Prescribing and Deprescribing for Heart Failure

By Christine Kilgore

Optimizing heart failure therapies, including the newer angiotensin-receptor neprilysin inhibitors (ARNIs), is critically important for older residents who have symptomatic heart failure with reduced ejection fraction (HFrEF), said Meenakshi Patel, MD, FACP, CMD, at the Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

"We need to make sure residents are on the appropriate medications, and right now that includes angiotensin-converting enzyme inhibitors [ACEIs], angiotensin II receptor blockers [ARBs], or ARNIs, along with beta blockers and aldosterone receptor antagonists," said Dr. Patel, a practicing geriatrician at Valley Medical Primary Care in Centerville, OH, and assistant professor of geriatrics at Wright State University Boonshoft School of Medicine in Dayton. She emphasized, "We don't need to walk away from ARNIs when patients have kidney disease."

ANRIs target both the renin-angiotensin-aldosterone system and the natriuretic peptide system, and should not be used with an ACEI. The American College of Cardiology/American Heart Association/Heart Failure Society of America guideline update published in 2016 recommends switching appropriate patients who are stable on ACEIs/ARBs to ARNI therapy (*Circulation* 2016;134:e282–e293).

Sacubitril/valsartan, the first-in-class ARNI, was approved by the Food and Drug Administration in 2015 for the treatment of chronic HFrEF (NYHA class II–IV) after the PARADIGM-HF (Prospective Comparison of ARNI with ACEI to Determine Impact on Global Mortality and Morbidity in Heart Failure) trial showed that patients taking the combination drug had a 20% greater reduction in cardiovascular mortality — from both sudden cardiac death and worsening heart failure — compared with patients taking the ACEI enalapril (Eur Heart J 2015;36:1990–1970). The benefits of the new agent were seen across all age groups, with a favorable benefit–risk profile in all age groups (*Eur Heart J* 2015;36:2576–2584).

With over 8,000 patients aged 18 to 96, the PARADIGM trial was the largest mortality-morbidity trial ever conducted in patients with HFrEF, Dr. Patel noted. In addition to the mortality reductions, the trial showed "reductions in hospitalizations by about 44%, which is huge for us," she said. "And [sacubitril/valsartan] did not have a negative impact on renal function compared to enalapril."

"I'd venture to say that the drugs that cause the most adverse effects [in our residents] are the diuretics," said Dr. Patel. "So if we can start and/or maintain therapy with [our current menu of medications] and try to reduce the diuretic dosing, we will have done our patients a great favor."

Asked after her presentation what should be deprescribed in a patient whose ejection fraction and heart failure improve, Dr. Patel advised considering maintaining beta-blocker therapy and either the ACEI, ARB, or ARNI, and deprescribing the aldosterone receptor antagonist and the diuretic.

Another new heart failure medication, ivabradine, reduces the heart rate and may be beneficial in reducing heart failure hospitalizations, cardiovascular death, and death from heart failure when it is added to beta-blockade. Like the ARNIs, it is addressed in the 2016 ACC/AHA/HFSA guidelines.

"I haven't used this agent much in my facility, but it's an option that we have and something we should start looking at [for some patients]," Dr. Patel said. "The higher the heart rate, the higher the risk of cardiovascular mortality and heart failure hospitalizations."

In other key messages, Dr. Patel emphasized the importance of strict attention to weight and congestion. "Congestion or volume overload precedes hospitalization often by days," she said, giving facilities valuable opportunities to prevent hospitalizations with daily weights, preferably using the same scale and taken at the same time (first thing in the morning before breakfast and with an empty bladder, if possible).

Regarding the diagnosis of heart failure, "the echocardiogram is the single most important test we can do for heart failure," Dr. Patel emphasized. "It is vitally important [for determining ejection fraction] and knowing what type of heart failure [HF with reduced EF versus preserved EF] we're dealing with. And it's often missed."

