be communicated prior to discharge (1)

## This should include...

- 1 Early follow-up, ideally within 7 days (Class 2a)
- 2 Referrals to multidisciplinary HF management programs (Class 1)
- 3 Participation in benchmarking programs to improve GDMT and quality of care (Class 2a)
- 4 Addressing precipitating causes and high-risk factors (e.g. co-morbidities and SDOH)
- 5 Adjusting diuretics
- 6 Coordination of safety laboratory checks

Abbreviations: GDMT indicates goal-directed medical therapies; HF, heart failure; and SDOH, social determinates of health.





# Challenges

- Moving from one silo to another through continuum
- Post-acute care is often “fragmented and siloed” from the rest of the health care system.
  - ⇒ This can result in poor coordination of care, higher than normal readmission rates, and suboptimal patient outcomes
- HF treatment is very complex and requires an interdisciplinary team
- Legacy habit of cost shifting unintentionally takes precedence over outcome measurement in the healthcare industry
- Focusing on improving short term financial performance instead of outcome improvement perpetuates cycle of runaway cost for treating chronic diseases
- Financial success for health care professionals ≠ patient success

# MORRIS



- Transferred to home with homecare
- Proper HF evaluation/assessment done including:
  - Multi-disciplinary team evaluation
  - Medication reconciliation and discussion on importance, beliefs & concerns
  - Self-care compliance
  - SDOH
  - ADL/IADL evaluation
- Individualized HF care plan initiated
  - Ongoing assessments including remote patient monitoring and virtual visits
  - Care compliance plan
  - Ongoing communication with all clinicians



