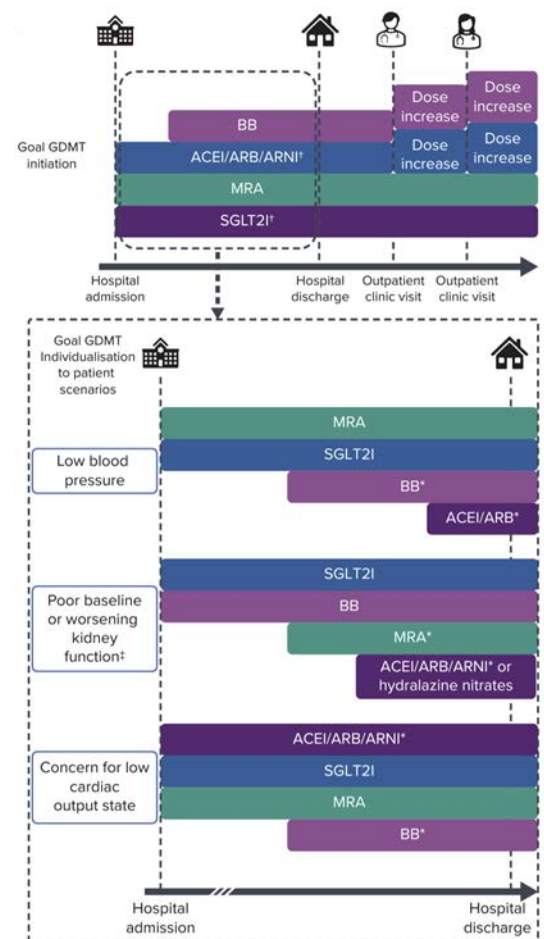


Context: The rate of HF is increasing, with no sign of decreasing; most admissions are readmissions

Current: Restore hemodynamics to normal; start lifesaving therapies to restore neurohormonal balance
Diurese to achieve euvolemia before discharge
Identify and treat precipitants to decompensation
Risk stratifying to help prevent readmission

Cutting Edge: Hospitalized patients are likely to have GDMT discontinued in those elderly, with renal dysfunction and renal failure, which impacts mortality¹
Most do not cause a significant drop in BP or renal function. GDMT can be individualized, apply while the patient is in the hospital, and observe in the hospital
Follow evidence-based guidelines to help start your patient on appropriate therapy²
Starting and maintaining GDMT is lifesaving within weeks and can help reduce heart failure hospitalizations³

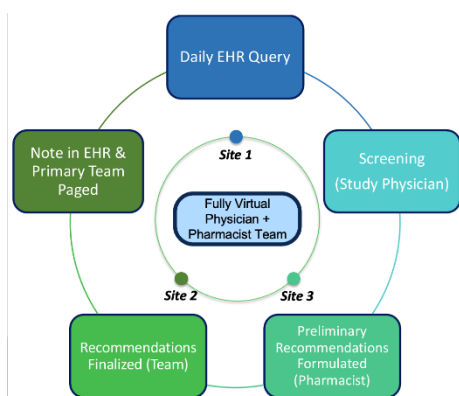


Initiation of GDMT in Heart failure

Context: What is the best practice for initiation of GDMT after acute heart failure?^{3,4}

Current: Start quadruple therapy at low doses as soon as possible, individual approach, can start 2 first, then add others within a week, ideally 4-6 weeks
Increasing Triple therapy (BB, MRA, ACEi/ARB/ARNi) up-titrated to full doses within 2 weeks of hospitalization showed benefit in both mortality and CHF course and progression
Safety profile is favorable, helps with renal outcomes

Cutting Edge: Benefits are seen within 30 days with a reduction in hospitalization, mortality and improved quality of life



Implementation Research in Heart Failure

Context: How do we put evidence-based practice and research into regular use by practitioners?

Current: Hospitalization is an opportunity for GDMT optimization: Targets high-risk patients in a well-resourced setting
Address reasons for poor outpatient GDMT optimization -time, reinforcement, education
Need hemodynamic and symptom monitoring
Can include patients hospitalized for and with HFrEF
Need to address clinical inertia and clinician concern

Cutting Edge: Potential for virtual nudging strategies to allow for large scale across integrated health systems to help with clinical inertia
Telehealth and outpatient visits in lower-risk patients can be used

References:

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- Cox Z et al. Card Fail Rev, 8:e21, 2022
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- Heidenreich P, Bozkurt B et al. 2022 AHA/ACC/HFSA Guideline
- Bhatt AS, et al. J Am Coll Cardiol. 2023