

Improving Heart Failure Care: Strategies for Increasing Utilization of Beta-Blockade

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The incidence and prevalence of heart failure in the United States continues to increase, and the associated morbidity and mortality remain unacceptably high. More than 1 million patients will be hospitalized with heart failure this year, with as much as \$23 billion dollars spent on the inpatient management of heart-failure patients. Patients who have been recently been hospitalized with heart failure are at particularly high risk for morbidity and mortality.

There is compelling clinical trial evidence that medical therapies including angiotensin-converting enzyme (ACE) inhibitors and β -blockers reduce the risk of hospitalization and substantially improve survival in patients with heart failure. Despite this evidence, as well as national and international clinical guidelines recommending ACE inhibitor and β -blocker treatment in stabilized patients with heart failure due to systolic dysfunction, a number of studies have documented low treatment rates in this patient population. The under-use of β -blocker therapy and other protective therapies in patients with heart failure represents a major clinical practice and public health issue. Recently, systems for in-hospital initiation of evidence-based medical therapies in patients hospitalized with cardiovascular disease have been shown to improve treatment rates, long-term patient compliance, and clinical outcomes. As the majority of patients hospitalized for acutely decompensated heart failure have achieved clinical stability and are no longer fluid overloaded prior to hospital discharge, hospitalization provides an important opportunity to initiate β -blocker therapy. Widespread application of hospital-based β -blocker treatment initiation programs for heart failure could dramatically increase rates of use for this proven, cost-effective therapy and thus substantially reduce the risk of recurrent hospitalizations and death in the large number of patients hospitalized with heart failure each and every year.

The goals of this supplement to *Reviews in Cardiovascular Medicine* are to describe the morbidity and mortality risk with heart failure and the opportunities to improve the quality of patient care for this patient population. The standard of care for patients with heart failure will be discussed, and the evidence for supporting β -blocker use in severe heart failure and special populations will be provided. Potential reasons for delayed uptake of evidence-based medicine among physicians will be reviewed. The value of hospital-based systems to improve treatment rates and clinical outcomes will also be described. Strategies that may be useful in bridging the gap between evidence-based medicine and clinical practice will be provided. It is our hope that this information will prove useful in improving the quality of heart-failure patient care and, through improved use of evidence-based, life-saving therapies, ultimately reduce death and disability due to this disease state. ■