American Heart Association.
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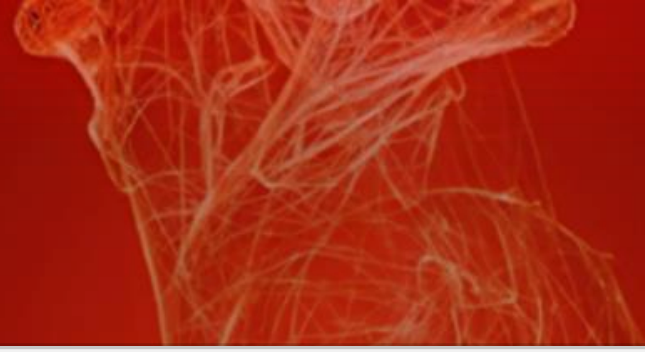
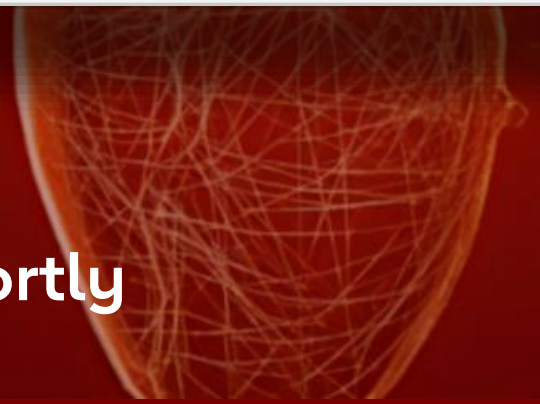


# Optimizing Post-Discharge Care for Heart Failure with Preserved and Mildly Reduced Ejection Fraction

## Strategies to Reduce Readmissions



**Webinar will begin shortly**

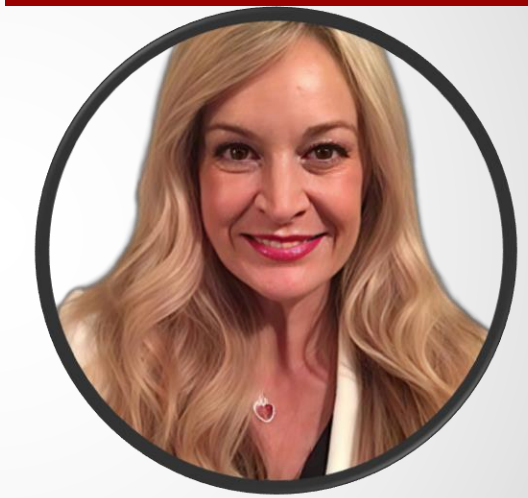
*The American Heart Association's IMPLEMENT-EF initiative is supported by Bayer*

American Heart Association.
IMPLEMENT-EF

# Welcome!

*Learn more:* ***heart.org/IMPLEMENTEF***

## American Heart Association Team

| Nancy Huard, MBA | Jennifer Everson, RN, BSN, MHA, CPHQ |
|---|---|
|  |  |
| **Program Manager**<br>IMPLEMENT-EF | **Program Manager**<br>IMPLEMENT-EF |

IMPLEMENT.EF@heart.org

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Scan the QR code to see a map of participating sites, stay informed about upcoming educational opportunities, and insights from the initiative.

heart.org/IMPLEMENTEF

In 2025, the American Heart Association, launched a quality improvement initiative to:

- Discover current gaps and identify ideal care models in the HFpEF/HFmrEF patient journey
- Build a network of multidisciplinary team members focused on improving HFpEF/HFmrEF care
- Amplify HFpEF/HFmrEF awareness with providers and monitoring adherence to evidence-based therapies for HFpEF/HFmrEF patients in hospitals

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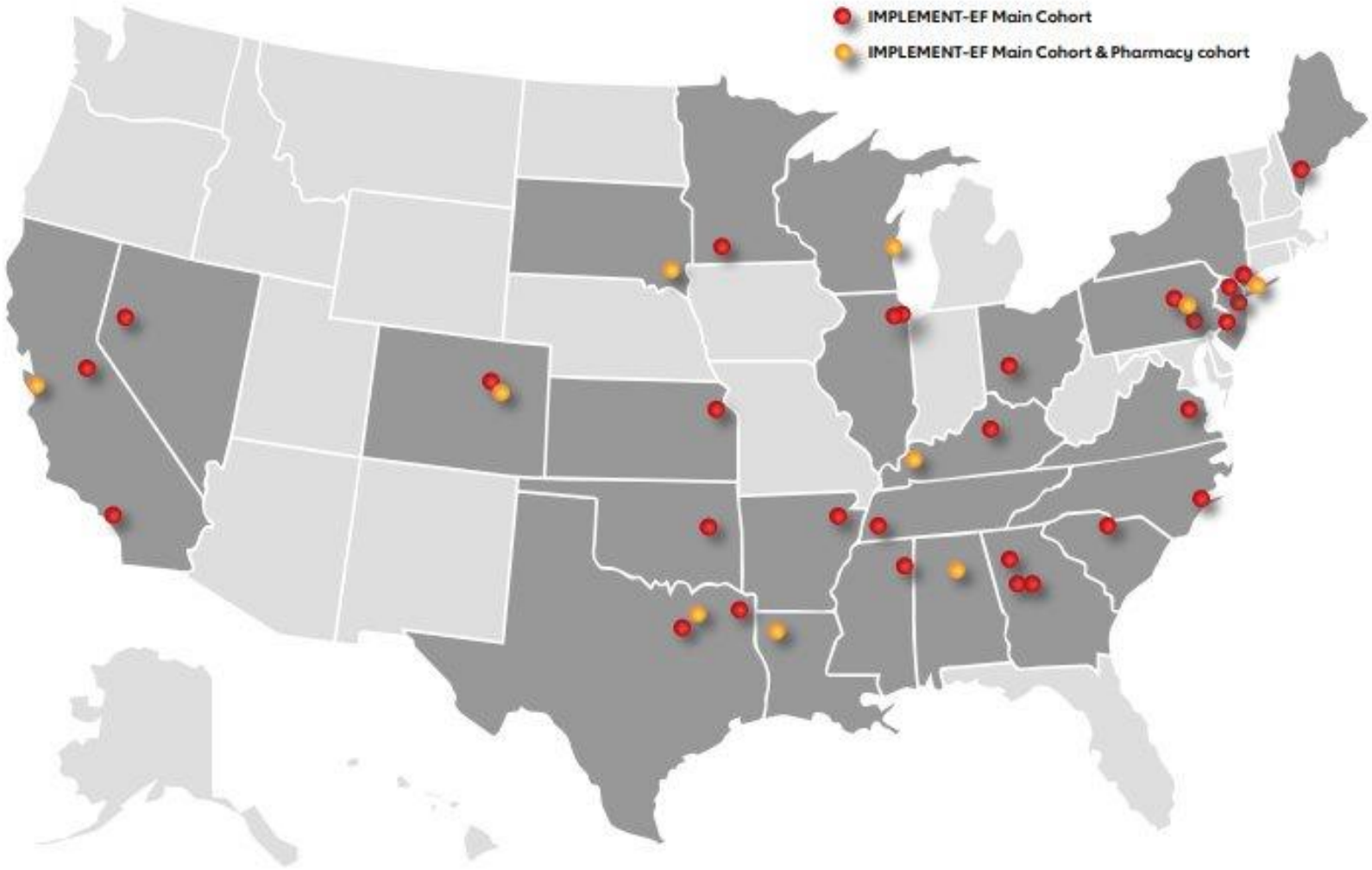
# IMPLEMENT-EF Participating Sites




## Participating Sites

| | | |
|---|---|---|
| 1. | AdventHealth Redmond | Rome, GA |
| 2. | AdventHealth Shawnee Mission | Shawnee Mission, KS |
| 3. | Avera McKennan Hospital & University Health Center* | Sioux Falls, SD |
| 4. | Baptist Health Paducah* | Paducah, KY |
| 5. | Baptist Health Lexington | Lexington, KY |
| 6. | Baptist Memorial Hospital - Memphis | Memphis, TN |
| 7. | Bon Secours St. Mary's Hospital | Richmond, VA |
| 8. | Carolina Pines Regional Medical Center | Hartsville, SC |
| 9. | Carteret Health Care | Morehead City, NC |
| 10. | Dayton Veterans Affairs Medical Center | Dayton, OH |
| 11. | Froedtert Hospital* | Milwaukee, WI |
| 12. | Froedtert West Bend Hospital | West Bend, WI |
| 13. | Geisinger Medical Center | Danville, PA |
| 14. | Hackensack Meridian JFK University Medical Center | Edison, NJ |
| 15. | Hackensack Meridian Southern Ocean Medical Center | Manahawkin, NJ |
| 16. | Hackensack University Medical Center | Hackensack, NJ |
| 17. | MaineHealth Maine Medical Center Biddeford | Biddeford, ME |
| 18. | Mount Sinai Health System | New York, NY |
| 19. | Murray County Medical Center | Slayton, MN |
| 20. | NEA Baptist Memorial Hospital | Jonesboro, AR |
| 21. | North Mississippi Medical Center | Tupelo, MS |
| 22. | Northwestern Medicine Palos Hospital | Palos Heights, IL |
| 23. | NYC Health + Hospitals / Elmhurst* | Elmhurst, NY |
| 24. | Ochsner LSU Health Shreveport* | Shreveport, LA |
| 25. | Penn Medicine Lancaster General Health | Lancaster, PA |
| 26. | Penn State Health Milton S. Hershey Medical Center* | Hershey, PA |
| 27. | Renown Regional Medical Center | Reno, NV |
| 28. | Saint Francis Hospital Muskogee | Muskogee, OK |
| 29. | Stanford Health Care* | Stanford, CA |
| 30. | Sutter Medical Center, Sacramento | Sacramento, CA |
| 31. | Texas Health Fort Worth* | Fort Worth, TX |
| 32. | Titus Regional Medical Center | Mount Pleasant, TX |
| 33. | UCHealth - Memorial Hospital Central | Colorado Springs, CO |
| 34. | UCHealth University of Colorado Hospital* | Aurora, CO |
| 35. | UI Health | Chicago, IL |
| 36. | University of Alabama at Birmingham Hospital* | Birmingham, AL |
| 37. | University of California Irvine Medical Center | Orange, CA |
| 38. | University of Texas Southwestern Medical Center | Dallas, TX |
| 39. | WellStar Kennestone Regional Hospital | Marrieta, GA |
| 40. | WellStar Paulding Hospital | Hiram, GA |

*Participating in the Pharmacy cohort

**Audio:**
All attendees are muted.

**Video:**
Only Panelists will be on camera.

**CC Closed Captions:**
are available and can be engaged by clicking on the CC icon at the bottom of your screen.

**Recording:**
This session is being recorded and will be shared afterward.

**Q&A:**
Use the Q&A panel for questions anytime.

**Technical Help:**
If you experience issues, try leaving and rejoining the webinar or checking your internet connection.

