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

participants with unexplained dyspnea and no HFpEF diagnosis, **35%** had a **high-risk H_2FPEF score** (≥5), indicating many true cases go unrecognized.[9]

CLINICAL SCENARIO	CLINICAL SIGNIFICANCE IN OLDER ADULTS[1,10]	KEY PCP CONSIDERATIONS*[1,4,11]
Newly diagnosed HFrEF, LVEF ≤40%	Early risk of hospitalization and death is **high**	Start the four foundational classes **rapidly** at **low doses** when hemodynamically stable; **do not wait** to maximize one class first
HFmrEF, LVEF 41%-49%	Often behaves biologically like **lower-EF HF**, especially **near 40%**	Use an **SGLT2 inhibitor**; consider ARNI/ACE inhibitor/ARB, beta-blocker, and MRA **when appropriate**
HFpEF, LVEF ≥50%	Common in **older adults with**: hypertension, obesity, CKD, diabetes, and atrial fibrillation	Use an **SGLT2 inhibitor** to **reduce HF events**; treat congestion and comorbidities; **avoid reflexive HFrEF-style polypharmacy without a clear indication**
Recent HF hospitalization	**Highest-risk period** for readmission and death	**Reconcile and initiate GDMT** before or promptly after discharge; contact **within 48-72 hours** and **complete follow-up within 7 days** when feasible
CKD or modest creatinine rise	Common reason for **inappropriate undertreatment**	Interpret **renal changes** in clinical context; **monitor closely** rather than automatically stopping RAAS inhibition, MRA, or SGLT2 therapy
Frailty, falls, or low blood pressure	Treatment tolerance may be limited by **reserve rather than age**	**Assess**: orthostasis, volume status, and competing drugs; prioritize therapies with mortality benefit and reduce nonessential BP-lowering agents
Polypharmacy	**Increases**: hypotension, AKI, bradycardia, and nonadherence	**Reconcile every visit**; remove NSAIDs, duplicate RAAS blockade, unnecessary potassium, and other avoidable contributors

ABBREVIATIONS: PCP = primary care provider; HFrEF = heart failure with reduced ejection fraction; LVEF = left ventricular ejection fraction; HFmrEF = heart failure with mildly reduced ejection fraction; EF = ejection fraction; HF = heart failure; SGLT2 = sodium-glucose cotransporter 2; ARNI = angiotensin receptor-neprilysin inhibitor; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; MRA = mineralocorticoid receptor antagonist; HFpEF = heart failure with preserved ejection fraction; CKD = chronic kidney disease; GDMT = guideline-directed medical therapy; RAAS = renin-angiotensin-aldosterone system; BP = blood pressure; AKI = acute kidney injury; NSAIDs = nonsteroidal anti-inflammatory drugs

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Direct Savings and Value Impact Matrix

VALUE LEVER	CLINICAL STRATEGY[1,4]	FINANCIAL MECHANISM AND IMPACT[3,10,12]
Rapid four-pillar initiation	**Start eligible HFrEF patients on**: ARNI/ACE inhibitor/ARB, evidence-based beta-blocker, MRA, and SGLT2 inhibitor within weeks	**Reduces preventable worsening HF**, emergency care, hospitalization, and mortality
Discharge medication closure	Reconcile therapy **before discharge** and confirm access, laboratory orders, and follow-up	Targets the **period of greatest readmission risk** and prevents unintentional discontinuation
Congestion surveillance	**Track**: weight, edema, orthopnea, blood pressure, and diuretic response	**Enables outpatient intervention** before congestion requires emergency or inpatient care
Generic substitution	Use **generic** carvedilol, metoprolol succinate, spironolactone, ACE inhibitors, ARBs, and loop diuretics **when clinically appropriate**	Preserves evidence-based therapy while **reducing out-of-pocket cost** and abandonment
Laboratory stewardship	Pair RAAS therapy and MRAs with **scheduled potassium and renal monitoring**	Prevents **avoidable hyperkalemia and AKI** while reducing inappropriate permanent discontinuation
Medication avoidance	**Remove**: NSAIDs, thiazolidinediones, harmful nondihydropyridine calcium channel blockers in HFrEF, and duplicate RAAS blockade	**Reduces**: congestion, renal injury, decompensation, and medication-related admissions
Adherence support	Use **90-day fills**, synchronized refills, pharmacist review, teach-back, and patient-specific cost checks	**Improves persistence and proportion of days covered** while reducing therapeutic gaps

ABBREVIATIONS: HFrEF = heart failure with reduced ejection fraction; ARNI = angiotensin receptor-neprilysin inhibitor; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; MRA = mineralocorticoid receptor antagonist; SGLT2 = sodium-glucose cotransporter 2; HF = heart failure; RAAS = renin-angiotensin-aldosterone system; AKI = acute kidney injury; NSAIDs = nonsteroidal anti-inflammatory drugs
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INDICATIONS AND CONTRAINDICATIONS

Indications

Medication selection begins with: HF phenotype, LVEF, symptoms, congestion, kidney function, potassium, blood pressure, rhythm, and recent hospitalization history.

HFrEF: Four Foundational Pillars

- **ARNI, ACE inhibitor, or ARB**: **Sacubitril/valsartan** is preferred when feasible. Use an ACE inhibitor or ARB **when ARNI therapy is not tolerated**, contraindicated, or affordable. **Never combine these classes**[4]
- **Evidence-based beta-blocker**: Use carvedilol, metoprolol succinate, or bisoprolol in **clinically stable patients**. These are **not interchangeable** with every beta-blocker[4]
- **MRA**: Use spironolactone or eplerenone in **eligible symptomatic HFrEF** when **eGFR is >30 mL/min/1.73 m**^{2} and **potassium is <5.0 mEq/L**, with close monitoring[1]
- **SGLT2 inhibitor**: Use dapagliflozin or empagliflozin for **HFrEF regardless of diabetes status** when not contraindicated. No titration is required[4]