Heart failure with preserved ejection fraction is also common in the senior population, particularly in women, and is treated primarily with fluid management and diuretics. "Stay tuned — there are a couple of trials with newer agents that are looking at heart failure with preserved ejection fraction," Dr. Patel said. "For the moment, however, [symptom control] is all we have."

In another presentation, Luke D. Kim, MD, CMD, assistant professor of medicine at the Cleveland Clinic Lerner College of Medicine, said that optimizing clinical care in hospital-discharged skilled nursing facility patients with heart failure can improve outcomes. The Cleveland Clinic instituted a "connected care" program in 2011–2014 in which patients at seven SNFs in the area were visited four to five times a week by hospital-employed physicians and advanced practice professionals, and greater attention was paid to goals-of-care discussions and medication reconciliation. There was a monthly outcome review, and the providers were evaluated by outcomes rather than productivity.

In comparing the intervention SNFs to other SNFs (usual care), Dr. Kim and his coinvestigators found that absolute reductions in hospital readmission ranged from 4.6% for patients at low risk of admission to 9.1% for patients at high risk (*J Hosp Med* 2017;12:238–244).

Dr. Kim said he is anticipating the publication of the results from another randomized trial conducted in the Denver metro area, the SNF Connect Trial, in which usual care was compared with a heart failure disease management program. The program has seven components covering clinical care — such as daily weights, symptoms, and activity assessment, ejection fraction documentation, and daily surveillance — and discharge measures. Rehospitalizations, emergency visits, and mortality are being assessed.

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ICD Deactivation

Discussions about deactivating an implantable cardioverter defibrillator (ICD) should take place early and more often, urged Meenakshi Patel, MD, FACP, CMD. "Fewer than 45% [of ICDs] are deactivated even after a do-not-resuscitate (DNR) order is in place, and 8% get shocked within minutes of death," she said. "This should be a proactive action, not an omission."

ICD deactivation is an important element of goals of care discussions and advance care planning, and it's important to discuss it before palliation becomes the focus. Advanced heart failure (stage D) is something "we all deal with," Dr. Patel said. "We initially treat these patients pretty aggressively and try to get them in optimized physical condition, but there comes a time when we need to focus on palliation."

Aliens

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an N-95 face mask when I go to see her, and she can barely see my face or hear my voice behind the mask. She asks, "Could you really help me?" She says she has already told her son that aliens have invaded the building and she wants him to take her back home. She tells me her distress will not be getting any better because the aliens are not going away.

We acknowledge that she cannot be discharged from the facility due to her medical condition and daily living needs. To the best of our ability we attempt to ease her anguish: we tell her that a strange new virus (COVID-19) has crept in everywhere, and that we are making efforts to prevent and control it. For us, it is easier said than done; for her, the COVID situation has become a genuine problem — she cannot see her loved ones in person, and no one knows for how long! So we strive to support her with appropriate humor and jokes, the best nonpharmacological therapy in most situations.

The last resident I review today is one of my favorite older residents, who has progressive dementia. She lost her husband last year here in the facility due to complications of advanced dementia. Since then she has socialized with other residents, and she enjoys roaming the hallways. During the COVID pandemic she has remained in her room for all the activities. The staff have informed me that she has become very quiet, with minimal conversation. Her appetite has been declining as well, despite maximum efforts to offer her favorite food choices. Her current weight is only 86 pounds with a downhill trend; her dementia, which had been in the early stages a few months ago, appears to have adopted a fast track. Currently she seems to have all the symptoms of end-stage dementia.

For her situation, nothing is working to reverse her condition. We have exhausted our efforts, and her family members are getting ready for her departure, based on her advance directive and our advance care planning discussion. So we will continue our efforts to alleviate her suffering and provide comfort.

Today, I wonder if this loneliness is our new company and whether finding solace in social distancing is the new norm. What about the residents who can't see or can't hear? What about those who have cognitive challenges? What will this new norm bring for them? What person-centered approach can we use to improve their quality of life? Seeking answers, we keep marching, hoping to see the end of this tunnel.

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