Stay until the end for **live Q&A**.

"Resources" icon located at the bottom of your screen (looks like three pieces of paper). Choose "Documents" and click on the arrow to download the resource.

Connect with us
IMPLEMENT.EF@heart.org

# Disclaimer

***The recommendations and opinions presented by our guest speakers may not represent the official position of the American Heart Association. The materials are for educational purposes only, and do not constitute an endorsement or instruction by the Heart Association. The American Heart Association does not endorse any product or device.***


## Amanda Riddle, MSN, APRN, AGACNP-BC, CCRN

**Heart Failure Coordinator**

***Texas Health Ft. Worth Hospital – Ft. Worth, TX***


*No Disclosures*

May 13, 2026

# IMPLEMENT EF
# Post-Discharge Needs


## Amanda Riddle, MSN, APRN, AGACNP-BC, CCRN

Texas Health
Harris Methodist Hospital®
FORT WORTH

# Our faith-based, nonprofit health system cares for more patients in North Texas than any other provider

**29,000+** EMPLOYEES

**400+** points of access

Across sixteen counties

**Home to 8M North Texans**

## Hospitals

**29** HOSPITAL LOCATIONS

**4,390** Licensed Hospital Beds

- 6,400+ Physicians with Active Medical Staff Privileges
- Acute Care, Short Stay, Rehabilitation & Transitional Care

## Physicians Group

**450+** Primary Care Providers in 130 Locations

**380+** SPECIALISTS IN 80 LOCATIONS

**310+** Hospitalists and Post-Acute Providers

## Outpatient & Community Access

**26** Breeze Urgent Care Centers and growing

**35** SURGERY CENTERS

- 25+ Imaging Centers
- Employer Clinics
- Home Health Care
- Hospice Care
- Quick Care Video Visits
- Primary Care Video Visits

## Clinically Integrated Network

Formed by Texas Health Resources and UT Southwestern Medical Center

PHYSICIAN NETWORK

HOSPITAL NETWORK

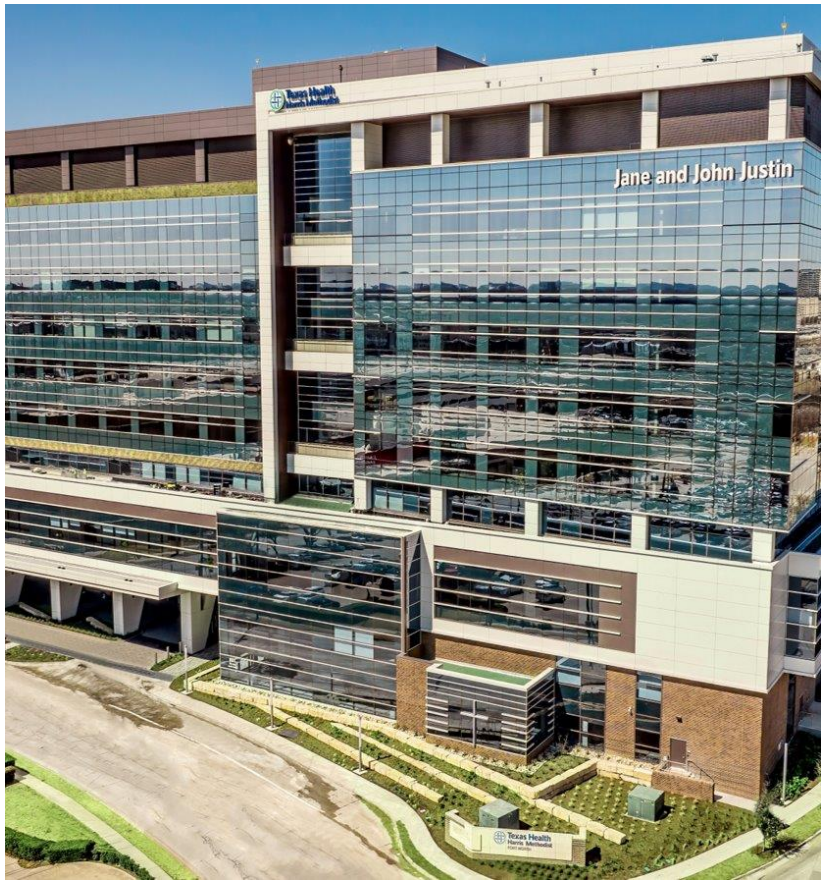
- Population Health Services
- Health Insurance Plan

# Texas Health Fort Worth

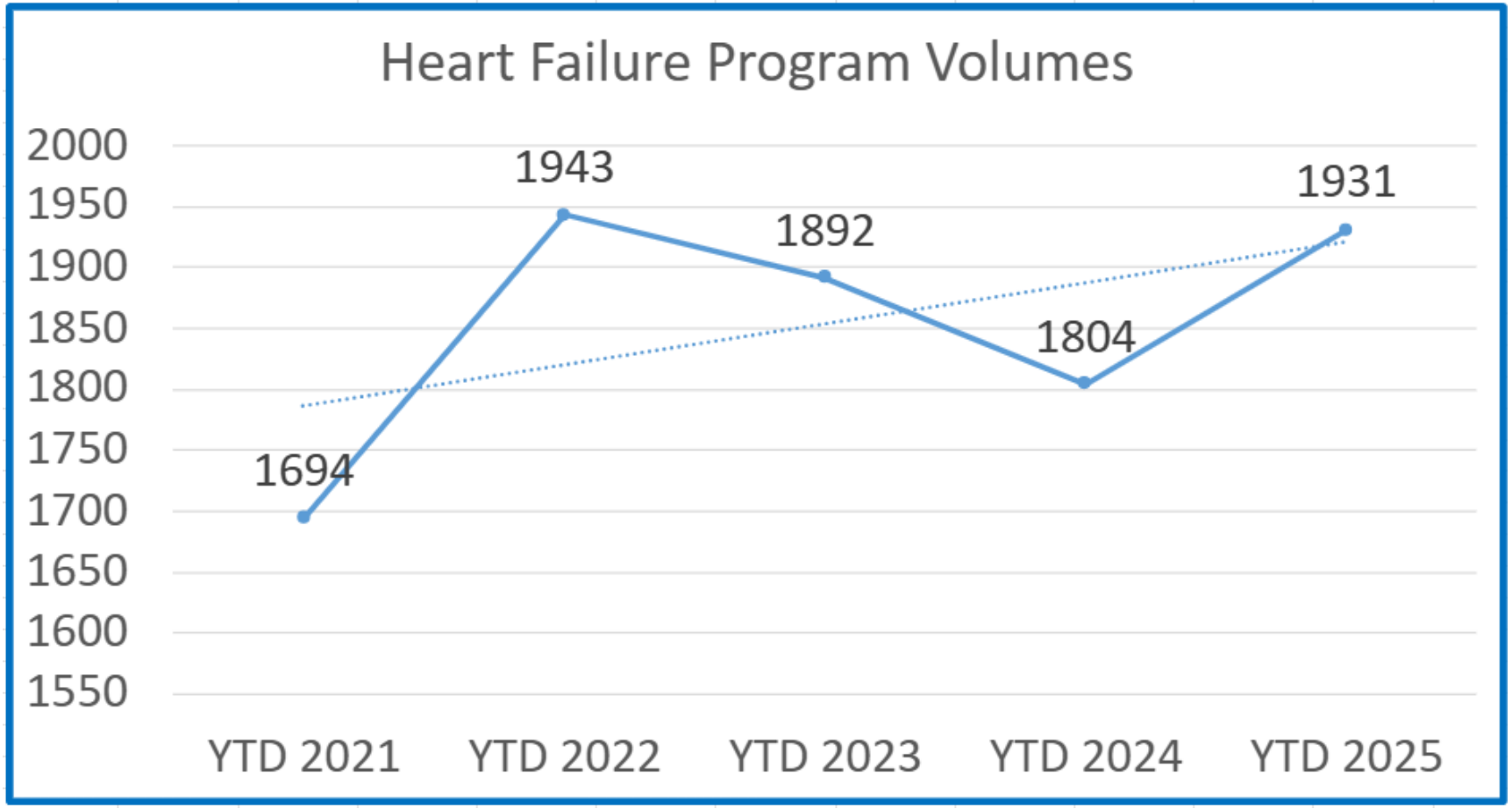
- 851 In-patient beds
- 100 ED beds
- Dedicated Cardiac Tower 100 beds
  - CV ICU, CV Step down and 2 Med Surg Tele

2024 Statistics

- Emergency Visits 159,426
- Inpatient Volume 42,641
- Outpatient Volume 202,087
- Observation Patients 4,820
- Overall Hospital LOS (IP) 5.83