Symptom Control and Add-On Therapy

- **Loop diuretic**: Furosemide, torsemide, or bumetanide for **clinical congestion**. Adjust to **maintain euvolemia**; diuretics improve symptoms but are **not substitutes for mortality-reducing GDMT**[4]
- **Hydralazine/isosorbide dinitrate**: Add for self-identified **Black patients with persistent NYHA class III-IV HFrEF** despite optimal therapy, or consider when ARNI/ACE inhibitor/ARB therapy **cannot be used**[1]
- **Ivabradine**: Consider for **stable symptomatic HFrEF with LVEF ≤35%**, sinus rhythm, and resting heart rate ≥70 beats/min **despite maximally tolerated evidence-based beta-blocker therapy**[1]
- **Vericiguat**: Consider after **recent worsening HFrEF** requiring hospitalization or intravenous diuretics despite GDMT[1,5]
- **Digoxin**: May reduce HF hospitalization in **selected symptomatic HFrEF patients** but requires cautious dosing and monitoring, especially in **older adults and CKD**[1]
- **Intravenous iron**: Consider for **symptomatic HF with iron deficiency** after appropriate laboratory confirmation; o**ral iron is generally inadequate** for this purpose[10]

HFmrEF and HFpEF

- Use **dapagliflozin** or **empagliflozin** to reduce worsening HF and hospitalization across the **preserved and mildly reduced EF spectrum**[1,11]
- Use loop diuretics for congestion at the **lowest dose that maintains euvolemia**[11]
- Consider an MRA, ARNI, or ARB in **selected patients**, particularly when **LVEF is closer to 40%-50%**, while monitoring blood pressure, potassium, and kidney function[1]
- Treat hypertension, atrial fibrillation, coronary disease, obesity, diabetes, CKD, and sleep apnea as **independent drivers of symptoms and outcomes**[11]

Special Considerations in Older Adults

CONSIDERATION	KEY POINTS*[4,10,11,13–15]
Age is not a contraindication	GDMT efficacy is **consistent across age subgroups**, including ≥75 years, with the highest event rates, and **greatest absolute benefit**, in the oldest patients; time to benefit is generally **within 1 month**
Start low, monitor closely	Altered pharmacokinetics **raise risk of**: hypotension, hyperkalemia, and renal change; **recheck**: BP, potassium, creatinine, and heart rate 1–2 weeks after each change
Falls and orthostasis	**Multifactorial** (orthostasis, overdiuresis, sedatives, deconditioning); stagger BP-lowering doses and deprescribe non-GDMT antihypertensives before reducing GDMT
Polypharmacy	**Reconcile at every visit**; use **Beers** or **STOPP/START** to identify inappropriate medications; **prioritize GDMT** over non-evidence-based agents
CKD	**MRAs generally avoided at eGFR <30**; SGLT2 inhibitors may be used down to **eGFR 20 mL/min/1.73 m^2**; **do not** reflexively stop RAAS inhibition for modest, stable creatinine rises
Multimorbidity	Favor agents treating **several conditions at once** (e.g., SGLT2 inhibitors for HF, CKD, diabetes) to **limit pill burden**
Goals of care	With severe frailty, advanced dementia, or limited prognosis, **individualize GDMT intensity** through shared decision-making; **deprescribing** may be appropriate **when burden exceeds benefit**

ABBREVIATIONS: GDMT = guideline-directed medical therapy; BP = blood pressure; STOPP/START = Screening Tool of Older Persons' Prescriptions/Screening Tool to Alert to Right Treatment; CKD = chronic kidney disease; MRAs = mineralocorticoid receptor antagonists; eGFR = estimated glomerular filtration rate; SGLT2 = sodium-glucose cotransporter 2; RAAS = renin-angiotensin-aldosterone system; HF = heart failure
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Contraindications

CATEGORY	CONTRAINDICATION/ PRECAUTION*[1,4,16–18]	APPLIES TO*[1,4,16–18]	PCP RESPONSE[1,4,16,19]
Angioedema	Prior ACE inhibitor- or ARNI-associated **angioedema**	ARNI; ACE inhibitor	**Avoid the implicated class**; ARNI is contraindicated with a history of ACE inhibitor/ARNI-related **angioedema**
Pregnancy	Pregnancy or planned pregnancy	ARNI, ACE inhibitor, ARB, MRA, SGLT2 inhibitor	Avoid because of **fetal risk**; coordinate alternative therapy
Hyperkalemia	Potassium **≥5.0 mEq/L** at initiation	MRA; caution with RAAS inhibitors	**Correct reversible causes**; **do not initiate MRA** until eligible; intensify monitoring
Kidney dysfunction	**eGFR ≤30 mL/min/1.73 m^2** for MRA initiation	Spironolactone, eplerenone	**Do not initiate routinely**; seek specialist input if benefits may outweigh risks
Severe hypotension	Symptomatic **hypotension or shock**	ARNI/ACE inhibitor/ ARB, beta-blocker, diuretic	Assess perfusion and volume; **reduce nonessential BP-lowering drugs** and excess diuresis before abandoning GDMT
Acute decompensation	**Cardiogenic shock**, severe hypoperfusion, or inotrope requirement	Beta-blocker initiation or up-titration	**Do not initiate or increase until stabilized**; continuation decisions should be individualized
Bradycardia/ heart block	Symptomatic **bradycardia** or advanced AV block without pacing	Beta-blocker, ivabradine, digoxin	Hold or reduce **rate-slowing therapy** and **evaluate rhythm**
Type 1 diabetes/ DKA risk	Type 1 diabetes, active ketoacidosis, prolonged fasting, or major acute illness	SGLT2 inhibitor	**Avoid in type 1 diabetes**; **temporarily hold** during serious illness, prolonged fasting, or surgery according to product guidance
Dialysis/very low eGFR	Renal function below the product-specific initiation threshold or dialysis	SGLT2 inhibitor	Follow current FDA labeling; **do not use glucose-lowering thresholds as the sole HF threshold**
Negative inotropy	HFrEF with reduced systolic function	Verapamil, diltiazem	**Avoid routine use** because these agents can worsen HFrEF

CATEGORY	CONTRAINDICATION/ PRECAUTION*[1,4,16–18]	APPLIES TO*[1,4,16–18]	PCP RESPONSE[1,4,16,19]
Fluid retention/ renal injury	HF, especially with congestion or CKD	NSAIDs, COX-2 inhibitors, thiazolidinediones	**Avoid when possible**; choose alternatives and educate patients about OTC products