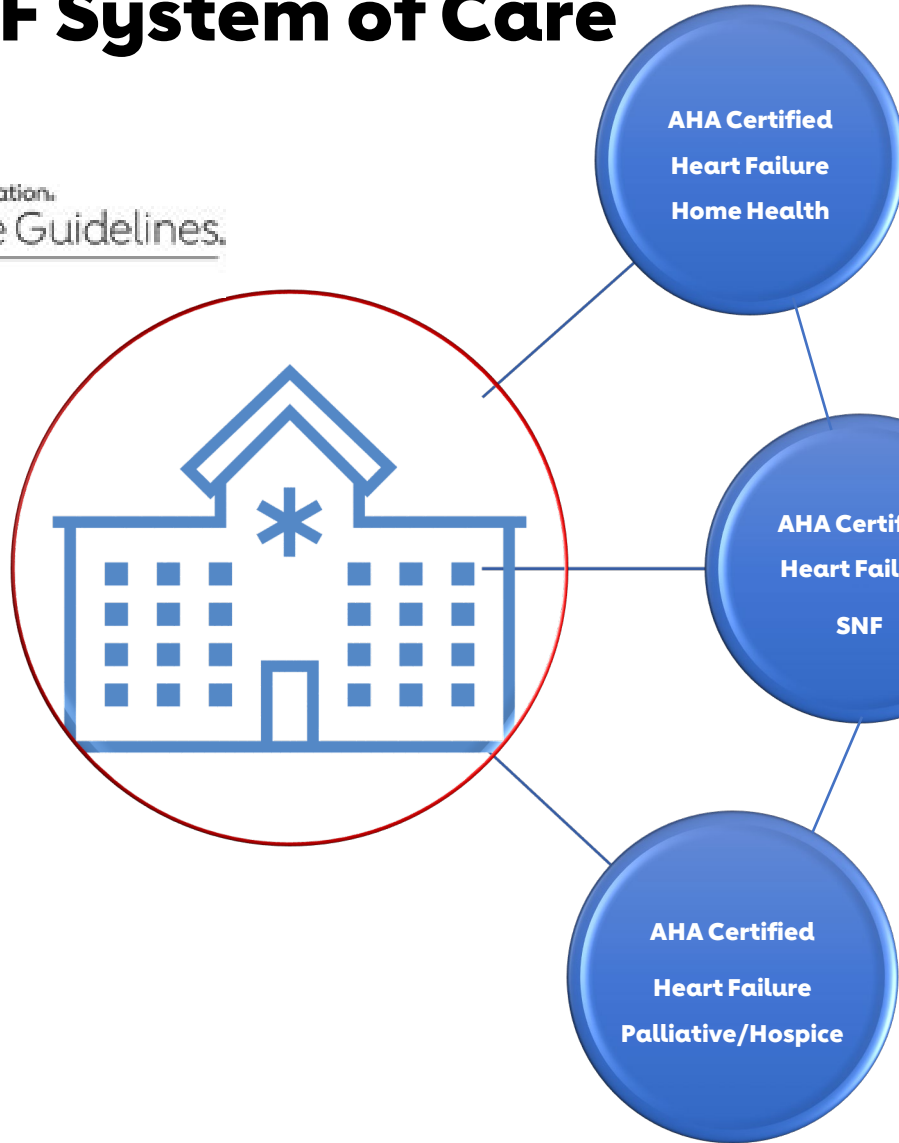
# Optimal Solution

- Develop a robust, standardized method of treating HF patients that includes:
  - Having a specialized HF program
  - Comprehensive HF education
    - Staff
    - Patient/Caregivers
  - Collaboration with clinicians and hospital systems to ensure flawless transitions of care.
  - Close, real-time monitoring of patient
  - Protocols in place to adjust to changes in profile
  - Strict following of evidence-based guidelines
  - Perpetual performance improvement and outcome measurement



# Optimal HF System of Care

 American Heart Association.  
Get With The Guidelines.  
Heart Failure  
Hospital



 American Heart Association.  
**Certified Care™**  
Home Health  
Heart Failure

 American Heart Association.  
**Certified Care™**  
Skilled Nursing Facility  
Heart Failure

 American Heart Association.  
**Certified Care™**  
Palliative/Hospice  
Heart Failure



# MORRIS

Morris gained a thorough understanding of importance of treatment regime with following:

- Prescribed medications
- Increased activity
- Daily weights
- Modified diet

His EF improved and functional status increased, increasing his overall quality of life. He required community resources to improve his dietary intake and ability to follow his medication regimen. He was discharged from home care after 60 days and has had regular follow-ups with his health care team. He continues to remain at home and has not had a hospital re-admission for the past 9 months.



# Resources

## Q & A



# Guideline: Supporting Materials

- [2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure:](#)
- [Get With The Guidelines® Heart Failure Infographic](#)
- [Top Things to Know: 2022 Guideline for the Management of Heart Failure](#)
- [NEW! CardioNerds Podcast Series: Decipher The HF Guidelines](#)
- [Executive Summary](#)
- [Guideline Slide Set \(PDF\)](#)
- [AHA Clinical Update Slide Set \(PPTX\)](#)
- Editorial: [The Updated Heart Failure Guidelines: Time for a Refresh](#)
- AHA News: [New heart failure guidelines expand focus on people at risk or showing early signs](#)
- News Release: [ACC, AHA, HFSA Issue Heart Failure Guideline](#)
- [Guideline Central: Heart Failure](#)
- [Guideline Central: Heart Failure Guidelines 2022 \(Flipbook\)](#)





**2023**  
**HOSPITAL RECOGNITION CRITERIA**  
*(based on 2022 data)*

**ACHIEVEMENT SCORE 85% OR GREATER ON ALL MEASURES**



ACEI/ARB or ARNI at Discharge for Patients with LVSD (AHAHF1)

Evidence-Based Beta Blocker Prescribed at Discharge (AHAHF2)

Left Ventricular Function Assessed (AHAHF3)

Post-Discharge Appointment Scheduled (AHAHF4)

**GOLD**  
2 consecutive  
calendar years

**SILVER**  
1 calendar  
year

**BRONZE**  
1 calendar quarter  
and ≥30 patients



**2023**  
**HOSPITAL RECOGNITION CRITERIA**  
(based on 2022 data)

**QUALITY MEASURES + AWARD**

≥75% on at least 4 measures

\*Must achieve Silver or Gold to be eligible

AHAHF5 - Aldosterone Antagonist Prescribed at Discharge for Patients with HFrEF (LVEF ≤35)

AHAHF6 - Angiotensin Receptor-Nephrilysin Inhibitor (ARNI) Prescribed at Discharge

AHAHF7 - Anticoagulation Prescribed at Discharge for Patients with AFib/AFlutter

AHAHF8 - Cardiac Resynchronization Therapy Defibrillator (CRT-D) or Pacemaker (CRT-P) Placed or Prescribed at Discharge

AHAHF9 - DVT Prophylaxis by End of Hospital Day 2

AHAHF10 - Follow-up Visit Within 7 Days of Discharge

AHAHF11 - Hydralazine/Nitrate at Discharge

AHAHF12 - ICD Counseling, or ICD Placed/ Prescribed at Discharge

AHAHF13 - Influenza Vaccine During Flu Season

AHAHF14 - Pneumococcal Vaccine Prior to Discharge  
HF91 - Lab Monitoring Follow-up

AHAHF91 - Lab Monitoring Follow-Up

AHAHF92 - Quadruple Medication Therapy at Discharge for Patients with HFrEF

AHAHF93 - SGLT2 Inhibitor at Discharge for Patients with HFrEF

AHAHF106 - Defect-Free Care for Quadruple Therapy Medication for Patients with HFrEF