# Programmatic Growth

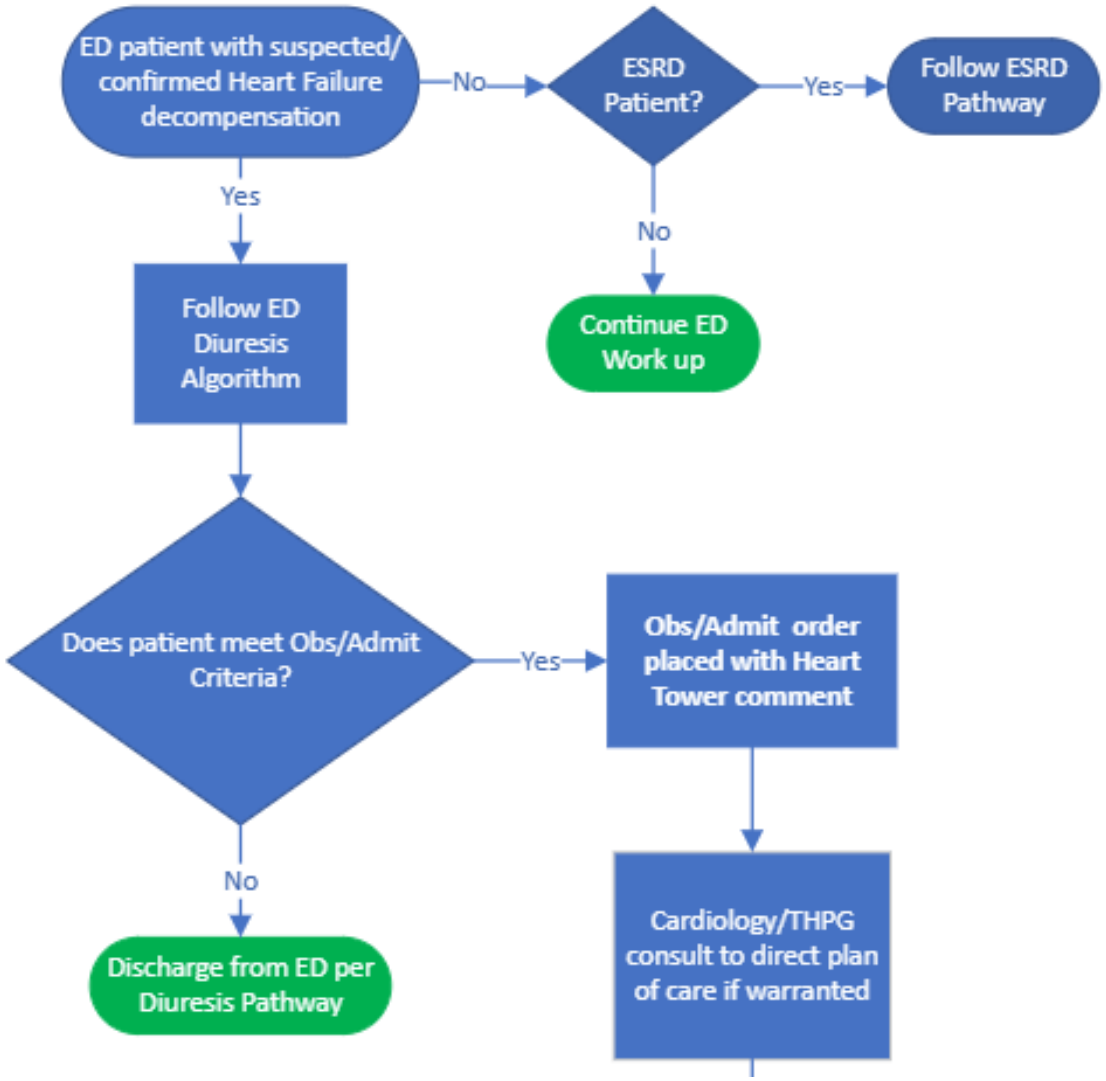


# From Risk to Action in HFpEF and HFmrEF

- High comorbidity burdens
  - Hypertension
  - Obesity
  - Type 2 DM
  - CKD
  - A Fib
  - PH
  - Ischemic heart disease
- Challenge
  - Address chronic comorbidities during hospitalization by strengthening PCP coordination
- Possible solutions
  - Improved patient education?
  - PCP outreach?

# Drivers of Vulnerability First 30 days

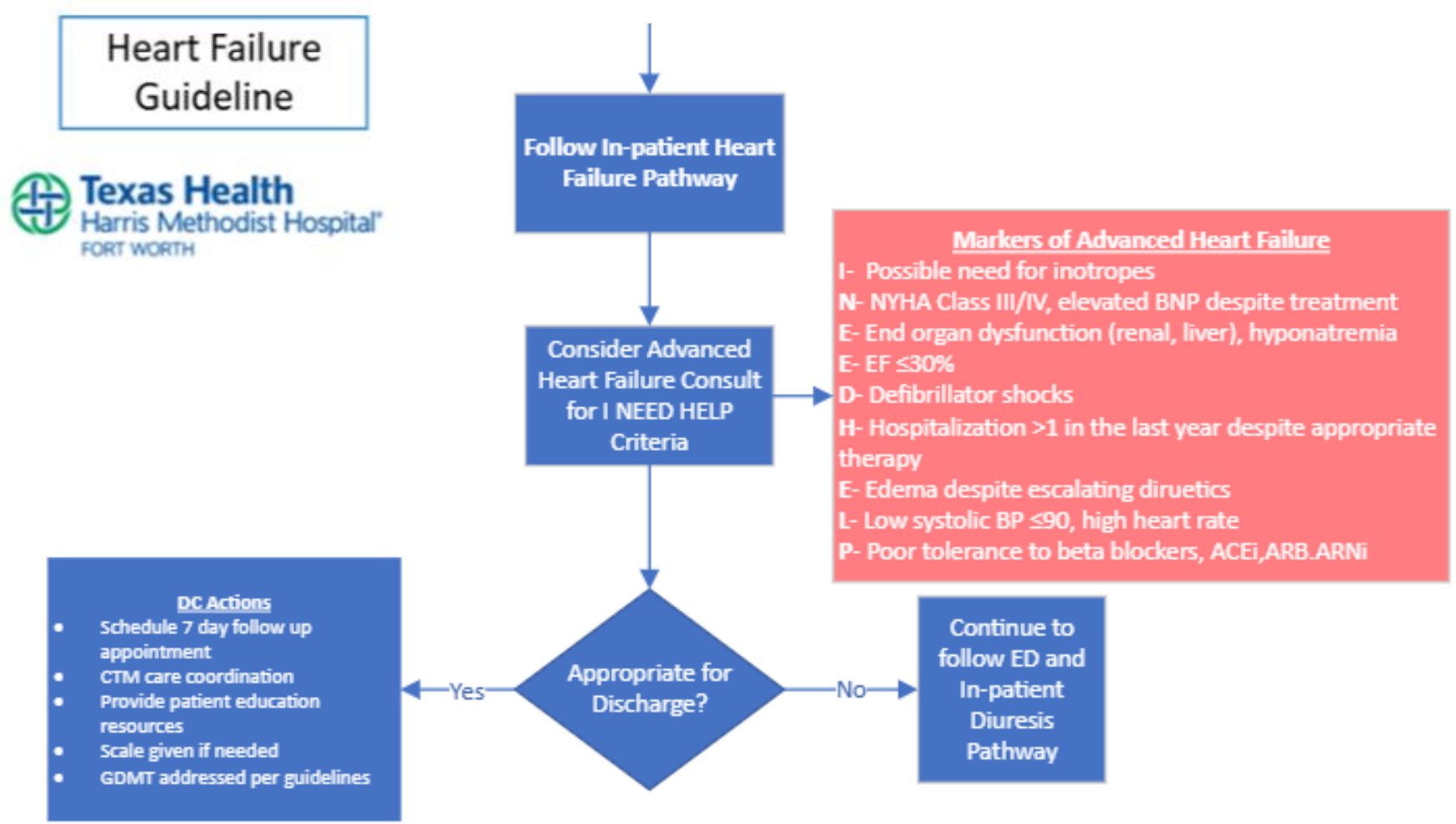
- Patient related factors
  - SDOH Assessments
    - Barrier- subjective often from patient perspective
- Disease related factors
    - Barriers- Limited expertise, resources, performance metric driven care
- Comorbidities
    - Barriers- need for specialist assistance
- System related factors
  - Tailor patient resources with supportive services to meet needs
- Triggers for early readmission
    - Barriers- clinical blind spots leading to preventable readmissions