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Major HF Medication DDIs

INTERACTION	INTERACTING AGENTS*[1,20]	HF DRUG AFFECTED*[1,19]	CLINICAL EFFECT*	PCP RESPONSE*[1,19,21]
RAAS-related hyperkalemia	**Potassium supplements**, potassium-containing salt substitutes, trimethoprim-sulfamethoxazole, **heparin/LMWH**	ARNI, ACE inhibitor, ARB, MRA	**Additive hyperkalemia**, amplified by diabetes, CKD, and older age	**Discontinue potassium supplements** when starting an MRA; **avoid TMP-SMX** when possible; recheck potassium/renal function after any change
Combined RAAS blockade	ACE inhibitor + ARB, or either + MRA, or aliskiren	ARNI, ACE inhibitor, ARB, MRA	**AKI and severe hyperkalemia**; ARNI + ACE inhibitor also causes **angioedema**	**Do not combine ACE inhibitor + ARB + MRA** (triple RAAS blockade discouraged); **never co-prescribe** ARNI with an ACE inhibitor; **avoid aliskiren**
NSAID/RAAS renal injury	NSAIDs, COX-2 inhibitors	ARNI, ACE inhibitor, ARB, MRA, diuretics	**Worsening renal function/ AKI** (especially if elderly, volume-depleted, or on diuretics); blunted diuretic and antihypertensive effect	**Avoid NSAIDs**; if unavoidable, **monitor renal function and volume**; counsel on OTC NSAID products

INTERACTION	INTERACTING AGENTS*[1,20]	HF DRUG AFFECTED*[1,19]	CLINICAL EFFECT*	PCP RESPONSE*[1,19,21]
Lithium toxicity	Lithium	ARNI, ACE inhibitor, ARB, MRA/diuretics	Reduced lithium clearance → **elevated levels and toxicity**	Monitor serum lithium levels during concomitant use
CYP3A4 inhibition (eplerenone)	**Strong CYP3A inhibitors** (clarithromycin, ketoconazole, itraconazole, ritonavir, nefazodone)	Eplerenone	Increased eplerenone exposure → hyperkalemia	**Eplerenone is contraindicated with strong CYP3A inhibitors**; choose an alternative antimicrobial or MRA
Additive bradycardia/ AV block	**Nondihydropyridine CCBs** (verapamil, diltiazem), digoxin, amiodarone, other rate-slowing agents	Beta-blocker, ivabradine	**Symptomatic bradycardi**a or high-grade AV block	**Avoid nondihydropyridine CCBs with beta-blockers in HFrEF**; assess rhythm and reduce/hold rate-slowing agents
Additive hypotension	Other antihypertensives, alpha-blockers, nitrates, PDE5 inhibitors, volume depletion	ARNI, ACE inhibitor/ARB, beta-blocker, diuretic	**Symptomatic hypotension**, **dizziness**, falls in older adults	**Correct volume depletion**; reduce nonessential BP-lowering drugs before down-titrating GDMT
Enhanced diuresis/ volume depletion	**Loop or thiazide diuretics**	SGLT2 inhibitor	**Additive natriuresis/ diuresis** → hypovolemia, hypotension, prerenal azotemia	Anticipate and consider **reducing loop diuretic dose** at SGLT2 inhibitor initiation; monitor volume status and renal function
Digoxin assay interference	Digoxin (lab monitoring)	Spironolactone	**Falsely elevated digoxin** radioimmunoassay levels	Use a digoxin assay that **does not cross-react with spironolactone**
Reduced diuretic/ antihypertensive efficacy	Sympathomimetics (pseudoephedrine), venlafaxine	Any HF antihypertensive /diuretic	**Attenuated BP-lowering** and diuretic effect via sodium retention	**Avoid OTC decongestants**; counsel patients and choose alternatives

INTERACTION	INTERACTING AGENTS*[1,20]	HF DRUG AFFECTED*[1,19]	CLINICAL EFFECT*	PCP RESPONSE*[1,19,21]

ABBREVIATIONS: CTPA = CT pulmonary angiography; CT = computed tomography; DVT = deep vein thrombosis; PE = pulmonary embolism; RV = right ventricular; V/Q = ventilation/perfusion; SPECT = single-photon emission computed tomography; TTE = transthoracic echocardiography; LV = left ventricular; TAPSE = tricuspid annular plane systolic excursion; PERC = Pulmonary Embolism Rule-Out Criteria; HR = heart rate; SpO_2 = peripheral oxygen saturation; VTE = venous thromboembolism; ED = emergency department; BNP = B-type natriuretic peptide; NT-proBNP = N-terminal pro-B-type natriuretic peptide; sPESI = simplified Pulmonary Embolism Severity Index
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CLINICAL PEARL: ESSENTIAL PCP PRE-TREATMENT CHECKS

Before initiating or switching HF therapy:

- **Confirm phenotype and stability**: Document LVEF, NYHA class, congestion, blood pressure including orthostasis, heart rate/rhythm, and recent hospitalization[1,4,22]
- **Obtain safety data**: Basic metabolic panel, eGFR, potassium, and relevant liver testing; check hemoglobin, ferritin, and transferrin saturation when iron deficiency is suspected[1,2]
- **Reconcile medications**: Identify NSAIDs, potassium supplements, duplicate RAAS blockers, nondihydropyridine calcium channel blockers in HFrEF, thiazolidinediones, and **excessive vasodilator or diuretic burden**[1,23,24]
- **Confirm access and follow-up**: Choose **covered agents**, arrange **laboratory monitoring**, provide sick-day instructions, and **schedule titration** rather than issuing an open-ended prescription[2,4]

DOSE RECOMMENDATIONS AND RAPID OPTIMIZATION

HFrEF Initiation and Titration Framework

TRIGGER	ACTION*[1,2,4,19,25]
New, stable HFrEF	Start **low doses of all four foundational classes** as rapidly as clinically feasible, often **within 2-4 weeks**
Congestion present	**Start or adjust loop diuretic first or concurrently**; reassess weight, symptoms, renal function, and electrolytes
Stable after ARNI/ACE inhibitor/ARB start	Recheck **blood pressure**, **creatinine/eGFR**, and **potassium** in approximately 1-2 weeks; titrate every 2-4 weeks as tolerated

