LBS 9 EMBARGOED Media Briefing 7:30-8:30 am CT, Tuesday, Nov. 17, 2020.

[LBS 9 Briefing Speakers](https://newsroom.heart.org/_gallery/get_file/?file_id=5facb9862cfac2160eb376f5&file_ext=.docx&page_id=) (doc) (Updated 11/16/2020)

Larry Allen – EPIC-HF

It's my honor on behalf of my colleagues to present the [Indiscernible] funded EPIC-HF trial. As Don nicely summarized were well aware of gaps in prescribing evidence-based medications to patients with heart failure. As Don also showed there are significant efforts that have been made to close that gap. Primarily I think for two approaches. One is the focus of providers and decisions around their prescribing, as well as focus on patients trying to educate them about adherence and self- care. And I think that this is being held up by clinical inertia on the providers side and disempowerment on the patient's eye. We believe that and activate a patient who participate in shared decision-making around prescribing decisions could help overcome these problems. Therefore, we developed the EPIC-HF intervention which postulated that patient activated prior to a clinical appointment would be more likely to engage their clinician around their medication plan, which will prompt greater prescribing of medications known to improve outcomes. This involved a three minute video that was delivered to patients either through a [Indiscernible] e-mail URL link, which then led to one page checklist that patients were encouraged to bring to their appointments. We conducted this study through the UC health or University of Colorado health system which is centered in Denver and spans the front range of Colorado. We screened 699 patients. Of these about 200 we're ineligible either because they did not have e-mail and text capability or their physician felt they were not ideally suited for the trial. Another 200 or so patients said they were not interested in the study leaving us 306 patients who we're randomized to either receive the intervention or not. As it turned out in each arm about eight patients did not attend clinic, and so we were left with 145 patients in each arm of the trial, all of whom attended the clinic visit and were alive 30 days later. These patients were similar to many studies of HERE have. Average age was about 65 years. 30% we're female, 11% were African American, 15% had Medicaid as the primary insurance. About 50% of patients received the tool through text messages and the other half through e- mail. And then importantly most of these patients did not have a blood pressure heart rate or renal dysfunction that would preclude the use of many therapies for HEFreF.

This is a summary of the medications for HEFreF patients were getting coming into the index clinic visit. This is prior to seeing their provider when they were either in control or have the intervention. Importantly the vast majority of these patients were on evidence-based beta-blocker but half of those patients were at a dose less than 50% recommended. In terms of [Indiscernible] majority were on these but again dosing was suboptimal. Very few patients were on [Indiscernible] R10. About half the patients were on [Indiscernible] or [ Indiscernible]. Importantly, when you look at these together 0 percent of patients were on target dose of evidence-based beta-blocker and [Indiscernible] receptor antagonist. When we went and looked at whether patients received the intervention, about two-thirds of patients said they viewed the video and the checklist. And then about half of the patients dropped the checklist to the clinic to discuss it with their provider. Here is the primary endpoint which was any increase guideline directed medical therapy at 30 days from before clinic visit until after. You can see that in the control group about [Indiscernible] percentage of patients had permanent guideline directed medical therapy. In the intervention group this was increased by 19% to about 50% of patients. This was a statistically significant improvement in care. It would look at the types of intensification looking at the breakdown of what happens to these patients, most of the changes that happened we're due to an increase in the dosing or up titration of existing medicines that patients were already getting. And one look by drug class we could see that the majority of the intensification's actually occurred for generically prescribed evidence-based beta- blockers with a dose intensification of those. We did look at safety. The study was not powered to see important differences in clinical outcomes, but at 30 days there were no deaths and the summary of that hospitalization and Emergency Department were 10% in the treatment group and 6% in the control group. And nonsignificant 4% increase of in those receiving the i ntervention. In conclusion, three-minute patient activation video plus one page medication checklist liver to patients with HrEFF immediately before cardiology visit resulted in increased from 30% to 49% of patients who had an intensification of the guideline directed medical therapy. The majority of these is involved a dose increase in generic beta-blockers. Clinical inertia accounts for some portion of underuse of guideline directed medical therapies in HrEFF and this can be partially overcome by engaging patients in describing decisions. Thank you.