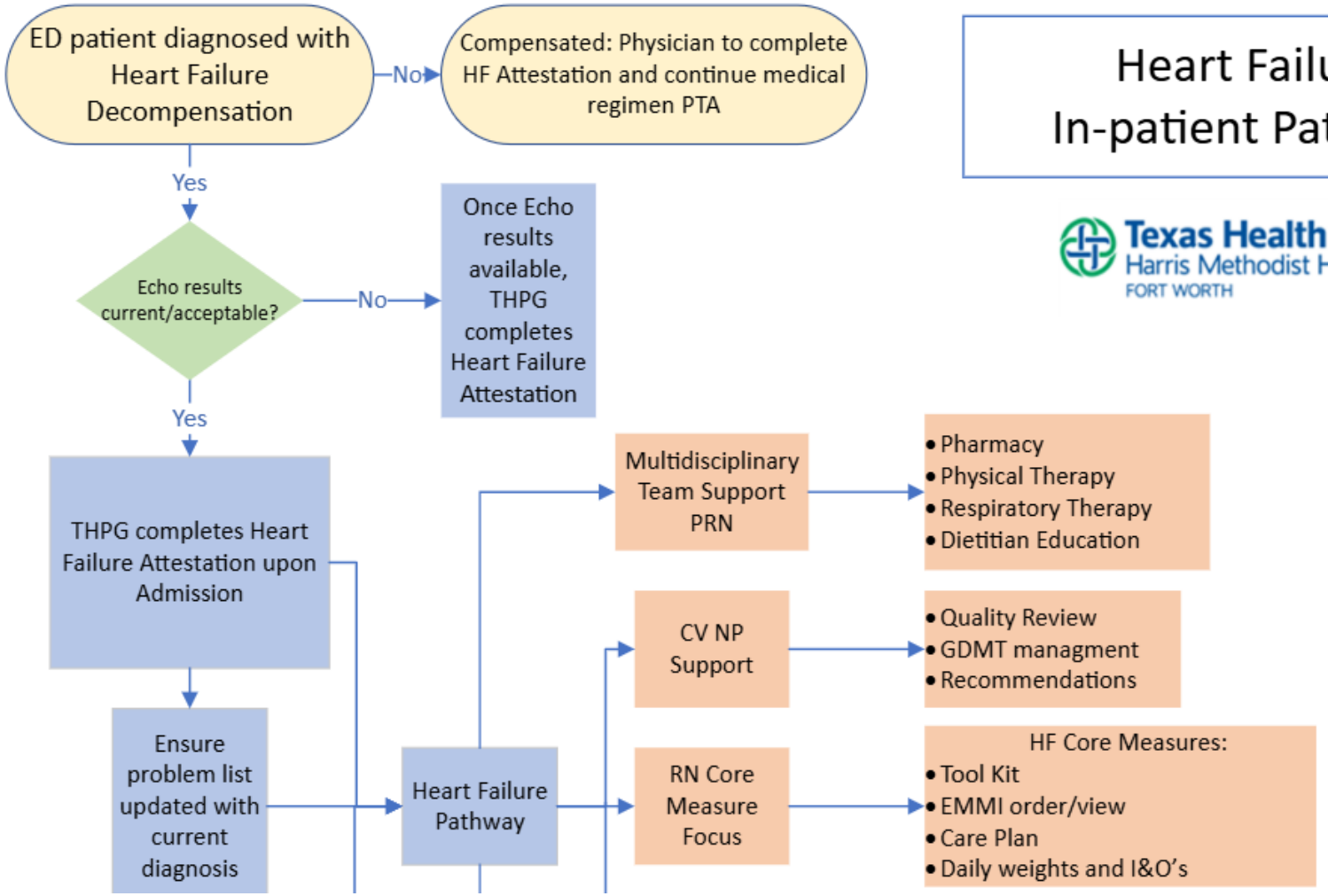

# Heart Failure Guideline

Texas Health Harris Methodist Hospital FORT WORTH

Continued

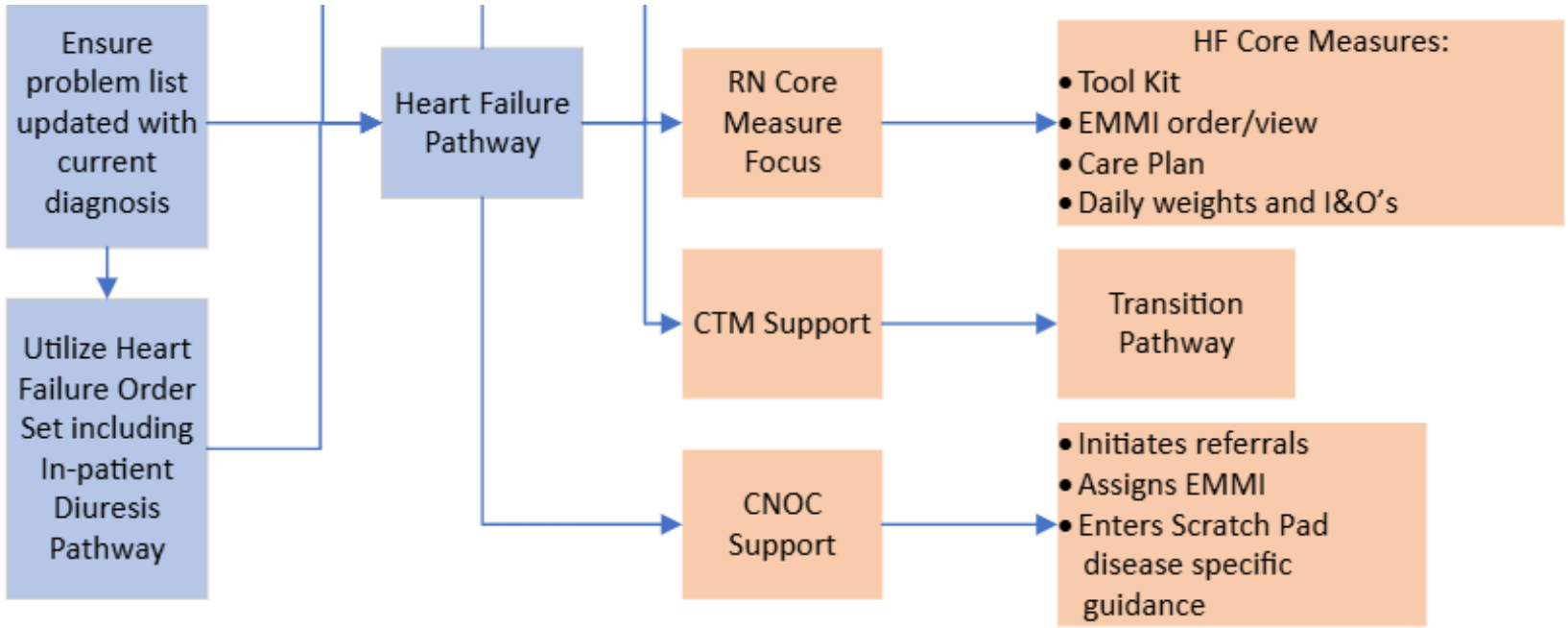

Heart Failure Guideline
Texas Health Harris Methodist Hospital FORT WORTH
Follow In-patient Heart Failure Pathway
Consider Advanced Heart Failure Consult for I NEED HELP Criteria
Markers of Advanced Heart Failure
I- Possible need for inotropes
N- NYHA Class III/IV, elevated BNP despite treatment
E- End organ dysfunction (renal, liver), hyponatremia
E- EF ≤30%
D- Defibrillator shocks
H- Hospitalization >1 in the last year despite appropriate therapy
E- Edema despite escalating diruetics
L- Low systolic BP ≤90, high heart rate
P- Poor tolerance to beta blockers, ACEi,ARB.ARNi
Appropriate for Discharge?
Yes
No
DC Actions
Schedule 7 day follow up appointment
CTM care coordination
Provide patient education resources
Scale given if needed
GDMT addressed per guidelines
Continue to follow ED and In-patient Diuresis Pathway

# Heart Failure In-patient Pathway



# Heart Failure In-patient Pathway

Texas Health Harris Methodist Hospital FORT WORTH



# Readmission Avoidance Program

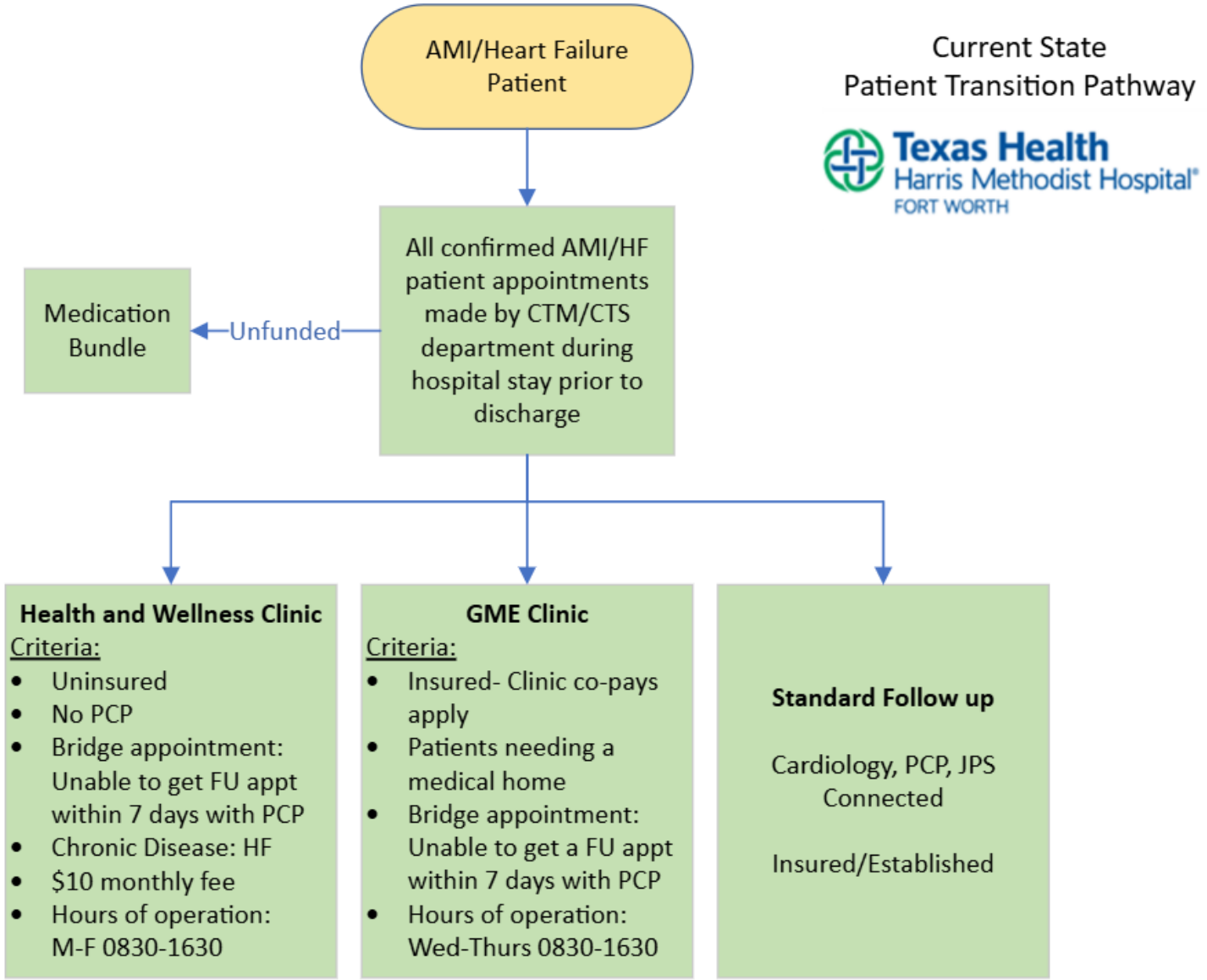
- Patient identified focus groups
  - MI, HF, COPD, PNA, CABG, Total Hip/Knee
- Goals
  - Reduce unplanned readmissions
  - Streamline workflows and bridge discharge gaps
  - Out-patient CTM phone call once a week for 30 days
- Risk Unplanned Readmit (RUR) score
- Facilitate post-discharge care needs
- EPIC row visible for team
  - Identified and enrolled

| | |
|---|---|
| High: | 24 - 100 |
| Moderate: | 16 - 23 |
| Low: | 9 - 15 |
| Mild: | 0 - 8 |