TRIGGER	ACTION*[1,2,4,19,25]
Stable after beta-blocker start	**Increase every 2 weeks as tolerated**; **do not** titrate during worsening congestion, shock, or symptomatic bradycardia
MRA initiation	Use only when **potassium <5.0 mEq/L** and **eGFR >30**; recheck potassium and renal function at about 3 days, 1 week, monthly for 3 months, then every 3-6 months
SGLT2 inhibitor initiation	Start the **evidence-based fixed dose**; review volume status and sick-day/perioperative holding instructions; no titration required
Symptomatic hypotension	**Confirm orthostasis and volume status**; reduce nonessential antihypertensives, nitrates without a compelling indication, or excessive diuresis **before stopping foundational therapy**
Modest early eGFR decline	Reassess volume, NSAID exposure, and potassium; a small expected change alone **should not trigger automatic discontinuation**
Persistent hyperkalemia	**Stop potassium and interacting drugs**, review diet and renal function, adjust MRA/RAAS therapy, and consider potassium-lowering strategies when appropriate
Improved LVEF above 40%	**Continue HFrEF GDMT** because withdrawal increases relapse risk

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CLINICAL PEARL: AGING RESHAPES HF TREATMENT

Older adults remain candidates for disease-modifying therapy, but frailty, orthostasis, CKD, cognitive impairment, and competing medications often **determine tolerability**.[4,10] **Biological reserve** should guide pacing, **not whether treatment is offered**.[10,26] Start low, **add classes early**, and titrate with shorter feedback loops.[2,4] A fall or low office blood pressure should **prompt evaluation of**: dehydration, autonomic dysfunction, sedatives, alpha-blockers, and unnecessary antihypertensives **before foundational HF therapy is abandoned**.[10,27]

Duration of Therapy

HF therapy is long-term.[1,28] Patients whose LVEF improves after treatment have HF with improved ejection fraction, **not a cured cardiomyopathy**.[1,29] Continue HFrEF GDMT **unless a specific contraindication emerges**.[1,22,29] Diuretic dose may be **reduced when euvolemia is sustained**, but disease-modifying therapy should **not be withdrawn** solely because symptoms or LVEF improve.

Recommended Initial Regimens

CLINICAL SCENARIO	PREFERRED MEDICATION APPROACH*[1,4,30]	KEY NOTES*[1,4,27,30]
Stable HFrEF	ARNI + evidence-based beta-blocker + MRA + SGLT2 inhibitor	**Establish all four early**; titrate in parallel
HFrEF with congestion	Four pillars plus loop diuretic	Decongestion is urgent, but **diuretic therapy does not replace GDMT**
HFrEF with low BP	**Prioritize SGLT2 inhibitor** and MRA when eligible; use low-dose beta-blocker and RAAS therapy **as tolerated**	Remove **nonessential BP-lowering agents** and avoid overdiuresis
HFrEF with CKD	Use SGLT2 inhibitor and RAAS therapy **with laboratory surveillance**; MRA **only when eligible**	Expect some **hemodynamic eGFR change**; monitor rather than reflexively stop
HFmrEF	**SGLT2 inhibitor**; consider HFrEF classes, especially when EF is near 40%	**Individualize** by BP, rhythm, CKD, and prior LVEF
HFpEF	**SGLT2 inhibitor + diuretic** for congestion; treat hypertension and comorbidities	**Consider MRA/ARNI/ARB selectively**, particularly at lower EF

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Regimen Optimization and Treatment Failure

Optimization in Stable Patients

- Confirm the patient is receiving **all eligible foundational classes** before focusing only on target doses[3,4]
- Convert ACE inhibitor or ARB therapy to **sacubitril/valsartan when appropriate** and affordable, using the **required washout** after an ACE inhibitor[1,18]
- Use only **carvedilol**, **metoprolol succinate**, or **bisoprolol** for the HFrEF mortality indication[1,2]
- **Reduce loop-diuretic dose** when euvolemia and orthostasis permit, but retain access to a written adjustment plan[1,31]

- Continue therapy **after LVEF improves**, because improvement reflects **remission**, **not cure**, and withdrawal causes **relapse in ~40% within 6 months**[1]
- Recheck **coverage and out-of-pocket cost** before switching; an unaffordable prescription is **not an effective regimen**[4,10,12]

Managing Apparent Treatment Failure

SCENARIO	ACTION*[1,10,19,32,33]
Persistent dyspnea	**Assess**: congestion, ischemia, atrial fibrillation, anemia/iron deficiency, lung disease, obesity, sleep apnea, and deconditioning **before escalating diuretics**
Recurrent congestion	**Review**: sodium intake, adherence, NSAID use, renal function, diuretic absorption, and dose timing; consider **loop-diuretic intensification** or **specialist-directed sequential nephron blockade**
Rising creatinine during decongestion	Interpret with volume status and response; persistent congestion may be **more dangerous** than a modest transient creatinine rise
Symptomatic hypotension	**Check orthostasis** and reduce non-HF BP medications or excess diuretic first; seek HF input if foundational therapy remains limited
Bradycardia	**Review**: beta-blocker, digoxin, amiodarone, ivabradine, and conduction disease; **adjust rate-slowing therapy**
Hyperkalemia	**Remove**: potassium, NSAIDs, trimethoprim, and duplicate RAAS therapy; repeat labs and **individualize MRA/RAAS adjustment**
Worsening HF despite four pillars	**Confirm adherence and dosing**; consider hydralazine/isosorbide dinitrate, ivabradine, vericiguat, digoxin, intravenous iron, devices, or **advanced HF referral** according to phenotype
Cardiogenic shock or escalating hypoperfusion	**Emergency evaluation and specialist management**; do not attempt routine outpatient titration

ABBREVIATIONS: NSAID = nonsteroidal anti-inflammatory drug; HF = heart failure; BP = blood pressure; RAAS = renin-angiotensin-aldosterone system; MRA = mineralocorticoid receptor antagonist
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On-Treatment Monitoring Schedule

