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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Pathways to Reducing Risk of Hospitalization for Patients with HFpEF

Announcer:
You're listening to *Heart Matters* on ReachMD, and this episode is sponsored by Novartis. Here's your host, Dr. Charles Turck.

Dr. Turck:
According to recent data, more than 50% of patients who have heart failure with preserved ejection fraction, or HFpEF for short, are hospitalized. Given that troubling statistic, how can we as clinicians work together to reduce the risk of hospitalization among these patients?

Welcome to *Heart Matters* on ReachMD. I'm Dr. Charles Turck. And here to help answer that key question are doctors Jonathan Rich and Paul Doghramji. Dr. Rich is an Associate Professor of Medicine at Northwestern University Feinberg School of Medicine. He also serves as the Medical Director of the Mechanical Circulatory Support Program and as the Program Director of the Advanced Heart Failure and Transplant Fellowship Program at Northwestern Memorial Hospital in Chicago. Dr. Rich, welcome to the program.

Dr. Rich:
Thanks so much. Pleasure to be here.

Dr. Turck:
And Dr. Doghramji is not only a senior family practice physician at Collegeville Family Practice and the Medical Director of Health Services at Ursinus College in Pennsylvania, but he's also one of ReachMD's very own hosts. Dr. Doghramji, it's great to have you with us.

Dr. Doghramji:
Thank you. Great to be here.

Dr. Turck:
To start us off, Dr. Rich, can you tell us what factors you consider when selecting a therapy for your patients with HFpEF?

Dr. Rich:
The most common type of HFpEF patient is the elderly, male or female, often a female, who has many comorbidities: hypertension, diabetes, sleep apnea, perhaps obesity. And so my approach is sort of two pronged. Number one is real aggressive treatment of those comorbidities; controlling blood pressure, controlling diabetes, and glycemic control if it's present. If there's atrial fibrillation, ensuring that anticoagulation isn't onboard, determining a rhythm versus rate control strategy, perhaps the patient has sleep apnea. And we can go on and on. This is a very typical patient profile.

Then I focus though on the heart failure syndrome itself. Is this patient presenting with symptoms? And if so, oftentimes, those symptoms are dyspnea and volume overload. And so decongesting the patient is one of the first steps we'll take to allow the patient to start to feel better, breathe better, loop diuretics, for example, pretty commonplace. I mentioned controlling blood pressure will help that as well.

But then the last thing I'll mention and then I'll pause is that there are some therapies that have emerged that many of us are leveraging more these days because the evidence behind them is a lot stronger than some of the older generation therapies, which frankly, have been largely disappointing.

Dr. Turck:
Turning to you now, Dr. Doghramji, once a patient begins therapy, what additional strategies do you recommend to help them reduce

their risk of hospitalization?

Dr. Doghramji:
Well, there are several things that are very important to keep in mind when patients have HFpEF or preserved ejection fraction heart failure. These patients need to be seen very frequently because typically, they have a lot of comorbidities, and they need to all be managed well. In primary care, this is one of the things that we do very often is to manage patients with a lot of comorbidities. These, of course, include things like hypertension, diabetes, obesity, atrial fibrillation, and obstructive sleep apnea, just to name a few. And these can be quite a challenge to juggle. But it's very important that we help patients manage them as best as possible.

To do so, it takes my medical assistant, it takes my nurse practitioners, and physician assistants that are helping me out; it takes my front staff, everybody has to be involved. But on the patient's side, there's also their family members that have to be involved as well in helping the patient do the things that they need to do.

And those things are to adhere the right lifestyle changes that may be salt restriction; it may be exercise; it may be weight control. These are important. And also, of course, to be sure that they're taking their medications properly, that there is no issues with the pharmacy level. And also there's no issues with side effects or any drug interactions.

These are all done at the primary care level. And it takes time to do that. So typically, a patient that's coming into the office will need the time to ensure that all these are taken care of so that they don't end up back in the hospital.

Dr. Turck:
For those just tuning in, you're listening to *Heart Matters* on ReachMD. I'm Dr. Charles Turck. And I'm speaking with Drs. Jonathan Rich and Paul Doghramji about how we can reduce the risk of hospitalization for patients with heart failure with preserved ejection fraction, or HFpEF for short.

Switching gears here a bit, I'd like to focus on how cardiologists and primary care physicians can better coordinate care for these patients. Dr. Doghramji, how do you approach communicating with cardiologists about your patients' heart health?

