GDMT Without Gaps: Building and Maintaining Optimal Therapy Across the Patient Journey

2026 OSHP Annual Seminar

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Disclosure Statement

I have no relevant financial relationship(s) with ineligible companies to disclose.

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Learning Objectives

1. Apply evidence-based practices to safely initiate and titrate guideline directed medical therapy across the patient care continuum.
2. Evaluate barriers during transitions of care and opportunities for meaningful pharmacist's interventions.
3. Design patient-centered medication regimens that optimize heart failure patient outcomes.

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Pre-Test Question #1

Which of the following is true regarding initiation of GDMT?

a) SGLT2-inhibitors frequently cause urinary tract infections and should be avoided in women

b) A patient with a history of angioedema while taking lisinopril can be cautiously initiated on ARNI

c) MRA's have strong blood pressure lowering effects, and should only be initiated in patients with a SBP > 110

d) MRA's can cause hyperkalemia and should not be initiated in patients with eGFR < 30 or K > 5.0

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Pre-Test Question #2

Which of the following are potential barriers to medication adherence in the heart failure population?

a) Complex pharmacotherapy regimens

b) Medication cost

c) Low health literacy

d) All of the above

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Pre-Test Question #3

DB is a 68 year old male who has been admitted to the hospital for new onset heart failure. Prior to presentation, he had gained about 30 lbs over the past 6 months and noted a progressive loss of exercise tolerance over time. So far this admission, DB has received several doses of IV furosemide. His SCr today is 1.5 (baseline ~1.1). Today, the medical team would like to start GDMT and reach out to you for your recommendations. You tell them:

a) Initiation of GDMT in the hospital setting has been associated with poor outcomes and should be delayed until stable post-discharge.

b) Due to the patient's AKI, initiation of ARNI, MRA, and SGLT2i should be delayed until the SCr returns to baseline.

c) The addition of ARNI, MRA, and SGLT2i may help augment diuresis and can be safely started concomitantly at this time.

d) Metoprolol succinate should be initiated and up-titrated daily with the goal to reach target dose by day of discharge.

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Burden of Heart Failure

- 6.7 million Americans diagnosed with heart failure
- 1.2 million heart failure hospitalizations annually
- $32 billion in direct medical costs annually

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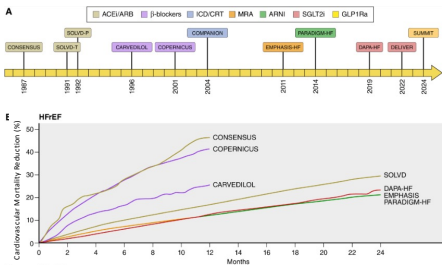

Circulation. 2025; 151(9): 585-588.

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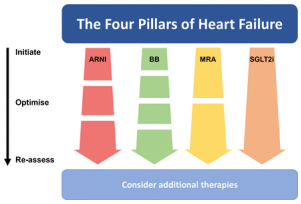
The Core Four



Open Heart. 2021;8:e001585.

ARNI, angiotensin receptor-neprilysin inhibitors; BB, beta-blocker; MRA, mineralocorticoid receptor antagonists; SGLT2i, sodium-glucose co-transporter 2 inhibitors

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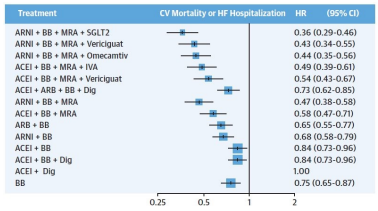
The Impact of Combination Therapy



JACC: Heart Failure, 2022; 10(2): 73-84

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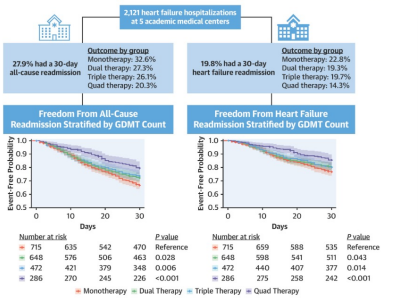
CENTRAL ILLUSTRATION: Probability of Readmission Within 30 Days



JACC Adv. 2026; 5(1): 1-11

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… Yet many patients don't receive optimal treatment regimens

	2021	2022	2023
BB at discharge	93.4%	94.3%	94.6%
→ ARNI at discharge	49.3%	57.0%	61.1%
ACE, ARB, or ARNI at discharge	91.8%	92.6%	92.6%
→ MRA at discharge	57.1%	61.3%	68.1%
→ SGLT-2i at discharge	10.8%	37.5%	60.6%