MEASURE	TIMING AND PURPOSE*
Weight, edema, orthopnea, dyspnea	**At every contact**; **daily home weight** for patients able to act on a defined plan
Blood pressure and orthostasis	**At initiation**, **every titration**, and whenever dizziness or falls occur

MEASURE	TIMING AND PURPOSE*
Heart rate and rhythm	**At every visit**; ECG when bradycardia, palpitations, syncope, or interacting rate-slowing therapy is present
Creatinine/eGFR and potassium	**Baseline and** about **1-2 weeks** after RAAS therapy changes; more intensive schedule after MRA initiation
Volume status and loop-diuretic need	**At every visit** and **within days** after a major dose change or discharge
SGLT2 safety	**Review**: volume depletion, genital infection symptoms, ketoacidosis warning signs, and sick-day/perioperative holding instructions
Symptoms and function	NYHA class and preferably KCCQ-12 **at baseline** and **follow-up**
Medication access/ adherence	**Every visit**; use refill data, teach-back, and patient-specific benefit checks
LVEF	Repeat after an appropriate interval of optimized GDMT when recovery would affect device or other management decisions

ABBREVIATIONS: ECG = electrocardiogram; eGFR = estimated glomerular filtration rate; RAAS = renin-angiotensin-aldosterone system; MRA = mineralocorticoid receptor antagonist; SGLT2 = sodium-glucose cotransporter 2; NYHA = New York Heart Association; KCCQ-12 = Kansas City Cardiomyopathy Questionnaire-12; LVEF = left ventricular ejection fraction; GDMT = guideline-directed medical therapy
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Closed-Loop HF Medication Pathway for PCPs

- **Identify:** Use EHR triggers for LVEF ≤40%, HF hospitalization, loop-diuretic escalation, rising natriuretic peptide, or an **eligible patient missing a foundational class**[1,4]
- **Confirm**: Document HF phenotype, LVEF, NYHA class, congestion, blood pressure, rhythm, kidney function, potassium, and precipitating cause[1,4]
- **Initiate**: Establish **four-pillar HFrEF therapy rapidly at low doses**; use an SGLT2 inhibitor and congestion management across the EF spectrum when appropriate[4]
- **Monitor**: **Pre-order laboratories**, check symptoms and home weights, and titrate every 2-4 weeks until target or maximally tolerated doses are reached[1]
- **Close the loop**: After discharge, **complete medication reconciliation**, confirm fills and lab completion, contact within 48-72 hours, and arrange an early clinical visit[1]
- **Escalate**: **Refer for** refractory congestion, recurrent hospitalization, severe valvular disease, suspected infiltrative/genetic cardiomyopathy, device candidacy, inotrope dependence, or advanced HF evaluation[4]

PCP and Specialist Responsibilities

CARE FUNCTION	PRIMARY CARE[1,3,4]	CARDIOLOGY/HF TEAM/ PHARMACIST[4,34–36]
Diagnosis and phenotype	**Recognize HF, order baseline testing, document LVEF and congestion**	Clarify complex etiology, imaging, hemodynamics, and advanced phenotype
Foundational therapy	**Initiate and titrate eligible GDMT; monitor labs and access**	Resolve intolerance, advanced CKD/ hyperkalemia, refractory hypotension, and complex titration
Congestion	**Adjust routine oral diuretic therapy and written action plan**	Manage diuretic resistance, outpatient IV therapy, ultrafiltration, or recurrent admissions
Comorbidities	**Manage hypertension, diabetes, CKD, obesity, COPD, sleep apnea, and medication harms**	Coordinate rhythm control, valve intervention, ischemia evaluation, and advanced therapies
Devices/advanced HF	**Identify possible candidates and refer**	Evaluate ICD/CRT, LVAD, transplant, palliative inotropes, and advanced-care planning

ABBREVIATIONS: HF = heart failure; LVEF = left ventricular ejection fraction; GDMT = guideline-directed medical therapy; CKD = chronic kidney disease; IV = intravenous; COPD = chronic obstructive pulmonary disease; ICD = implantable cardioverter-defibrillator; CRT = cardiac resynchronization therapy; LVAD = left ventricular assist device
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

COST-SMART PRESCRIBING

Cost strategy should protect class coverage. **Generic** carvedilol, metoprolol succinate, bisoprolol, lisinopril, losartan, spironolactone, furosemide, torsemide, and bumetanide provide **low-cost foundations**.[37,38] **Sacubitril/valsartan** and **SGLT2 inhibitors** may carry **higher out-of-pocket costs**, so clinicians should check the patient-specific formulary, prior-authorization requirements, deductible phase, and 90-day pricing **before prescribing**.[37,38] Use real-time benefit tools, Medicare Part D payment options (including **Extra Help**), manufacturer assistance when available, and pharmacist navigation.

BRAND OR HIGHER-COST OPTION	GENERIC/ ALTERNATIVE (EST. COST)*	EST. SAVINGS + COST-SMART TIP*[1,37,39–41]
Brand sacubitril/ valsartan (Entresto) (~$590–$700/ mo WAC Medicare OOP ~$42–$47/ mo)	**Generic** ACE inhibitor (lisinopril **~$1–$12/mo**) or ARB (losartan **~$3–$27/mo**)	Saves **~$550–$680/mo** WAC (**~$40–$45/ mo** Medicare OOP) ARNI preferred (**Class 1**); higher Rx cost offset by **~$790/yr lower inpatient spending**; IRA-negotiated Part D price effective 2026; Co-pay card (**$10/mo**) for commercial; if unaffordable, use generic ACEi/ARB, **not no RAAS therapy**
Sacubitril/valsartan vs generic valsartan (~$16/ mo) or enalapril (~$15/ mo)	**Generic valsartan** or **enalapril** at target dose	Saves **~$550–$680/mo** WAC Total healthcare spending roughly cost-neutral (higher Rx offset by fewer hospitalizations); patient OOP **~$109/yr higher** with ARNI; complete **36-hour ACEi washout** before switching
Eplerenone (~$125–$137/ mo WAC Medicare OOP ~$30–$47/ mo)	**Generic spironolactone** (**~$2–$19/mo**)	Saves **~$100–$130/mo** **Spironolactone is first-line MRA**; reserve eplerenone for **gynecomastia** or **endocrine side effects**; both start at 25 mg daily
Brand empagliflozin (Jardiance) (~$658/mo WAC; Medicare OOP ~$42–$47/mo)	Brand dapagliflozin (Farxiga) (**~$639/mo** WAC; Medicare OOP **~$42–$47/mo**)	Minimal WAC difference Both FDA-approved for HF (**Class 1**); compare **formulary status** and **net patient cost**; IRA Part D prices effective 2026; manufacturer savings cards available; never substitute a non-evidence-based SGLT2i
Brand beta-blocker (~$45–$49/mo uninsured)	**Generic** carvedilol, metoprolol succinate, or bisoprolol (**~$4–$36/ mo**)	Minimal; already low-cost Confirm one of three HFrEF-proven beta-blockers; **metoprolol tartrate is not interchangeable with metoprolol succinate**; all three are **high-value generics**
Brand or higher-cost loop diuretic (e.g., brand torsemide)	**Generic** furosemide (**~$4–$10/mo**) or bumetanide (**~$10–$15/ mo**)	Variable; generics very inexpensive **TRANSFORM-HF** showed no mortality difference between torsemide and furosemide; choose by **clinical response and absorption**

