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In-hospital Initiation of Medical Therapy for HFrEF - Worth the Effort or Defer to Outpatient?

Dr. Greene:
Welcome to our program today. I'm Dr. Stephen Greene, a cardiologist and clinical researcher at Duke in the Duke Clinical Research Institute. And I am pleased to be joined today by two very close friends and colleagues who work also with me at Duke. We have Cody Carson, who's a clinical pharmacist at Duke University, and we also have Jaime McDermott, who's an advanced practice provider at Duke University, as well. Thank you, guys, so much for joining me today.

Dr. McDermott:
Thank you for having us.

Dr. Carson:
Thanks for having us.

Dr. Greene:
So we are gonna be discussing what I think is a critical topic in heart failure care. And that is the idea of in hospital initiation of guideline directive medical therapy for HFrEF. Arguably there is no more impactful implementation measure we can make for improving both the outcomes and quality of care for our patients with HFrEF than in hospital initiation. So I'm really happy to be talking about this today with two close colleagues and experts here. But let's jump right in. Cody, from the pharmacist perspective, I know you and I have discussed on rounds multiple times, the rationale for in hospital initiation, why it's so important. What are some of the things that you think about with why we need to really do our very best to send people home on the best medications possible?

Dr. Carson:
Thanks, Steve. Yeah, I think even looking in our historical heart failure trials like MERIT-HF, COMET, RALES, EMPHASIS, we do see early divergence of Kaplan Meier event curves. But what I think is really fascinating and really underlines the urgency of GDMT initiation is that even in the trials that evaluate our newer therapies this principle still applies. For instance in PARADIGM-HF with sacubitril/valsartan, as well as DAPA-HF and EMPEROR-Reduced looking at dapagliflozin and empagliflozin in a population that includes class three and even some class four heart failure patients on top of medications, we already know reduced mortality and readmissions. We still saw incredible incremental benefit early in therapy. Our event curve separate within days to weeks after starting these medications. And because the hospitalized heart failure population is an extremely high risk subset, the data shows us that we simply cannot afford to delay initiation of drugs that we know rapidly reduce the risk of death and readmission and even improve heart failure symptoms for our patients.

Dr. Greene:
Well, I don't think I can say it any better Cody. And I think you hit on a couple of key points. One is that of all the subsets of HFrEF the patients hospitalized are among the highest risk subset. Data suggests that one in four of these patients hospitalized for HFrEF are either passed away or back in the hospital after 30 days. So you have this high risk cohort there but then you juxtapose that with these

therapies that don't take months to years to show clinically meaningful benefit but they improve hard outcomes like risk of death, hospitalizations, just within a few days. 12 days, for example with the EMPEROR-Reduced trial of starting these therapies. So any delay, even to days to weeks, you are putting your patient at needlessly higher risk by not doing your very best to send them home on these therapies at time of discharge. So I couldn't agree more with those key points. Now, Jaime, from the advanced practice provider, I oftentimes think of you as the quarterback of our team on rounds, really trying to do our very best to send people home on the best possible therapy, advocate for all and leaving no stone unturned for doing our very best to get people home on the best possible therapy. What do you think of the in-hospital initiation from your perspective and how do you actually orchestrate this when you're actually on service?

Dr. McDermott:
Yeah, so we need to really use every point of contact we have with the patient to optimize their medical therapy for HFrEF. Ideally the inpatient setting is the best place to do this. It really provides healthcare team members with the opportunity to maximize the patient's access to the medication whether this means initiating an alternative to their current medication regimen such as transitioning to an ARNI or really prescribing these newer therapies that are available for HFrEF, such as SGLT2 inhibitors. From a medical perspective, patients who are hospitalized are receiving frequent monitoring with telemetry vital signs as well as laboratory evaluation. This is objective tangible data, and it really allows the healthcare team to prescribe medical therapies for HFrEF and monitor patient tolerance in a controlled setting. The strategy does have the potential also to assist with patient adherence to therapy. They're able to communicate directly and frequently with the healthcare team of any side effects they may be experiencing. And also they get assurance from the team that the medication is medically necessary for their disease process. Now, all too frequently prescribed medications are very costly for medications. So there are some medications that do require pre-authorization. The hospital does have access to resources to assist patients in obtaining their medications. Some of which may not be known by providers who practice outside the acute care setting. So within the acute care setting, we have personnel, mainly advanced practice providers, to ensure prescribed therapies are affordable for patients. And we really can assist in obtaining those prior authorizations for medications if needed. So really I would implore healthcare providers to use the acute care setting, use that opportunity to initiate medical therapy for HFrEF patients and hopefully improve their outcomes and quality of life.

Dr. Greene:
Can't agree more again. So many important points you just highlighted there. Just to summarize a couple that really stand out to me is the word opportunity. Yes, every time you have an interaction with a heart failure patient whether it's inpatient or outpatient, that is an opportunity look at their medication list and try to optimize care as best possible. But the key thing with the inpatient setting is that for some of these newer medications that might have more logistical things to potentially go through like prior authorizations and maybe affordability challenges you have more resources to try to combat those challenges in the inpatient setting. I think as compared to the outpatient setting and we know from outpatient studies there is such a strong culture, unfortunately, of clinical inertia in US clinical practice for outpatient HFrEF care where there are very few medication changes made over longitudinal outpatient follow up. But in contrast, there are data in real world US practice that say that when we do in-hospital initiation of those therapies, that actually doesn't just improve the medication use in the early post discharge setting. But you actually set the course for the medications those patients are gonna receive over the long haul, over that one year even post discharge. So you really have a chance to send the patient home on the right trajectory in terms of their medical therapy. And we cannot assume that you have an eligible patient in front of you and you say, well, I'm just gonna diarize and discharge the patient. It's not my job to "rock the boat" and start that new medicine. I'm just gonna let the outpatient doctor or clinician make those changes. Unfortunately, the data suggests that deferring initiation of in-hospital therapies results in either delay of that therapy being started substantially or it never gets started at all. So I think we really have to implore ourselves one, for the early clinical benefits that Cody highlighted, the early divergence of event curves in a very high risk patient population but two, to combat clinical inertia in the major gaps that we see in outpatient practice. We can help our outpatient colleagues substantially by doing in-hospital initiation and most importantly help our patients.

So with that, I really wanna thank Jaime and Cody for joining me today. This was a really impactful conversation and I hope you'll take these pearls and tools with you to your own practice and focus on in-hospital initiation of GDMT for HFrEF.