# Multidisciplinary Readmission Avoidance

- Utilization of risk stratification in ED
  - EHMRG Risk Score
- Diuresis Algorithm
- Care Transition Specialist role
  - Removes transitional barriers post-discharge
  - Isolates best/practical follow up for patient scenario
  - Offers resources based on clinical need

# Current State
# Patient Transition Pathway



# Thank you!

## Gretchen Cunanan, RN, BSN, CHFN

**Heart Failure Navigator**

***Northwestern Medicine Palos Hospital – Palos Heights, IL***

*No Disclosures*

## Kristen Juarez, MSN, RN

**Heart Failure Navigator**

*Northwestern Medicine Palos Hospital – Palos Heights, IL*

*No Disclosures*

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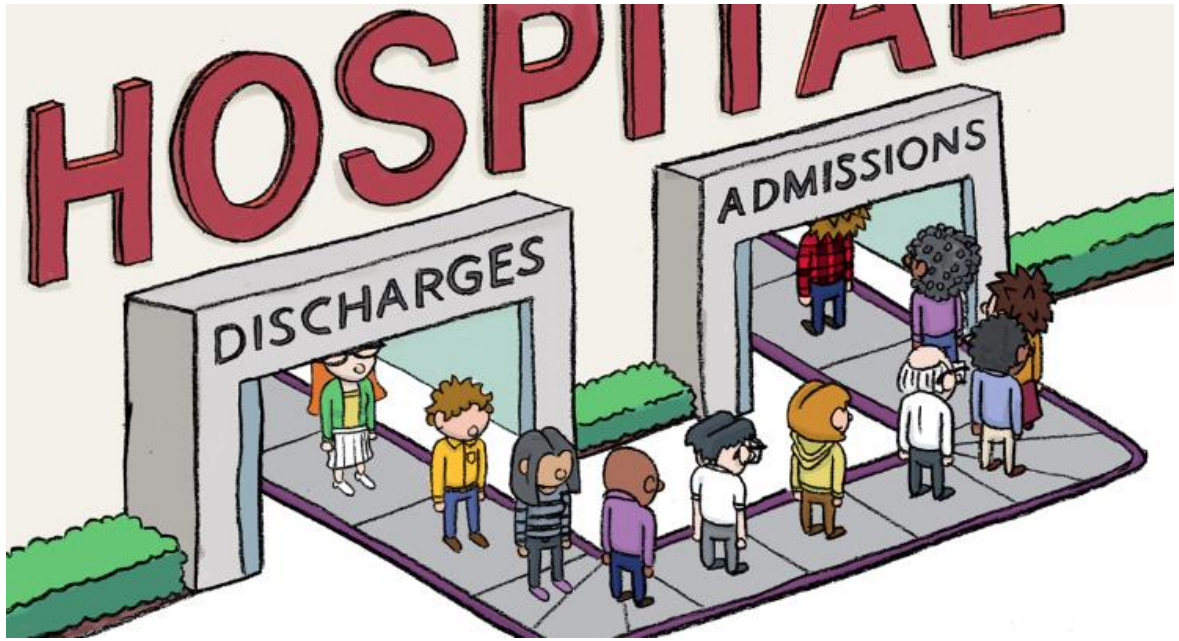
# Optimizing Post Discharge Care for HFpEF/HFmrEF: Strategies to Reduce Readmissions

Presented By:
Northwestern Medicine Heart Failure Nurse Navigators
Gretchen Cunanan, BSN, RN, CHFN
Kristen Juarez, MSN, RN, CV-BC

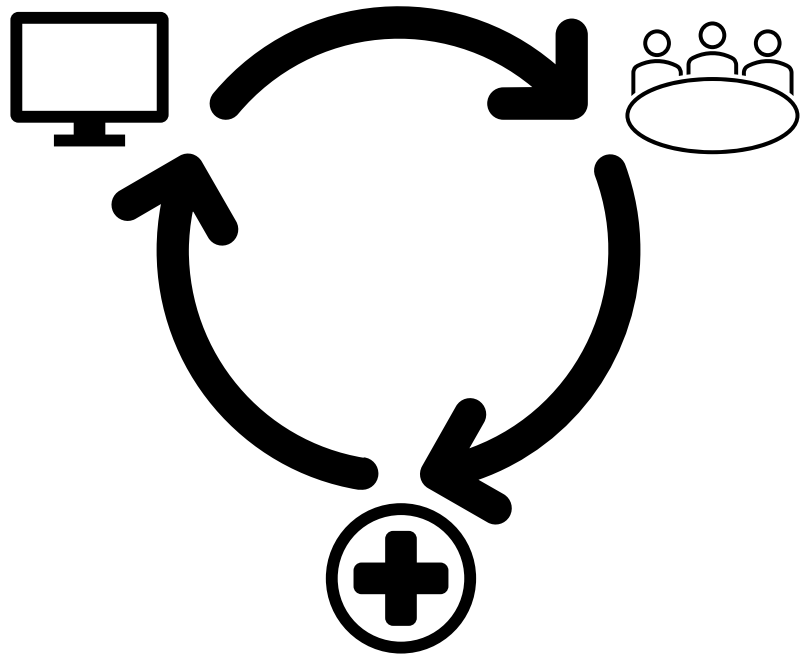
# Common Reasons for Readmissions

- Lack of compliance with medications
- Lack of compliance with dietary recommendations
- Lack of understanding of disease process/progression
- Lack of affordable medications
- Lack of clinical Inertia
- Inadequate diuresis or discharge appropriateness
- Inadequate follow up
- Poorly controlled co-morbidities
- Uncertainty about when to contact a health care professional vs returning to ED



# Patient Identification

- HF Navigator consult through manual chart review and MD consult
- Epic Report
- Heart Success Unit
- Heart failure rounds (hospitalists, HF APP, SW, Pharmacist, Clinical Coordinator, Unit Manager, HF Navigator)
- Coordinating care through discharge- >CHF clinic, Cardiology office



# Post Discharge Calls

72 hr, 2 week and 4 week follow-up calls

SmartForm (Read-Only)

Heart Failure Post Transitional Care Phone Call:

Initial Call/Week: 72 hours | Week 1 | Week 2 | Week 3 | Week 4 | Program Complete

Hospital Discharge Information

Patient's hospital discharge disposition: Home-Self Care | Home-Home Health Nursing | Skilled Nursing Facility | Hospital | Assisted Living

Symptoms:

The patient reports feeling: Patient overall feeling well at home

REPORTS the following symptoms: Cough | Dizziness | Edema/Swelling | Fatigue | Lightheadedness | Nausea | Orthopnea | Palpations | Shortness of Breath

DENIES new or worsening symptoms including: ✓ Cough | ✓ Dizziness | ✓ Edema/Swelling | ✓ Fatigue | ✓ Lightheadedness | ✓ Nausea | ✓ Orthopnea | ✓ Palpations | ✓ Shortness of Breath

Activity Level:

Are you able to perform your activities of daily living (using the toilet, eating, drinking, bathing, sleeping, mobility) as you were at discharge? Yes | No

Are you physically active? Yes | No

If Yes, describe: Using stationary bike

SmartForm (Read-Only)

Discharge weight method: Standing scale | Bed scale | Infant scale | Lift scale | Wheelchair scale | Length based tape | Patient/family stated | Estimated

First reported home weight (lbs): 253 lb Date: 4/1/2026

Daily weight today (lbs): 250 lb 12.8 oz Date: 4/2/2026

Patient obtaining and recording daily weights: Yes | No

Patient monitoring BP and HR daily: Yes | No

Reported Results:

BP Today: 139/65

BP Yesterday: 127/68

HR Today:

HR Yesterday: 73

Medications:

☐ Reviewed the list of medications provided at discharge

Did you pick up any new medications or needed refills from the pharmacy? Yes | No

Have you been taking all medications as prescribed? Yes | No

Have you been experiencing any side effects from your medications? Yes | No

Has your provider added or discontinued any of your medications or modified doses? Yes | No

Have you been utilizing a medication management system Yes | No

If Yes, please describe:

Diet and Fluids:

Have you been compliant with a 2000 mg low sodium, 64 oz daily fluid restriction, heart healthy diet? Yes | No

Please describe your breakfast, lunch, dinner, and snacks over the past 24 hours:

Lifestyle Management:

Do you currently smoke or have a history of tobacco use? Yes | No

Are you drinking alcohol or using illicit drugs? Yes | No

Education:

Additional education provided on the following topics: ✓ diet | ✓ daily weights | ✓ medication indications | ✓ medication prescribed frequency | ☐ diabetes management | ☐ anticoagulation therapy | ☐ cardiovascular risk factors | ☐ activity guidelines

Follow Up Plan of Care

Next follow-up appt: 4/3/2026 Next Appt Provider: Aryelle Schicht APRN

Patient's wife instructed to call his cardiologist or primary care physician for weight gain of more than 2-3 pounds overnight and/or 5 pounds in one week and/or increased shortness of breath, swelling, chest pain, and/or lightheadedness. For severe symptoms of shortness of breath, swelling, chest pain, and/or lightheadedness patient advised to seek emergency medical care .