BRAND OR HIGHER-COST OPTION	GENERIC/ ALTERNATIVE (EST. COST)*	EST. SAVINGS + COST-SMART TIP*[1,37,39–41]
Ivabradine (generic available since Jan 2026)	**Generic** ivabradine	Substantial vs prior brand (**~$590/mo**) Brand Corlanor discontinued Jan 2026; **generic now available**; **only for**: HFrEF with LVEF ≤35%, sinus rhythm, HR ≥70 on max beta-blocker
Preventable HF hospitalization (~$17,000–$25,000/admission)	Rapid quadruple GDMT + monitoring + early outreach	**~$9,780/yr** per patient in reduced hospitalization cost Quadruple GDMT **reduces HF hospitalizations ~87%**; generic regimen (~$100/mo) yields **~$8,556/yr** net savings; always weigh medication cost against **avoided acute-care spending**

ABBREVIATIONS: WAC = wholesale acquisition cost; OOP = out-of-pocket; ARNI = angiotensin receptor-neprilysin inhibitor; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; IRA = Inflation Reduction Act; Rx = prescription; ACEi = angiotensin-converting enzyme inhibitor; RAAS = renin-angiotensin-aldosterone system; MRA = mineralocorticoid receptor antagonist; FDA = US Food and Drug Administration; SGLT2i = sodium-glucose cotransporter 2 inhibitor; HFrEF = heart failure with reduced ejection fraction; LVEF = left ventricular ejection fraction; HR = heart rate; GDMT = guideline-directed medical therapy; HF = heart failure
***Consult FDA labels for the most up-to-date dosage and duration information, contraindications, and drug-drug interactions**

Do not use copay cards for Medicare or other federal-program beneficiaries when prohibited. Verify **current plan** and **assistance-program rules**.

NON-PHARMACOLOGICAL AND PATIENT-CENTERED CARE

Nonpharmacological measures complement guideline-directed medical therapy **across the full trajectory of heart failure**, from reducing incident risk in at-risk older adults to lessening symptom burden and hospitalizations after diagnosis. The strongest evidence supports **regular physical activity** and **cardiac rehabilitation**, structured self-care with daily monitoring, and multidisciplinary follow-up, all of which **improve functional status** and **reduce hospitalizations**, while sodium and fluid measures should be individualized rather than aggressively restricted.[1,22] **In older patients**, tailor each intervention to **frailty**, **comorbidities**, **cognition**, and **functional capacity** so that recommendations remain safe and achievable.[1,22]

INTERVENTION	RECOMMENDATION[1,24,42–44]
Sodium and fluid	**Individualize**; avoid indiscriminate extreme restriction, but **identify high-sodium foods** and excessive fluid intake in congestion; **reasonable targets**: sodium **~1.5–2.3 g/day** (ESC advises <5 g/day) and fluid **1.5–2 L/day** only in selected congested patients

INTERVENTION	RECOMMENDATION[1,24,42–44]
Alcohol	Advise abstinence in suspected **alcohol-related cardiomyopathy**; otherwise limit to **≤1 drink/day** (women) or **≤2 drinks/day** (men); **heavy use** (≥15/8 drinks/wk men/women) and **≥21 drinks/wk raise HF risk and progression**
Physical activity/cardiac rehabilitation	Encourage activity and rehabilitation **appropriate to stability**, **function**, and **frailty**; **general target** ~150 min/wk moderate activity (or ~30 min, 5 days/wk) plus **resistance training twice weekly**; refer eligible NYHA II–IV, LVEF ≤35% patients to **cardiac rehab**
Daily monitoring	**Use weight and symptom trends** with a written threshold-based action plan (e.g., alert for ~≥2 lb/day or ~≥5 lb/week gain); avoid data collection without a response pathway
Vaccination	Keep influenza, COVID-19, pneumococcal, RSV, and other age-appropriate **vaccines current**
Sleep and breathing disorders	**Evaluate obstructive sleep apnea** and **pulmonary disease** when symptoms persist **despite euvolemia**; confirm predominant apnea type (obstructive vs central) with a **sleep study before PAP**; for OSA, **offer CPAP** (bilevel or nocturnal oxygen as alternatives); moderate–severe OSA is **AHI ≥15/h**; in HFrEF with predominant central sleep apnea, **adaptive servo-ventilation is contraindicated**
Nutrition and frailty	**Monitor**: unintentional weight loss, sarcopenia, obesity, appetite, and functional decline; flag unintentional edema-free weight loss **≥5% over 6–12 months** (cachexia) and target **protein intake ~1.1–1.5 g/kg/day** with resistance training
Goals of care	Integrate prognosis, palliative symptom management, and advance-care planning **throughout serious illness**, **not only at end of life**