Journal of Cardiac Failure, 2026; 32(2): 439-498

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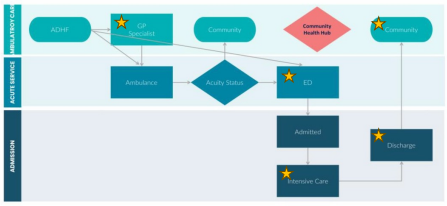
Heart Failure Patient Journey



All of these touch-points are opportunities to optimize GDMT

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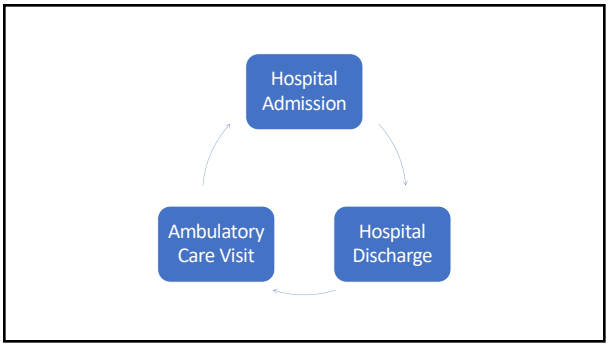

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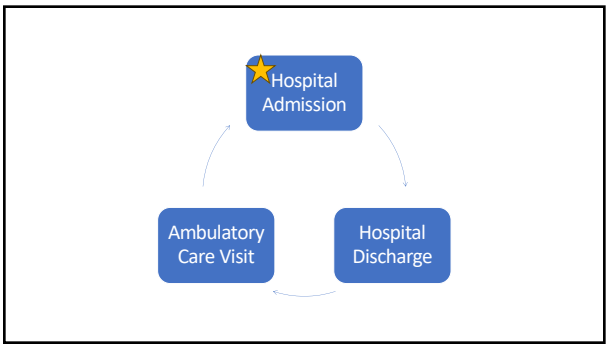

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Patient Case - DB

62 year old man with PMH of hypertension, type 2 diabetes, hyperlipidemia, and former tobacco use

Presenting with progressive dyspnea, orthopnea, and bilateral leg swelling

Key labs include:

- BNP 1,200 pg/mL
- A1c: 8.2%
- Scr 1.3 (baseline 1.0)

Current medications include:

- Lisinopril 10 mg daily
- Metformin 1000 mg BID
- Atorvastatin 40 mg daily

ECHO shows new LVEF 30%

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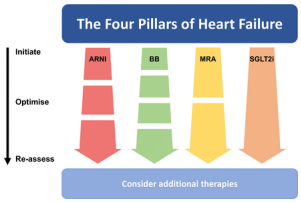
The Core Four – How to Initiate?



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ARNI, angiotensin receptor-neprilysin inhibitors; BB, beta-blocker; MRA, mineralocorticoid receptor antagonists; SGLT2i, sodium-glucose co-transporter 2 inhibitors

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Renin-Angiotensin System Blockade

Drug	Initial Daily Dose	Target Dose
ACEi		
Captopril	6.25 mg TID	50 mg TID
Enalapril	2.5 mg BID	10-20 mg BID
Lisinopril	2.5-5 mg once daily	20-40 mg once daily
Fosinopril	5-10 mg once daily	40 mg once daily
Perindopril	2 mg once daily	8-16 mg once daily
Quinapril	5 mg BID	20 mg BID
Ramipril	1.25-2.5 mg once daily	10 mg once daily
Trandolapril	1 mg once daily	4 mg once daily
ARB		
Candesartan	4-8 mg once daily	32 mg once daily
Losartan	25-50 mg once daily	50-150 mg once daily
Valsartan	20-40 mg once daily	160 mg twice daily
ARNI		
Sacubitril-valsartan	24-26 mg to 49-51 mg BID	97-103 mg BID

Circulation. 2022; 145(18): e895-1032.

