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Education

Q&A Summary
Heart Failure: Current Treatments and Readmission Avoidance

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Should a member be in the HF program with cardiomyopathy but no HF diagnosis?

If a member has multiple risk factors (CAD, afib, HBP, DM, etc.) and has had an episode of HF now or in the past, then they have HF. Then that member gets put through Evisor rules, which is another whole discussion. The bottom line is that currently 90 percent of members referred to the HF program (at least in M&R) have HF per the 2013 guidelines.

A member with HF is not feeling "so well." If you are unable to conference in their primary care provider (PCP), should you instruct the member to take his or her medication and call back in an hour, or should you tell him or her to go to ER or schedule to contact his or her PCP tomorrow?

There is no reason to delay care. Instruct the member to go to urgent care.

What are the thoughts about long-term use of Feldene® (Piroxicam)?

Feldene is an NSAID and should be avoided by heart failure with reduced ejection fraction (HFrEF) members.

The American Heart Association (AHA) has blood pressure (BP) guidelines slightly different from the American Diabetes Association (ADA) guidelines. The ADA bases BP and A1C goals on patient comorbidities. The AHA does not seem to have this BP goal guideline. Are BP guidelines the same for all patient demographics?

The 2017 updates were not included within the presentation; the HF B/P goal is 130/80.

What is the difference between Lopressor® (metoprolol tartate) and Toprol ER® (metoprolol succinate extended release), and which one is the best choice for HF members?

Lopressor is usually dosed twice daily. It can be effective for hypertension when dosed once daily, but low doses (e.g., 100 mg) given once daily may not control blood pressure for a full 24 hours. Toprol ER is dosed once daily. Toprol ER produces more level metoprolol concentrations than the immediate-release tablets (i.e., lower peaks and less peak-to-trough variation). The daily Toprol ER dose can be split and given twice daily, especially if patients are having dizziness or orthostatic hypotension with once-daily dosing, but it should be clarified. Toprol ER is recommended for HF members.

A member is experiencing breast pain with Aldactone® (spironolactone). Is there an alternative recommendation?

Inspra® (eplerenone) is an alternative recommendation. The rate of incidence of mastalgia with Insprais 0.3–1.3 percent, but it is unknown if it is lower than with Aldactone·

Is a member with a one-time diagnosis of HF at higher risk for chronic HF?

Yes.

Is the risk of HFrEF the same with topical NSAIDS as it is with oral?

The risk of HFrEF is much lower with topical NSAIDS compared to oral.

Do current studies demonstrate treating comorbidity of major depression improves HF outcomes?

No. However, there are ongoing studies to further evaluate.

Should a provider switch an HFrEF member from angiotensin-converting enzyme inhibitor/angiotensin II receptor blockers (ACE/ARB) and initiate Entresto® (sacubitril/valsartan) if the member is asymptomatic?

No. If the member is asymptomatic, that means the member is Class one according to the New York Heart Association, and therefore Entresto is not indicated per Federal Drug Administration (FDA) and American College of Cardiology (ACC) 2016 guidelines.

Do beta blockers contribute to and/or worsen depression?

A systematical view of trials has found no increased risk of depression. The benefit of beta blocker use for members with HFrEF reduces morbidity, and mortality clearly outweighs possible increased risk of depression.

A provider has a member with Stage D NYHA Class 4 HF. The ACC states that Entresto® (sacubitril/valsartan) is approved only for HFrEF with NYHA Classes 2 and 3 because they feel there was an inadequate number of NYHA 4 patients involved in the clinical trial leading to FDA approval. Would it be reasonable to provide Entresto to the member in this situation?

Yes, the FDA-approved Entresto use for persons with HFrEF, NYHA Classes 2, 3 , and 4.