ABBREVIATIONS: RSV = respiratory syncytial virus

CLINICAL PEARL: LEVERAGING MODIFIABLE NONPHARMACOLOGICAL CARE TO PREVENT HF READMISSIONS IN OLDER ADULTS

Nonpharmacological measures are among the most modifiable, high-value levers for keeping diagnosed heart failure patients out of the hospital and slowing disease progression—often at minimal cost. Structured self-care with **daily weight** and **symptom tracking** tied to a written action plan enables **early detection of congestion before decompensation**, and **exercise-based cardiac rehabilitation** improves functional capacity and **reduces hospitalizations**.[1,42,45] Individualized sodium and fluid guidance, alcohol moderation or abstinence, current vaccinations, and evaluation of sleep-disordered breathing further reduce avoidable admissions.[1,43,44,46] Because a single preventable HF hospitalization costs roughly **$17,000–$25,000**, consistent reinforcement of these adjustable behaviors, ideally through **multidisciplinary**, **team-based follow-up**, delivers substantial value **alongside guideline-directed medical therapy**.[1,42] For older adults, tailoring each intervention to frailty, cognition, and functional status **keeps recommendations both safe and achievable**, maximizing adherence and durable benefit.[10]

Patient-Centered Conversation Framework

- **Purpose**: Explain that some medications **prolong life** and **prevent hospitalization** even when the patient **does not feel an immediate effect**; diuretics mainly **relieve fluid symptoms**[2,4]
- **Teach-back**: Ask the patient to **identify each medicine**, **its purpose**, and **what to do** if dizziness, vomiting, poor intake, rapid weight gain, or worsening breathlessness occurs[4,47]
- **Action plan**: Specify the **usual weight range**, diuretic instructions, whom to call, and emergency symptoms such as severe dyspnea at rest, chest pain, syncope, confusion, or cyanosis[2,16]
- **Adherence**: Ask directly about cost, refill gaps, urinary frequency, sexual or genital adverse effects, fatigue, and fear of kidney injury[1,4]
- **Transitions**: After hospitalization, **compare the discharge list** with the **preadmission regimen** and explicitly document every continued, stopped, and restarted medication[1,16]

HCC and Quality Alignment

Accurate ICD-10 coding for HF encounters is essential for **risk adjustment**, **care coordination**, and **continuity** — from initial diagnosis through GDMT optimization, decompensation management, and comorbidity care. **At each encounter**, **document the HF phenotype with**: LVEF, NYHA class, congestion status, current GDMT, and any acute decompensation or associated conditions, as this drives HCC mapping and downstream care planning. HF codes span multiple HCC categories (**HCC 226** for chronic HF, **HCC 224** for acute on chronic, **HCC 222** for end-stage) with substantially different RAF weights, so phenotype and acuity specificity directly affect risk adjustment. **Each diagnosis must be reaffirmed annually** with MEAT (monitor, evaluate, assess, treat) criteria. The following table outlines the relevant ICD-10 codes for HF encounters.

↔ MAKING CONNECTIONS

For additional context on **HF coding**, please consult the **AAVBC HF QRG**.

Key HEDIS/MIPs/PQA Measures

Several HF–specific HEDIS and MIPS measures are active in MY2026:

- **HEDIS MAH**: Medication Adherence for Hypertension RAS Antagonists
- **HEDIS PBH**: Persistence of Beta-Blocker Treatment After a Heart Attack
- **HEDIS SPC-E**: Statin Therapy for Patients with Cardiovascular Disease
- **MIPS #492**: Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure
- **MIPS #377**: Functional Status Assessments for Heart Failure
- **MIPS #317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- **MIPS #243**: Cardiac Rehabilitation Patient Referral from an Outpatient Setting
- **MIPS #008**: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **MIPS #005**: HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD

2026 MEASURE	STANDARD	HF APPLICABILITY*[1,11,24,48,49]
MIPS #005: HF — ACE Inhibitor/ARB/ ARNI Therapy for LVSD	**Denominator**: patients ≥18 with HF diagnosis and current or prior LVEF ≤40% with ≥2 outpatient visits or 1 inpatient discharge during measurement year; **Numerator**: prescribed ACE inhibitor, ARB, or ARNI; **Exclusions**: heart transplant, LVAD, documented intolerance or patient refusal	**Core HF process measure**; **document**: LVEF, active prescription, and medical reason for any exception; aligns with ACC/AHA PM-5

2026 MEASURE	STANDARD	HF APPLICABILITY*[1,11,24,48,49]
MIPS #008: HF — Beta-Blocker Therapy for LVSD	**Denominator**: patients ≥18 with HF and current or prior LVEF ≤40% with ≥2 outpatient visits or 1 inpatient discharge; **Numerator**: prescribed evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol); **Exclusions**: heart transplant, LVAD, documented intolerance or patient refusal	Must be an **evidence-based beta-blocker**, not any beta-blocker; document **specific agent** and **LVEF**; aligns with ACC/AHA PM-4
MIPS #377: Functional Status Assessment for HF	**Denominator**: patients ≥18 with HF and ≥2 outpatient visits during measurement year; **Numerator**: patient-reported outcome tool (e.g., KCCQ-12) administered ≥1× during measurement year; **Exclusions**: none	Use a **validated instrument** (KCCQ-12 preferred); tracks **symptom burden** and **response to therapy**; aligns with ACC/AHA QM-2
MIPS #492: Risk-Standardized Acute CV-Related Admission Rates for HF	**Denominator**: Medicare FFS patients ≥65 with HF; **Numerator**: risk-standardized rate of acute CV-related inpatient admissions within measurement year (outcome measure — lower is better); **Exclusions**: ESRD	**Population-level outcome measure**; driven by **GDMT optimization**, congestion management, post-discharge follow-up, and comorbidity control
MIPS #243: Cardiac Rehabilitation Patient Referral from Outpatient Setting	**Denominator**: patients ≥18 with qualifying CV diagnosis (HF with LVEF ≤35%, MI, CABG, PCI, valve surgery) seen in outpatient setting; **Numerator**: referred to outpatient cardiac rehabilitation program; **Exclusions**: documented medical or patient reason precluding referral	Referral requires **documented communication** and **order**; HFrEF patients with LVEF ≤35% are eligible; aligns with ACC/AHA Rehab PM-4
MIPS #317: Preventive Care — Screening for High BP and Follow-Up	**Denominator**: patients ≥18 with ≥1 outpatient visit; **Numerator** : BP recorded and, if elevated, documented follow-up plan; **Exclusions**: none	HFpEF is **closely linked to hypertension**; BP documentation supports both HF management and the 2024 ACC/AHA HFpEF BP control performance measure
HEDIS MAH: Medication Adherence — RAS Antagonists	**Denominator**: patients 18–85 with ≥2 fills of ACE inhibitor, ARB, or ARNI during measurement year; **Numerator**: PDC ≥80% during measurement year; **Exclusions**: ESRD, kidney transplant, hospice	**Pharmacy claims–based**; captures RAAS therapy persistence in HF patients; suboptimal PDC **predicts HF hospitalization**