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Renin-Angiotensin System Blockade

Angiotensin Receptor – Neprilysin Inhibitors (ARNi)
- First line therapy for those with HFrEF
- De-novo initiation or as escalation of therapy

Angiotensin-Converting Enzyme Inhibitors (ACEi)
- First line in those who do not tolerate ARNI or if cost is a limitation
- Do not use if history of angioedema

Angiotensin-II Receptor Blockers (ARB)
- Agents of choice when ARNi and ACEi cough or angioedema develop

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ARNI Inpatient Initiation = Better Outcomes

PIONEER-HF
- Question: is ARNi initiation in-hospital safe/effective vs ACEi?
- At 4- and 8-week evaluation:
  - ARNi showed significantly lower NT-pro BNP vs ACEi
  - ARNi < HF rehospitalization 0.56 (0.37-0.84)
  - ARNi < composite of serious clinical events 0.54 (0.37-0.79)

TRANSITION Trial
- Question: is it safe to initiate ARNi in-hospital vs as outpatient?
- By 10 weeks post-discharge:
  - No difference in tolerability
  - No difference in rate of achieving 97/103 dose

PIONEER-HF. NEJM, 2019; 380(6): 539-548; TRANSITION. Eur J Heart Failure, 2019; 21: 998-1007

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RAAS Blockade – Clinical Pearls

ARNi
- Diuretic effect
- More hypotension
- May cause SrCr increase
- May increase uric acid
- Bradykinin cough possible
- Angioedema risk

ACEi
- Bradykinin cough possible
- May cause SrCr increase
- Daily dosing possible
- Angioedema risk

ARB
- May cause SrCr increase
- No effect on bradykinin
- Daily dosing possible, but BID dosing recommended

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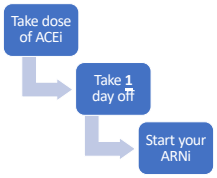
Transitioning ACEi to ARNI

Logistics: 36 hr washout



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Beta Blockers

Drug	Initial Daily Dose	Target Dose
Bisoprolol	1.25 mg once daily	10 mg once daily
Carvedilol	3.125 mg BID **with meals**	25-50 mg BID* **with meals**
Carvedilol CR	10 mg once daily **with food**	80 mg once daily **with food**
Metoprolol succinate XR	12.5-25 mg once daily	200 mg once daily

*Patients < 85 kg: target 25 mg BID
Patients > 85 kg: target 50 mg BID

Circulation. 2022; 145(18): e895-1032.

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Beta Blockers

- Not all beta blockers are created equally
- Guideline Recommended Beta Blockers:
  - Bisoprolol
  - Carvedilol
  - Sustained-release metoprolol succinate

Drug	Selectivity	B_1 activity	Alpha$_1$ activity
Bisoprolol	B_1 selective	+	0
Carvedilol	Nonselective	+	++
Metoprolol	B_1 selective	+	0

Clinical Pearl: carvedilol may have anti-hypertensive properties that metoprolol and bisoprolol do not

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Beta Blockers – Clinical Pearls

- Exercise intolerance is temporary
  - Important to talk to patients about this
- Dose titration = Start low, go slow
- Can take at bedtime to minimize fatigue
- Metoprolol succinate should not be quartered or crushed
- Carvedilol may have more blood pressure lowering effects

JACC, 2017; 69(20): 2542-2550. Circulation, 2022; 145(18): e895-e1032

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Mineralocorticoid Receptor Antagonists

Drug	Initial Daily Dose	Target Dose
Spironolactone	12.5-25 mg once daily	25-50 mg once daily
Eplerenone	25 mg once daily	50 mg once daily

When to initiate?

- eGFR > 30 mL/min/1.73 m^2 and serum potassium < 5.0 mEq/L

When to hold?

- Serum potassium cannot be maintained at < 5.5 mEq/L

Circulation. 2022; 145(18): e895-1032.

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Mineralocorticoid Receptor Antagonists

Ways to mitigate hyperkalemia?

- Add an SGLT2i
- Consider a potassium binder

What about blood pressure?

- Blood pressure minimally impacted by MRAs
- RALES (NS Δ), EPHESUS (↑ 5/3 mmHg vs ↑ 8/4 mmHg w/placebo), EMPHASIS-HF (↓ 2.5 mmHg vs ↓ 0.3 mmHg)

Gynecomastia risk?

- 10% with spironolactone vs <1% with eplerenone

RALES. NEJM, 1999:341:709-17. EPHESUS. NEJM, 2003;348(14):1309-21. EMPHASIS. NEJM, 2011;364(1):11-21. Int J Cardiol, 2015; 200(2015): 25-29.