Dr. Doghramji:
Well, we in primary care have our favorite cardiologists that we refer to and we know the practices of those cardiologists that could be a little bit different. We need to know those clinicians and know how to interact with them. And typically, we will then divvy the responsibilities between the two, which oftentimes have a lot of overlap, whether it's medication refills, whether it's seeing the patient to make sure that their HFpEF is maintained well, whether their comorbidities are controlled well. So these overlaps do occur.

But obviously getting correspondences from our cardiology colleagues is super important so that we know what they're thinking, what their test results are like, what their medication changes are. So these are important.

So there's overlap that we have with what we do with our cardiologists. That's one thing which happens. And the second thing is communication with our cardiology colleagues and making sure that that's done in a timely fashion. And it's done also very appropriately.

Dr. Turck:
And how about you, Dr. Rich? What are some best practices you follow when coordinating care for patients with HFpEF?

Dr. Rich:
Well, as Dr. Doghramji pointed out, communication is critical. Both the primary care physicians and the cardiologists are seeing these patients frequently. I also use in my practice a number of advanced practice nurses and physician assistants. And it's just really important that, given the fact that there is going to be the proverbial many cooks in the kitchen, we're all in touch on a regular basis. And sometimes a basic note being sent to your colleague is sufficient. But other times you have to pick up the phone. Some are more casual and willing to exchange text messages. I think all those approaches are reasonable on a case-by-case basis. Communication is just key. The patient really depends on it, expects it. And it's really going to be the best way that we care for our patients, to ensure that we're all on the same page, helping one another help our patients. So communication is of utmost importance. I can't emphasize and stress that enough.

Dr. Turck:
Now, we're almost out of time for today. So before we close, I'd like to open up the floor to each of you. Starting with you, Dr. Doghramji, do you have any final thoughts on how we can better care for our patients with HFpEF?

Dr. Doghramji:
Well, the first thing is to know about it and know what the disease is, and what the symptoms are, and how to control those symptoms.

These are all very important methods and necessities for a primary care in order for patients to manage their condition well and to not end up in the hospital. And that necessitates seeing the patient pretty frequently. It's very common for patients with HFpEF to be seen by their clinicians every three to four months or so, making sure that their medications are taken care of, making sure they're adhering to the right lifestyle changes, and also making sure that their family members are helping them in whatever matters that they may have that's important for them. And of course, just like Dr. Rich said, communicating with our cardiology colleagues and making sure we're all on the same page. These are all so very important in helping our patients have the best outcome for HFpEF.

Dr. Turck:
Thank you, Dr. Doghramji. And Dr. Rich, I'll give you the final word.

Dr. Rich:
Securing the right diagnosis is key. And the one pearl I want to throw out there I think is important is a lot of our patients with HFpEF are overweight or even obese. It's very easy to dismiss their symptoms as saying they are deconditioned; they need to lose weight. And while all that is likely true, we all know how hard it is to lose weight. And a lot of times they're short of breath, and you might check a BNP, and the BNP will come back normal. And folks will then say, 'Well, I guess it's not your heart failure.' And just keep in mind that obesity is actually a BNP deficient syndrome. So many, if not most of these patients, will actually have heart failure when they are presenting with classic signs and symptoms; it can often get dismissed. So I would just encourage all of us to not do so.

Then you know what the final thing I would say is at the end of the day, oftentimes these patients suffer. And while we don't have a magic bullet to treat HFpeF, we discussed all the different angles. The one that probably matters most to our patients is to treat them with compassion. I think that is the right thing to do. I think that helps motivate patients when they know that you really do care. And you really acknowledge and validate that their suffering. I think they're more inclined to work hard and adhere to sort of the management plan that the cardiologists and primary care physicians are ideally putting together in collaboration.

So many patients with heart failure preserved EF, as the patient population is growing in age which is of course a good thing, we want to prolong survival. We also want patients to not just live longer, but we want them to feel better. And so I think maybe that would be where I would end it.

Dr. Turck:
Well, with those final thoughts in mind, I want to thank my guests, Dr. Jonathan Rich and Paul Doghramji, sharing their insights on reducing the risk of hospitalization for patients who have heart failure with preserved ejection fraction. Dr. Rich, Dr. Doghramji, it was great having you both on the program.

Dr. Rich:
Thank you very much.

Dr. Doghramji:
Thank you.

Announcer:
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