Patient reminded of upcoming appointment with APRN Aryelle Schicht 4/3/26 1120 for a hospital follow-up.

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# Heart Failure Care Coordination

- **Ambulatory care coordination- Northwestern PCP**
  - Automatic service for pts w/ NM PCP
  - 4–6-month follow-up, minimum monthly calls
- **Multidisciplinary team (RN, SW, PharmD)**
- **Goal: Manage healthcare needs**
  - Education to manage symptoms and disease
  - Connection to community resources
  - Caregiver support
  - Connected care across settings: HHC and/or SNF

## Smart Data Element

Next Steps

- Please add the dot phrase **.HFENROLL** to your note templates


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# Transitional Care Management

**Future Appointments**

| Date | Time | Provider | Department | Center |
|---|---|---|---|---|
| 1/2/2026 | 9:20 AM | O'Malley, Chelsea K., APRN, CNP | PHHLWC | Palos80thAv |
| 2/19/2026 | 1:40 PM | Afana, Majed, MD | PHCARDIO | Palos80thAv |

**TCM**

Transitional Care Management (**TCM**):
Date: 12/26/25
Program of Outreach: Primary Care
Reason for **TCM**: Inpatient Stay
Inpatient Admission Date: 12/18/25 Inpatient Discharge Date: 12/22/25
Hospital: PALOS HOSPITAL IP
Discharge Disposition: Home or Self Care
Discharge Diagnosis: dyspnea, near syncope, dizziness, palpitations,
Call Start Time: 12/26/2025 1:47 PM
Outreach Number: 1st Call
1st Call Status: Completed Call
HIPAA Statement: Spoke to patient or patient support (spouse, relative, significant other, etc.), HIPAA verified. Explained role and purpose for the call. Introduced program.: Yes
How are you feeling since your discharge?: About the same
Do you have any questions about the purpose or side effects of any medications that you were prescribed during your visit? **TCM**: No
Medication Reconciliation: Completed
Medical Care Follow Up:
Medical Care Follow Up: PCP follow up NOT scheduled
Condition Knowledge/Education Provided:
Discharge Instructions Reviewed?: Yes
Do you have any questions regarding your discharge instructions and taking care of yourself at home? Yes
Discharge Instructions: Patient/patient support (spouse, relative, significant other, etc.) verbalized understanding?: No
Functional Status/Abilities:
Functional Status/Abilities: Walker, Cane
Adequacy of Support System:
Living Situation Stable?: Yes (Comment: lives alone - apartment 17 stairs to go up)
Barriers/Flags:
Barriers/Flags: Clinical, Functional
Community Resources:
Community Resources in Place?: No
Community Resources Needed?: No
Current Services in Place or Referred During Call: Refused to get home therapy
Patient Concerns:
Does patient have additional clinical or social questions/concerns?: No
Do you have any concerns or suggestions for improvement?: No
Is there anyone that you would like to recognize for going above and beyond?: No
Call End Time: 12/26/2025 2:05 PM
Transitional Care Mangement Complete?: Yes

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# Population Health Services

An interdisciplinary approach to care that promotes health and coordination through the care continuum for the diverse patient populations we serve

## Ambulatory Care Coordination

*Clinician driven support (Nurse + Social Work)*

*For patient referrals:* ***REF250 order in Epic***
*For general inquiries:* ***nmcarecoordination@nm.org***

**Programs**

- Care Coordination
- Complex Care Coordination
- Hi-risk pathways to care e.g.:
  - Multi-Visit Patient (MVP)
  - High Risk for Readmissions (HRR)
- Clinical pathways:
  - Diabetes Tune-up Pathway
  - HTN pathway (Nuna pilot)

**Goals**

- Develop patient centered goals
- Empower successful self-management
- Provide proactive care by partnering with primary care and other health professionals
- Improve health outcomes

**Eligibility**

Patients attributed to an NMPN primary care physician, with one or more of the following:

- High-risk chronic disease
- Barriers to care (medical and/or psychosocial)
- Enrolled in a value-based contract

## Outreach

*Interdisciplinary Support (Community Health Worker, Social Work, Nurse)*

*Services are automatic –* ***no referral needed***
*Epic Pools:* ***NM Outreach & NM Outreach - TOC***
*For general inquiries:* **nmoutreachteam@nm.org**

**Programs**

- Transitions of Care (TOC) Support
- Social Drivers of Health (SDOH) Follow-Up
- Care Gap Closure (Diabetes, Annual Wellness Campaigns)

**Goals**

- Address short term clinical and social needs
- Remove barriers to care and recovery
- Promote timely, equitable, and patient centered care
- Reduce administrative burden in clinics

**Eligibility**

TOC – enables TCM billing

- Inpatient or observation discharge home with an NM PCP and VBC contract and moderate or high risk

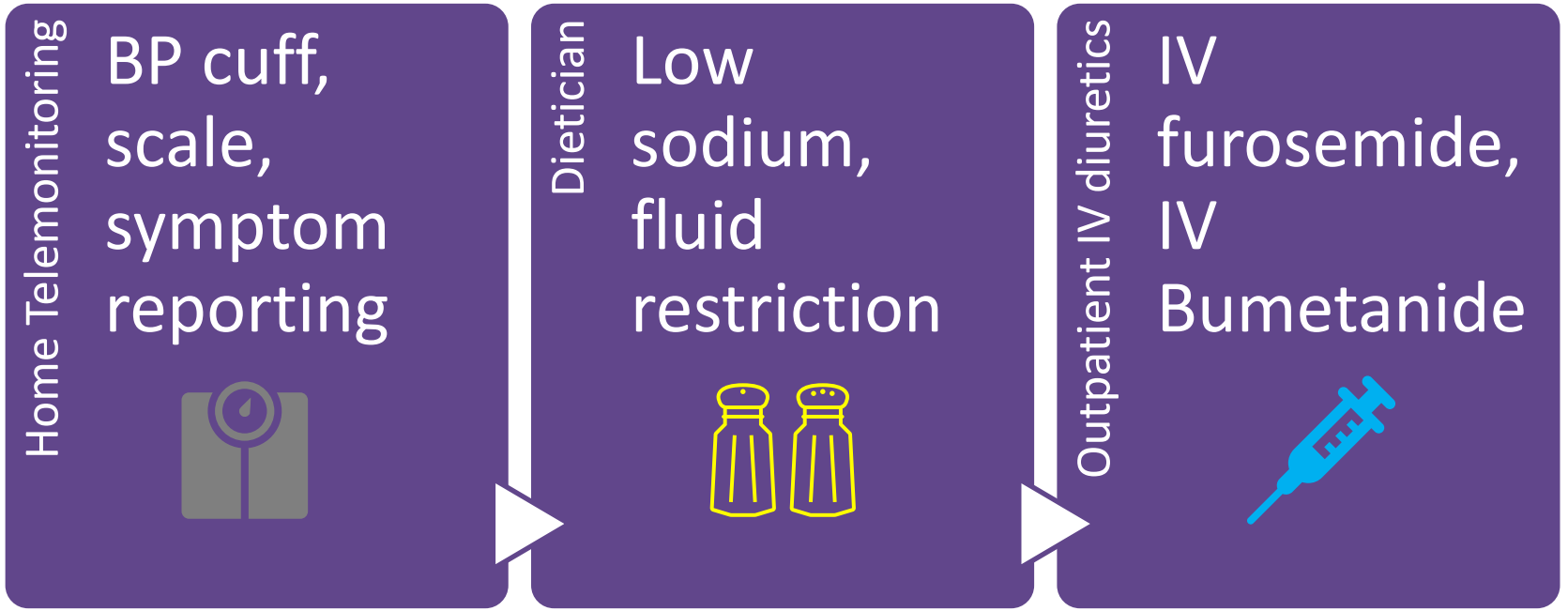
SDOH

- Patients with positive SDOH screen (new and annual appointments)

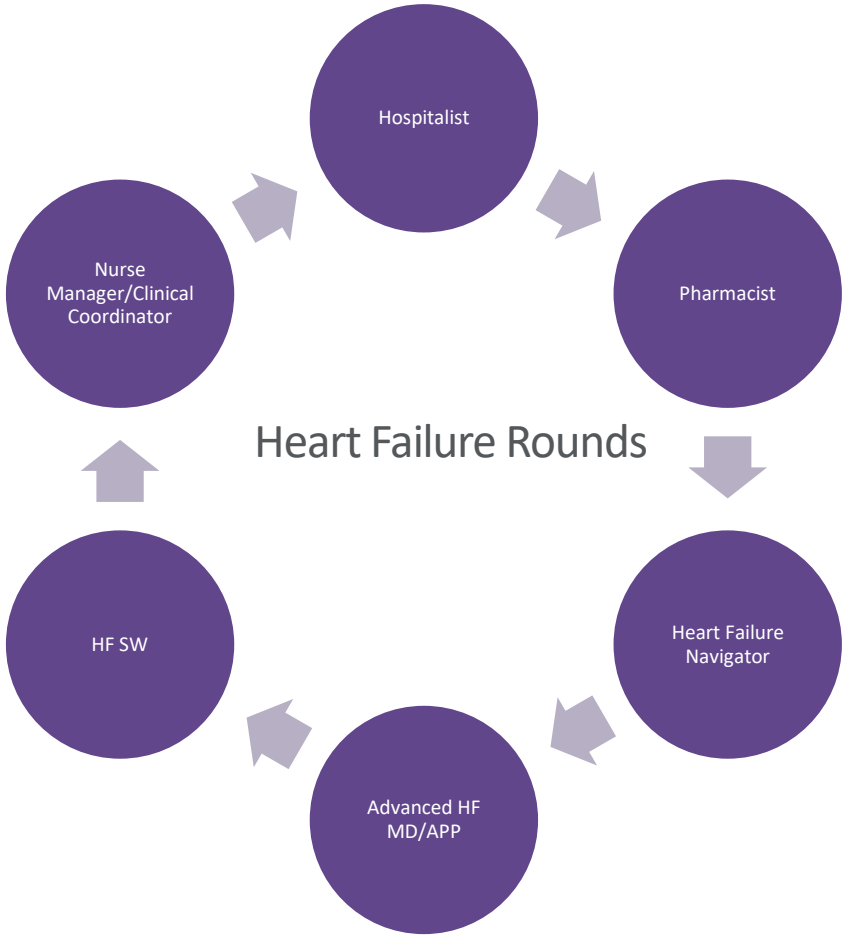
Care Reconnection Programs

- Patients needing extra support reconnecting to care

# Home Health


Home Telemonitoring
BP cuff, scale, symptom reporting
Dietician
Low sodium, fluid restriction
Outpatient IV diuretics
IV furosemide, IV Bumetanide

