Starting HF Meds in Hospital Boosts Adherence

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Orlando, Fla. — Starting heart failure patients on a β-blocker and an ACE inhibitor before hospital discharge increases the likelihood of adherence at follow-up 60-90 days later, Gregg C. Fonarow, M.D., reported at the annual meeting of the American College of Cardiology.

This tells us "that hospitalization can serve as a teachable moment for patients and clinicians regarding heart failure medications, that patients can be effectively initiated on these evidence-based therapies, and if they're started in the hospital they're much more likely to be on treatment during long-term follow-up," he said.

"We need to provide for all patients hospitalized with heart failure a systematic approach to ensure that the evidence-based therapies are started prior to discharge," said Dr. Fonarow, professor of cardiovascular medicine at the University of California, Los Angeles, and director of the Ahmanson-UCLA Cardiomyopathy Center.

He presented data on 4,434 patients with systolic heart failure (HF) treated at 86 hospitals participating in the Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients with Heart Failure (OPTIMIZE–HF) registry, a national quality-improvement project.

None of the patients in this subset of the larger OPTIMIZE–HF database had contraindications to β-blockers or ACE inhibitors/angiotensin receptor blockers (ARBs). Of the 86% discharged on a β-blocker, 95% remained on β-blocker therapy at follow-up 60-90 days post discharge, compared with 32% of patients who were not yet on a β-blocker at discharge.

"That means two-thirds of these eligible patients [discharged without β-blocker] remained untreated with what is our single most important life-saving therapy in heart failure: β-blocker treatment," said Dr. Fonarow, director of OPTIMIZE–HF.

The same was true for ACE inhibitors/ARBs: 84% of eligible patients were on one of these drugs at discharge, and 74% of this group remained on the medication at 60-90 days. Only 19% of patients not discharged on one of these drugs were taking one at follow-up.

"Many clinicians have kind of had the view, 'Well, we don't need to worry about starting treatment in the hospital, we'll get around to it on an outpatient basis.' There hasn't necessarily been a consensus that each of these therapies needs to be started prior to hospital discharge," Dr. Fonarow said.

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But that's changing fast, in large part because of the evidence gathered in OPTIMIZE–HF. At the ACC meeting, the American Heart Association launched a new nationwide, hospital-based, quality-improvement project called Get With The Guidelines–Heart Failure (GWTG–HF).

The program, aimed at accelerating adherence to ACC/AHA treatment guidelines, uses techniques similar to those in the OPTIMIZE–HF registry, including decision-support tools, customized patient education materials, real-time performance benchmarking, and collaborative workshops. Dr. Fonarow is chairman of the GWTG Science Subcommittee. "We hope that hospitals across the country will sign up and participate." Get With The Guidelines–Coronary Artery Disease has been in place for 2 years and "has shown remarkable improvements in care and is currently in more than 300 U.S. hospitals."

With 5 million Americans currently diagnosed with HF, and the ranks expected to swell further as baby boomers age, this type of systems approach is badly needed, according to John S. Rumsfeld, M.D., who chaired a session on quality-improvement programs at the ACC meeting.

"We can have all sorts of late-breaking clinical trials telling us about better care, but if we don't apply them, we won't actually be improving our population outcomes," noted Dr. Rumsfeld of the University of Colorado, Denver.

Dr. Fonarow is a consultant to and member of the speakers' bureau for GlaxoSmithKline Inc., which funds both GWTG–HF and OPTIMIZE–HF. ■