

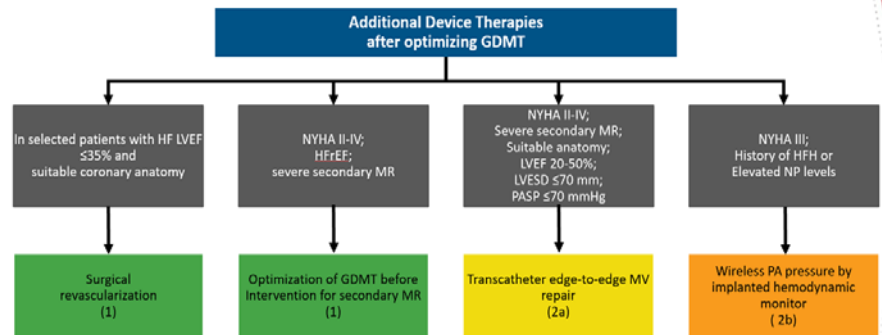
Advance Heart Failure for the Hospitalist Practice Gap

Context: There is emphasis on education of GDMT initiation, but what about the patients frequently readmitted with CHF at the end of life?^{1,2}

Current^{1,2}: Referral to a HF specialist should be considered in patients needing inotropes, NYHA class IIIB/IV symptoms, end-organ dysfunction, EF $\leq 35\%$, ICD shocks, readmissions, CHF, despite escalating diuretics, Low BP/high HR

Need to reduce GDMT

Additional Device Therapies after GDMT Optimization



Cutting Edge: Medications when you have optimized GDMT:² Ivabradine, Digoxin, Vieroiguat, PUFA, Potassium Binders

Pall Care Involvement (PAL-HF Study): stable care trajectories and reduced healthcare burdens & rehospitalization, manage CHF sx

Right heart catheterizations for persistent symptoms, AKI with diuresis, frequent hospitalization

An implantable sensor to guide filling pressure assessment (e.g., CardioMEMS) in ambulatory HF patients may be considered.

Consider patient monitoring devices (e.g., Scales) or smartphones or electronic health records can support such team-based care, Medication adherence with pharmacist co-management, cognitive behavioral therapies,

LVAD Referral

Context: Despite improving hemodynamic compromise, positive inotropic agents have not shown improved survival

Current: Median survival of adult transplant recipients is >12 years; (vs <2 y with stage D and no advanced therapy)

Cutting Edge: Consider LVAD referral as a bridge to transplant as a bridge or destination.³

Refer early! Delayed referral or lack of referral in patients who are likely to derive benefit from an advanced HF evaluation can have substantial adverse consequences for patients and their families.³



INDICATIONS	CONTRAINDICATIONS
<ul style="list-style-type: none"> Frequent hospitalizations for HF NYHA class IIIB to IV symptoms despite maximal GDMT Intolerance of GDMT Increasing diuretic requirement Symptomatic despite CRT Inotrope dependence Low peak VO_2 ($<14\text{-}16 \text{ ml/kg/m}^2$) End-organ dysfunction attributable to low cardiac output 	<p>Absolute</p> <ul style="list-style-type: none"> Irreversible hepatic, renal or neurological disease Severe psychosocial limitations Medical non-adherence <p>Relative</p> <ul style="list-style-type: none"> Age >80 years for destination therapy Untreated malignancy Obesity or malnutrition Severe PVD Musculoskeletal disease that impairs rehabilitation Active substance abuse Active systemic infection or prolonged intubation Impaired cognitive function Unmanaged psychiatric disorder Lack of social support

References: Maddox TM et al. J Am Coll Cardiol 2021;Jan 11 2. Heidenerich P Et al. Circulation 2022 May 3;145(18):e895-e1032. 3. Morris AA Circulation 2021 Oct 12;144(15):e238-e250