2026 MEASURE	STANDARD	HF APPLICABILITY*[1,11,24,48,49]
HEDIS PBH: Persistence of Beta-Blocker After Heart Attack	**Denominator**: patients ≥18 hospitalized for AMI with beta-blocker at discharge; **Numerator**: ≥180 days' supply of beta-blocker in 180 days post-discharge; **Exclusions**: asthma, LVAD, heart transplant	Overlaps with **MIPS #008** when post-MI patients have LVEF ≤40%; emerging evidence **questions long-term beta-blocker benefit** in preserved EF post-MI
HEDIS SPC-E: Statin Therapy for Patients With CVD	**Denominator**: patients with clinical ASCVD (MI, CABG, PCI, stroke/TIA, PAD) and ≥1 statin fill; **Numerator**: PDC ≥80% for high-intensity or moderate-intensity statin; **Exclusions**: ESRD, hospice, cirrhosis, rhabdomyolysis	**Most HF patients with ischemic etiology qualify**; statin adherence **reduces recurrent CV events** independent of HF therapy

ABBREVIATIONS: MIPS = Merit-based Incentive Payment System; HF = heart failure; ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; ARNI = angiotensin receptor-neprilysin inhibitor; LVSD = left ventricular systolic dysfunction; LVEF = left ventricular ejection fraction; LVAD = left ventricular assist device; ACC/AHA = American College of Cardiology/American Heart Association; PM = performance measure; QM = quality measure; KCCQ-12 = Kansas City Cardiomyopathy Questionnaire-12; CV = cardiovascular; FFS = fee-for-service; ESRD = end-stage renal disease; GDMT = guideline-directed medical therapy; MI = myocardial infarction; CABG = coronary artery bypass grafting; PCI = percutaneous coronary intervention; HFrEF = heart failure with reduced ejection fraction; BP = blood pressure; HFpEF = heart failure with preserved ejection fraction; HEDIS = Healthcare Effectiveness Data and Information Set; MAH = Medication Adherence for Hypertension; RAS = renin-angiotensin system; PDC = proportion of days covered; RAAS = renin-angiotensin-aldosterone system; PBH = Persistence of Beta-Blocker After Heart Attack; AMI = acute myocardial infarction; EF = ejection fraction; SPC-E = Statin Therapy for Patients with Cardiovascular Disease — Adherence; ASCVD = atherosclerotic cardiovascular disease; TIA = transient ischemic attack; PAD = peripheral artery disease

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

TEN KEY TAKEAWAYS FOR HEART FAILURE PHARMACOTHERAPY

1 Four-pillar HFrEF therapy is the default, not the finish line

Eligible patients should receive **ARNI/ACE inhibitor/ARB**, evidence-based **beta-blocker**, **MRA**, and **SGLT2 inhibitor**.[1,4]

2 Start classes early rather than titrating sequentially for months

Low doses of all four classes generally provide **broader benefit** than maximizing only one or two.[4,32]

3 Diuretics treat congestion, not the underlying mortality risk

Use the **lowest dose** that **maintains euvolemia** while **preserving disease-modifying therapy**.[1,4]

4 SGLT2 inhibitors benefit HF patients with and without diabetes

They **reduce HF events** across the EF spectrum when clinically appropriate.[1,50]

5 A modest creatinine rise is not automatic treatment failure

Reassess **volume**, **potassium**, **NSAIDs**, and **clinical response** before discontinuing therapy.[4,51]

6 Low blood pressure requires diagnosis, not reflexive deprescribing

Address **orthostasis**, **overdiuresis**, and **nonessential BP-lowering drugs first**.[4,52]

7 Continue GDMT when LVEF improves

Recovery often reflects treatment response, and **withdrawal can precipitate relapse**.[1,53]

8 Medication reconciliation after hospitalization is a high-value intervention

Confirm **access**, **laboratories**, **fills**, and **early follow-up**.[4,54]

9 Avoid drugs that worsen HF

NSAIDs, thiazolidinediones, harmful nondihydropyridine calcium channel blockers in HFrEF, and duplicate RAAS blockade **create preventable risk**.[1]

10 Affordability is part of clinical effectiveness

Use **generics**, **formulary checks**, **benefit tools**, **pharmacist support**, and **assistance pathways** to maintain evidence-based coverage.[12]

AAVBC SUMMARY AND CONCLUSION

Value-based HF medication management begins with early phenotype recognition and rapid delivery of the therapies **most likely to prevent hospitalization and death**.[4] For HFrEF, **PCPs should help establish all four foundational GDMT classes within weeks**, titrate them using planned laboratory and clinical follow-up, and **avoid allowing a single low blood pressure reading** or modest creatinine change to **permanently derail care**.[4,32] For **HFpEF** and **HFmrEF**,

SGLT2 inhibition, careful congestion management, and aggressive treatment of comorbidities **form the practical medication foundation**.[1,50]

The PCP role extends beyond prescribing. **Closed-loop care requires**: Medication reconciliation after hospitalization, identification of drugs that worsen HF, monitoring of potassium and renal function, teach-back, symptom and weight action plans, and explicit resolution of affordability barriers.[4] The highest-value regimen is **not simply the least expensive prescription**. It is the **safest evidence-based regimen the patient can obtain**, **understand**, **tolerate**, and **continue**, with a care team prepared to respond before congestion becomes another hospitalization.[10,12]

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