AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Heart Failure Medication Treatment

Quick Reference Guide

2026

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LANDSCAPE OF HF MEDICATION UTILIZATION IN VBC

Heart failure (**HF**) affects more than **6 million US adults** and is a leading cause of hospitalization in older adults.[1,2] The largest **avoidable treatment gap** is not the absence of effective therapy, but delayed initiation, incomplete use, and slow titration of **guideline-directed medical therapy** (**GDMT**).[3,4] In **heart failure with reduced ejection fraction** (**HFrEF**), the **four foundational medication classes** act through complementary pathways and should generally be **started rapidly** at low doses rather than prescribed sequentially over many months.[1,4] **Diuretics** remain essential for congestion but **do not replace GDMT**.[1,5]

AAVBC PERSPECTIVE

*The **American Academy of Value-Based Care** (AAVBC) supports a shift from **reactive diuretic management** to **accountable**, **longitudinal optimization of HF therapy**. For eligible patients with HFrEF, primary care clinicians should **help initiate** and **advance the four foundational pillars**: an **angiotensin receptor-neprilysin inhibitor** (**ARNI**), evidence-based **beta-blocker**, **mineralocorticoid receptor antagonist** (**MRA**), and **sodium-glucose cotransporter-2** (**SGLT2**) inhibitor.[3,4] The practical goal is **not** to maximize one drug before starting the next, but to **establish all four classes quickly** at **tolerated doses**, then titrate while monitoring blood pressure, renal function, potassium, heart rate, congestion, symptoms, and affordability.[1,4,6]*

***High-value HF care** also requires distinguishing congestion from **disease progression**, continuing GDMT **after ejection fraction improves**, **reconciling medications** after every hospitalization, and **removing drugs** that worsen HF.[1,7–9] In HF with preserved or mildly reduced ejection fraction (**HFpEF**/**HFmrEF**), SGLT2 inhibitors and careful volume management provide the **strongest medication foundation**, with additional therapy **individualized by**: Ejection fraction, comorbidity, blood pressure, kidney function, and congestion.*

↔ MAKING CONNECTIONS

For additional context on **clinical presentations of HF**, **clinical coding**, and **quality metrics**, please consult the **AAVBC HF QRG**.

Prevalence and Clinical Context in Older Adults

HF affects roughly **6.7 million U.S. adults** (crude prevalence ~1.9–2.8%), a burden that climbs steeply with age: from **~1.95%** at **ages 40–59** to **~5.9%** at **60–69**, **~8.2%** at **70–79**, and **~12.6%** in those **≥80 years**—and is projected to reach ~8.7 million by 2030 as the population ages.[6] Presentations split roughly evenly, with HFpEF accounting for **approximately 50%** (up to ~60%) of cases and reduced ejection fraction the remainder, and the HFpEF share is rising **~1% per year** toward becoming the dominant subtype.[7,8] Importantly, **HFpEF is substantially underdiagnosed**, particularly in older community-dwelling and Black patients—among ARIC

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