AHAHF109 - DOAC at Discharge for Heart Failure with Non-Valvular Atrial Fibrillation or Atrial Flutter Patients

AHAHF110 - Mineralocorticoid Receptor Antagonist at Discharge for Patients with HFrEF (LVEF ≤40)

**TARGET: HEART FAILURE**

≥50% on ALL measures

AHAHF1 - ACEI/ARB or ARNI at Discharge for Patients with Left Ventricular Systolic Dysfunction

AHAHF2 - Evidence-Based Beta Blocker Prescribed at Discharge

AHAHF5 - Aldosterone Antagonist Prescribed at Discharge for Patients with HFrEF (LVEF ≤35)

AHAHF10 - Follow-up Visit Within 7 Days of Discharge

AHAHF15 - Referral to HF Disease Management, 60 Minutes Patient Education, HF Interactive Workbook, or Referral to Outpatient Cardiac Rehabilitation Program

December 2022 | [www.Heart.org/quality](http://www.Heart.org/quality)

[HFRecognition-2023-122022\\_updated\(heart.org\)](http://www.Heart.org/quality)



## AHA Guidelines On-The-Go Mobile App

Access guidelines on your mobile device anytime, anywhere! Download the association's mobile app today and enjoy the benefits of staying up-to-date no matter where you are. Actionable at the point of care, users will be able to retrieve relevant pieces of content while also having access to additional support detail and evidence.

**For Android** >

**For iOS** >

To download Guidelines on an Android [CLICK HERE](#)

To download Guidelines to an iOS [CLICK HERE](#)



# Downloadables and Interactive Resources

- [Discharge Packet \(PDF\) | Spanish \(PDF\)](#)
- [HF Helper: An app that helps you manage heart failure](#)
- [My HF Guide: Our free interactive workbook](#)
- [Symptom Tracker \(PDF\) | Spanish \(PDF\)](#)
- [HF and Your Ejection Fraction Explained \(PDF\) | Spanish \(PDF\)](#)
- [How Can I Improve My Low Ejection Fraction? \(PDF\)](#)
- [Medication Tracker \(PDF\)](#)
- [Discussion Guide \(PDF\) - Make the most out of your next appointment](#)
- [Partnering in Your Treatment: Questions to Ask Your Doctor \(PDF\)](#)
- Patient Information Sheets
  - [What is Heart Failure? \(PDF\) | Spanish \(PDF\)](#)
  - [How Can I Live with Heart Failure? \(PDF\) | Spanish \(PDF\)](#)
  - [What is Transthyretin Amyloid Cardiomyopathy \(ATTR-CM\)? \(PDF\)](#)
- [Support Network online community](#)



# Evidence Gaps and Future Research Directions

## Common issues that should be addressed in future clinical research

### Definitions

- Cardiomyopathies
- Myocardial injury
- Ejection fraction ranges



### Screening

- Cost effectiveness
- Predict higher risk patients based on comorbidities



### Diagnostics & monitoring

- Treatment based on etiology
- Using biomarkers to optimize therapy



### Nonmedical strategies

- Dietary intervention
- Efficacy and safety of cardiac rehab



### Medical therapies

- See complete list in Table 33 of guideline document



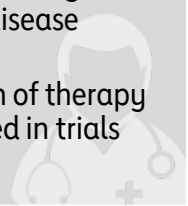
### Device Management and Advanced Therapies

- Timely selection for invasive therapies
- Interventional approach to tachyarrhythmias
- Safety and efficacy of nerve stimulation/ablation



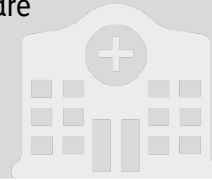
### Clinical outcomes

- Impact of therapy in patient-reported outcomes
- Addressing patient goals according to disease trajectory
- Generalization of therapy not represented in trials



### Systems of Care and SDOH

- Multidisciplinary care models
- Eliminating disparities
- Palliative care



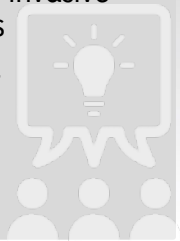
### Comorbidities

- Atrial fibrillation and Valvular heart disease
- Comorbidities and obesity
- Nutritional management
- Guideline therapy institution in patients with chronic kidney disease



### Future/Novel strategies

- Pharmacologic therapies
- Device therapy
- Invasive or non-invasive hemodynamics
- Telehealth and wearable technologies







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# Thank You



**LIVE  
FIERCE.**