



KEY TAKEAWAYS

The ACC's Heart House Roundtable, **Recent Advances and Ongoing Challenges in Heart Failure with Preserved Ejection Fraction (HFpEF)** identified the following 11 key opportunities when it comes to caring for patients with HFpEF:

HFpEF CARE TEAM/ WORKFORCE DEVELOPMENT

01

Develop awareness and educational campaigns.

There is a need to educate healthcare team members on recognition of HFpEF, red flags which should raise suspicion, and use of standardized diagnostic criteria and biomarkers to improve early and accurate treatment. Additionally, public health campaigns directed towards patients should be considered to promote awareness around HFpEF signs and symptoms to ensure they are not dismissed for other comorbidities or aging. This will help support timely, appropriate care.

02

Strengthen the workforce to accommodate the surge of patients.

Appropriate training and education of primary care and cardiovascular team members may help mitigate some of the challenges in overcoming limited access to heart failure specialists. ACC should consider partnering with other medical societies such as the American College of Physicians, and the American Association of Heart Failure Nurses, to increase awareness, develop joint programming and create toolkits and decision support tools to broaden awareness and among all health care team members involved in HFpEF care.

03

Reinforce the critical need for a multidisciplinary health team approach to provide care for complex comorbidities.

Patients with HFpEF have multiple comorbidities including diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and obesity among others. A multispecialty clinic centered around the patient may help facilitate appropriate and timely initiation of therapies directed to these comorbidities.

PROPER AND TIMELY DIAGNOSIS OF HFpEF

04

Highlight the importance of ruling out masqueraders or overlapping diagnosis.

There is a need for guidance regarding overlapping syndromes which need to be excluded prior to diagnosis of HFpEF. This should include guidance to screen for pulmonary hypertension and appropriate referral to a pulmonary hypertension program.

05

Identify criteria for provocative and/or invasive testing.

Some patients may require further testing including provocative stress testing or invasive testing. A set of criteria could be developed to guide clinicians on appropriate referral and indication for further testing.

06

Create a toolkit to promote timely and appropriate referral to specialists.

There is a need for creation of diagnostic algorithms and prompts to raise suspicion for HFpEF and facilitate timely referral of patients. ACC should develop toolkits, including mobile applications, that offer guidance in these areas for clinicians at different specialty and practice settings for their use at the point of care.

HFpEF THERAPIES

07

Identify a practical algorithm for HFpEF management.

New therapies are now available for the management of HFpEF. There is a need to define which therapy should be aligned with specific phenotypes. This would facilitate initiation of appropriate therapy by primary care and general cardiologists. Additionally, consensus recommendations are needed to guide initiation of therapy, recognize failure of response, and assist with referrals to specialists if additional testing or interventions are warranted.

08

Harness telehealth for care delivery and access, to reduce disparities.

Telehealth visits should be considered for patients requiring specialty care, particularly those in rural areas as well as the elderly and underserved communities, who have limited access to specialists and multidisciplinary care team members to address comorbidities.

09

Support payment models that encourage innovative care delivery

As telehealth and multispecialty care models evolve, further efforts need to be made to support payment models that include exercise therapy and weight reduction programs for patients with HFpEF. There is a need for innovative payment models for appropriate reimbursement of multidisciplinary care team participants.

10

Improve prior authorization process for novel HFpEF therapies.

With new pharmacological options available, clinicians need to be able to prescribe and avail of these therapies easily for increased adoption and implementation. Administrative burden and prior authorization requirements need to be streamlined to avoid treatment delays, overcome therapeutic inertia and improve outcomes for the patient.

11

Promote the need for further research on emerging therapies.

More clinical trials focused on HFpEF are needed to help develop evidence-based options for treatment with particular focus on defining particular groups which may benefit from specific therapies. Trial design should consider a more diverse set of patients to account for the heterogeneity of the syndrome to encourage a more personalized approach to management.