# Advanced Heart Failure Team




## South Suburbs

Lauren A. Farina, MD

Natalie Stella APRN

Jonathan N. Hourmozdi, MD

- Pharmacy Technician
  - Assist with PA's, benefits investigation
- Outpatient Pharmacist

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# Heart Failure Clinic

- Advanced Practice Providers and HF nurses
- Referral based clinic- Hospital based
- Must be established with a Cardiologist

| Rooming | APRN | RN | GDMT Titration |
| --- | --- | --- | --- |
| Vital signs, telemonitor during visit | Assessment | Education | Repeat labs 1 week following medication titration |
| Medication reconciliation | Education | IV Diuretic administration | Follow-up in clinic 2-4 weeks (stable telehealth) |
| Pharmacy confirmation | | | |
| Phlebotomy (BNP, BMP, Mag) | | | |

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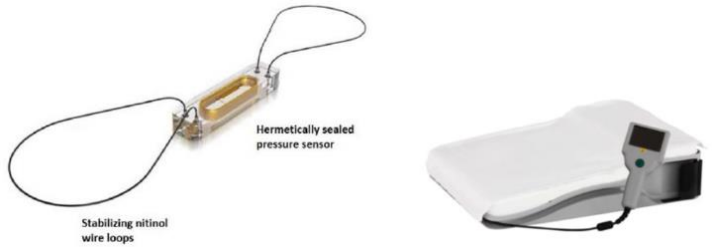
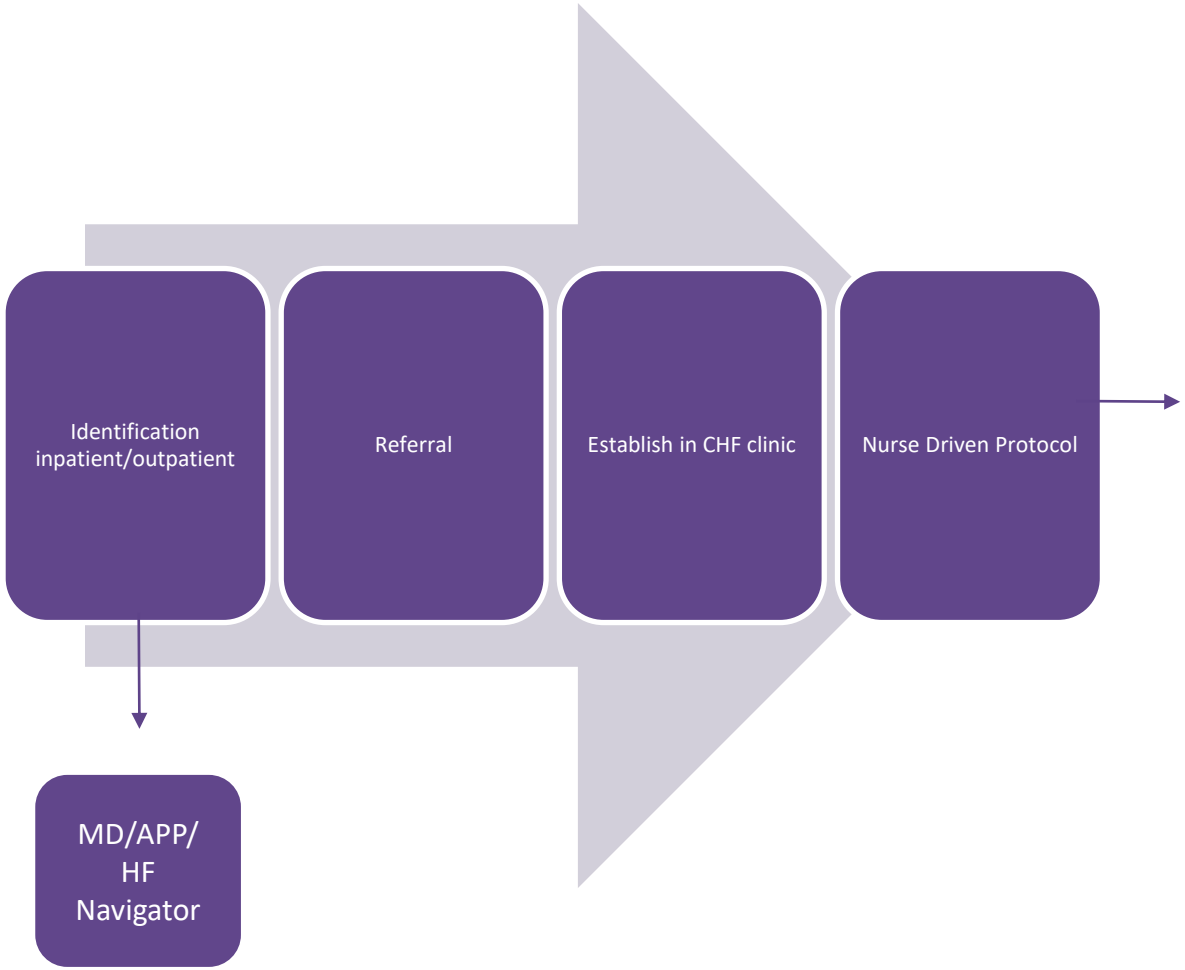
# Implantable PA Pressure Sensor




**Nurse Driven Diuretic Protocol**

- PAD Goal AND threshold to be established post-implant by APN or MD within 1-2 weeks.
- If PAD is trending >2 points above threshold for 2 or more days, diuretics increased by RN until PAD trends down.

**Bumetanide :** increase by 1-2 mg daily x2-3 days

**Furosemide:** increase by 20-40 mg x2-3 days

**Torsemide:** increase by 10-20 mg x2-3 days

**Metolazone:** must be reviewed by provider

**Furoscix (furosemide infusion):** must be reviewed by provider

- If PAD does not trend down within 3 days of above interventions, review with provider for further instruction and ensure there is a HFC appt within 3-5 days.
- If patient has not had BMP drawn within 60 days, review with provider.

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# South Region CKM Clinic

- Bluhm Cardiovascular Institute

- Inception: March 2023
- Goal: Provide patients with cardiovascular-kidney-metabolic syndrome a personalized multidisplinary care experience focused on lifestyle modifications and guideline-directed management of diabetes and concomitant heart disease.
- Patient Population: Internal cardiology and vascular clinic referrals with a primary focus on patients with CKM syndrome 2,3, and 4

**Julie E. Vanourek, APRN**

**Aryelle L. Schicht, APRN**

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## Advanced Practice Provider-Led Clinic Model

- CKM APRNs
- Pharm D/Pharmacy Tech
- Program Nurse Coordinator
- Primary Cardiologist
- Social Worker
- CKM Clinic Nurse Navigator

## Multidisplinary Collaboration

- Primary Care Physician
- Endocrinology, Hepatology, Nephrology
- Lifestyle Medicine

## Comprehensive Approach

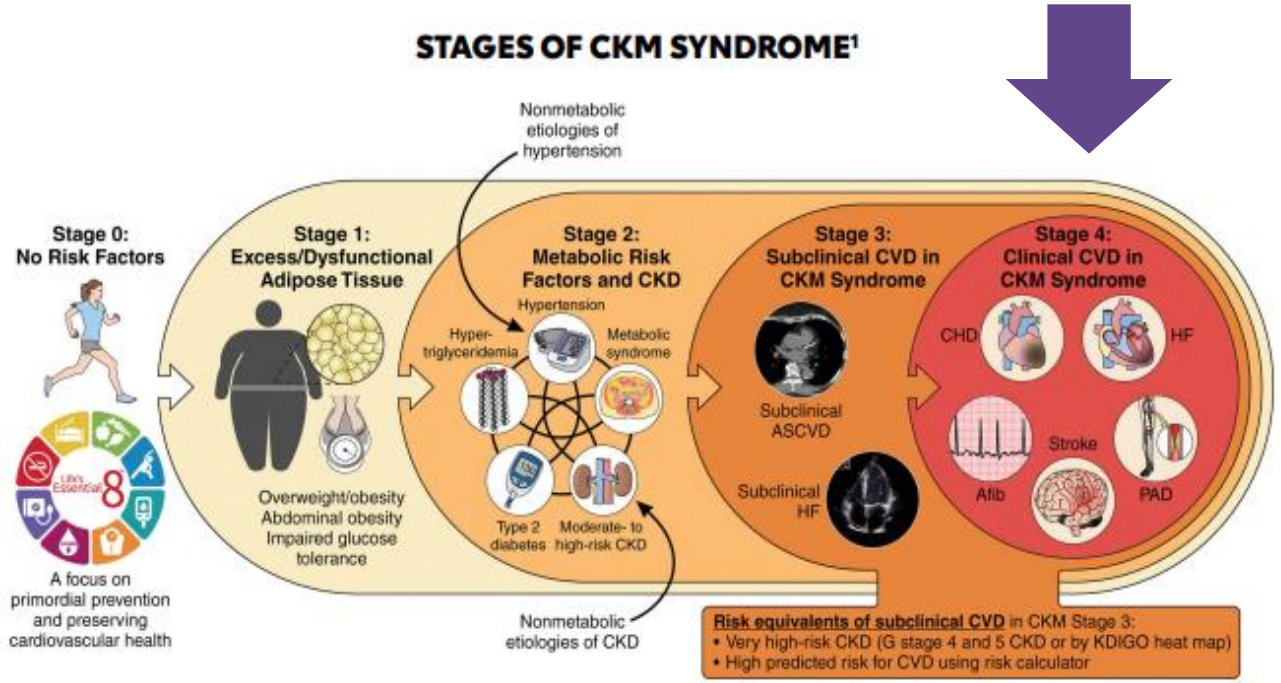
- MyFit RX Exercise Program, Cardiac Rehab, and Physical Therapy
- Diabetes Educator or Dietician
- OSA screening and smoking cessation assistance
- MASLD Screening
- KDIGO Heat Map Screening

# Referral to CKM Clinic

- A Relationship Built on Collaboration

## Heart Failure Clinic Referral Criteria

- Stage 2, 3,or 4 CKM
- T2DM
- HFpEF BMI >30* regardless of diabetes
- Moderate to Severe OSA
- MASH/MASLD




*Insurance coverage and cost are the main barriers to GLP-1 access. New CMS programs (e.g., BALANCE Model) aim to improve affordability and availability.

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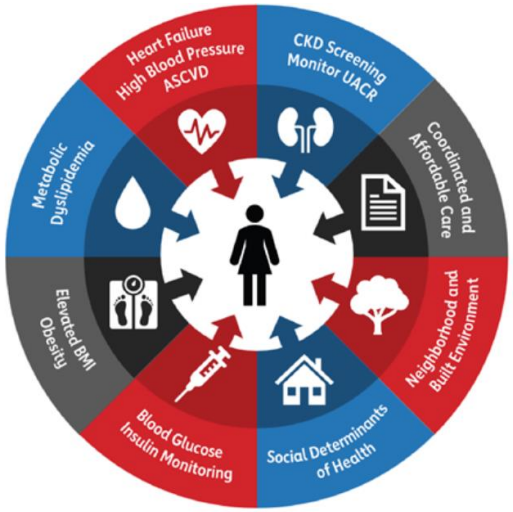
# Improving the Heart Failure Patient Experience

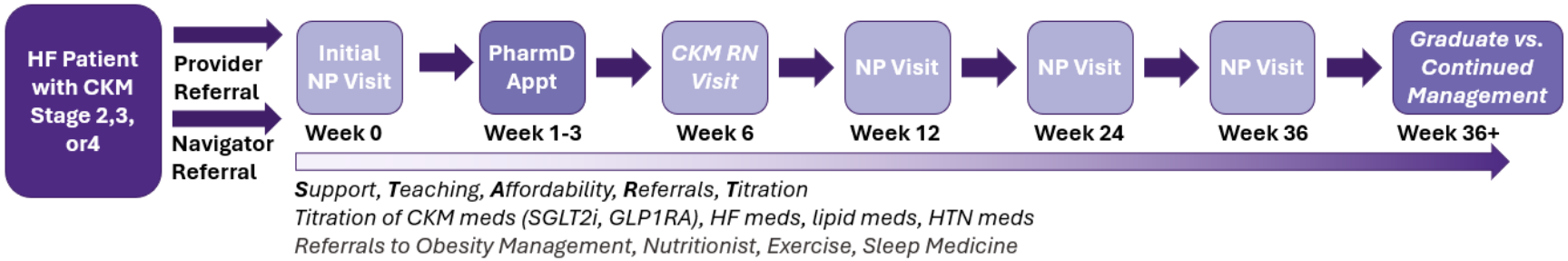
- A Relationship Built on Collaboration

  - **CKM APP** visits allows for dedicated patient time focused on CKM related patient education, medication optimization, and personalized SMART goal setting
  - **CKM PharmD** and pharmacy technician assists with improved medication adherence and cost affordability
  - **CKM RN** Visits assist with symptom management, injection education, and clinic standard of care
  - **CKM Navigator** assists with care coordination and outcomes management
  - **Social Worker** assists with addressing SDOH gaps

American Heart Association®
Cardiovascular-Kidney-Metabolic Health Initiative™




Ndumele, C.E. et al, Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart

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# Early Outcomes

- Clinically and statistically significant reductions in BMI, HgbA1c, systolic blood pressure, total cholesterol, triglycerides, and LDL cholesterol were noted
- In the 365 days prior to enrollment, 77 hospitalizations occurred in the cohort: during the mean time in the program of 327 days, there were 24 hospitalizations ($p<0.0001$), representing an annualized reduction in hospitalizations by 65.2%

| Characteristic | Baseline Value | Graduated or > 180 Enrolled Value |
|---|---|---|
| BMI (kg/m²) | 40.46 ± 9.37 | 37.32 ± 8.75 (p<0.0001) |
| HgbA1c (%) | 7.02±1.45 | 6.23±0.9 (p<0.0001) |
| Systolic BP | 122±15 | 117±14 (p<0.01) |
| Total Cholesterol (mg/dl) | 149±42 | 130±34 (p<0.0001) |
| LDL Cholesterol (mg/dl) | 79.2±35.2 | 65.1 ±25.8 (p<0.0001) |
| Triglycerides (mg/dl) | 173.9±178.9 | 132±76.6 (p<0.0004) |
| GLP1RA Use (%) | 26 (18%) | 144 (90%) |
| SGLT2i Use (%) | 59 (37%) | 96 (60%) |
| ARNI Use (%) | 44 (28%) | 57 (36%) |

Data reflective of graduate CKM patients or patients enrolled for >180 days between March 2024 and July 2025

# Opportunities & Challenges

**Challenges**

- Independent providers
  - Resource gaps
  - Variation in practice
- Disconnected systems EMR

**Opportunities- Monthly HF meeting**

- SDOH screening at 2/4-week call
- OPA- MRA/SGLT2i
- BMP order at discharge after MRA initiation

# Questions?

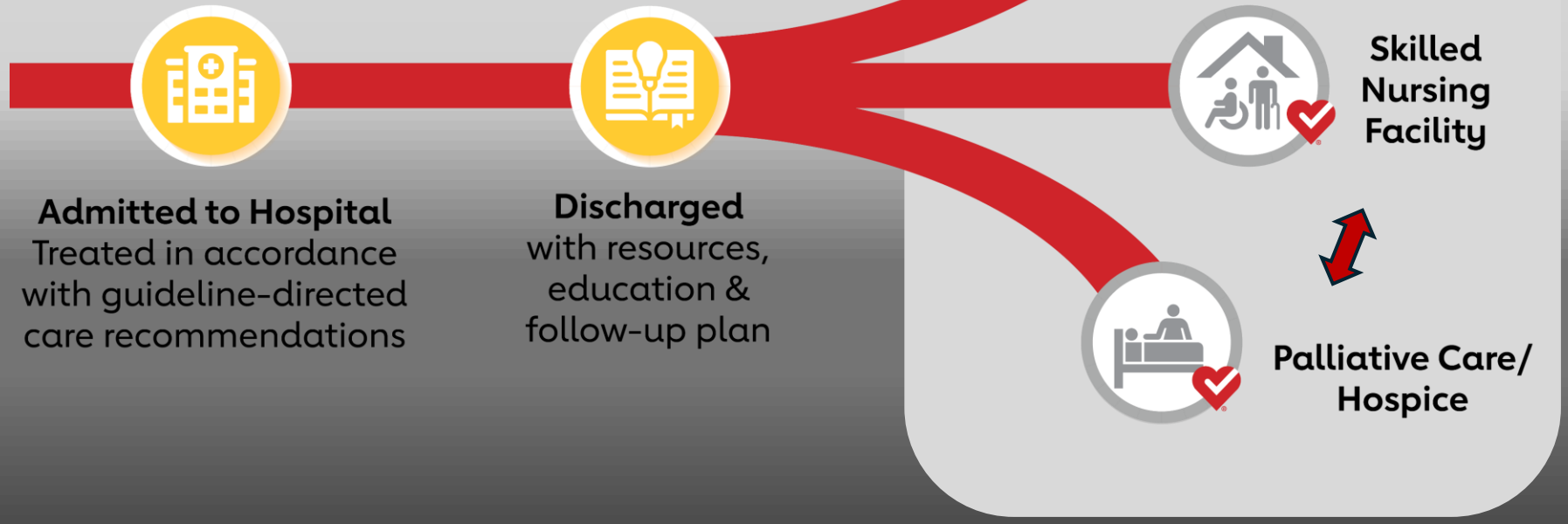

# *Thank You.*

**For any questions, please reach out to IMPLEMENT.EF@heart.org**

**Visit our website to keep up to date with IMPLEMENT-EF**
**heart.org/IMPLEMENTEF**

# A Stronger System of Care for Heart Failure Patients

American Heart Association.
Get With The Guidelines.
Heart Failure




**Admitted to Hospital**
Treated in accordance with guideline-directed care recommendations

**Discharged**
with resources, education & follow-up plan

## QUALITY IS ESSENTIAL

Are you ready to demonstrate your commitment to patient care and take your organization to the next level through American Heart Association certification?

Is your organization prepared to provide the guideline-directed quality care needed to prevent patients from returning to the hospital?

**TAKE THE FIRST STEP TODAY.**

Explore our Certified Care programs and learn how your organization can benefit from AHA certification by visiting:

**heart.org/certifiedcare**