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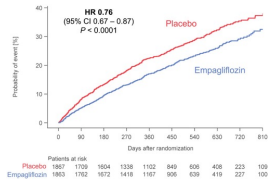
SGLT2i

Drug	Initial Daily Dose	Target Dose
Dapagliflozin	10 mg once daily	10 mg once daily
Empagliflozin	10 mg once daily	10 mg once daily
Sotagliflozin	200 mg once daily	400 mg once daily

58% relative reduction in death, hospitalization for heart failure, or an emergency or urgent heart failure visit at **12 days after initiation**



Circulation. 2022; 145(18): e895-1032. Circulation. 2021; 143(4): 326-336

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SGLT2i – Clinical Pearls

- Some diuretic properties – consider adjusting other diuretics
- Euglycemic DKA not reported in non-diabetic patients
- Currently considered contraindicated in Type 1 diabetic patients, but more studies underway
- Slows progression of kidney disease, more studies underway

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SGLT2i and UTI Risk

Trial	Study Drug	Number of Patients	UTI – Treatment	UTI – Control	Complicated UTI – Treatment	Complicated UTI – Control	Genital Mycotic Infection – Treatment	Genital Mycotic Infection – Control
DAPA-HF	Dapagliflozin	4,744	0.5%	0.7%	0.3%	0.3%	--	--
EMPEROR-Reduced	Empagliflozin	3,730	4.9%	4.5%	1.0%	0.8%	1.7%	0.6%

Meta-analysis of 72 SGLT2i trials showed no significant difference in UTI rate vs placebo (1.03 [0.93-1.11])

Discontinuation of SGLT2i can lead to increased all-cause death and heart failure related hospitalizations

Risk factors include:

- Female sex
- Older age
- Diabetes with uncontrolled A1c

JACC. 2024; 83(16): 1568-1578. Acta Diabetol. 2018; 55(58):503-514.

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What changes do you recommend for DB's regimen while he is admitted?

ECHO shows new LVEF 30%

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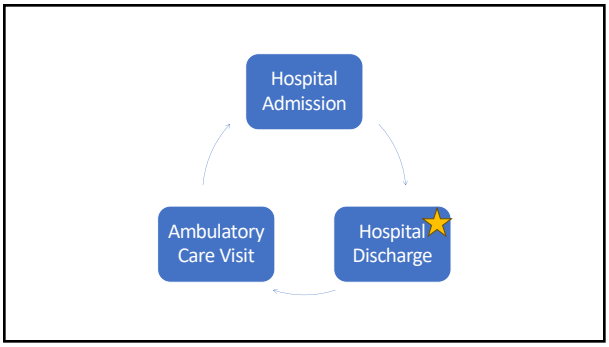

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Patient Case - DB

With diuresis, weight down 8 lbs and improved dyspnea

Key labs include:

- SCr 1.1
- K 4.8

Medically ready for discharge!

Discharge medications include:

- Sacubitril/valsartan 24/26 mg BID
- Metoprolol succinate 25 mg daily
- Spironolactone 25 mg daily
- Empagliflozin 10 mg daily
- Torsemide 20 mg daily
- Continue atorvastatin and metformin from prior to admission

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Original Article

Impact of Heart Failure Transitions of Care Program: A Prospective Study of Heart Failure Education and Patient Satisfaction

Aubrey A. Mills, Kathryn M. Rodeffer, and Sarah L. Quick

- Single center experience with implementing pharmacist-lead medication education for heart failure patients
- Primary outcome of 30-day all cause readmission
  - 13.5% vs 19.6% (p=0.0395)

Hosp Pharm, 2021; 56(4): 252-258

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Your Heart Failure Medications

There are several types of heart failure medications. Work with your healthcare provider to identify which medications you have been prescribed and the reason you are taking each of them. Taking your medications as prescribed will help manage your heart failure and symptoms.

Ask your healthcare provider and pharmacist what you should expect from your medications and ways to prevent or reduce side effects. Also, be sure to find out when to call your healthcare provider for help managing serious side effects.

Drug Class	Your Doctor Prescribed	How It Works	Side Effects	Notes
Angiotensin Converting Enzyme (ACE) Inhibitor	Lisinopril (Zestril, Prinivil) Enalapril (Vasotec) Benazepril (Lotensin) Captopril (Capoten) Quinapril (Accupril) Ramipril (Altace)	• Relaxes blood vessels which causes a decrease in pressure on the heart. This results in a lowering of blood pressure.	Low blood pressure (dizziness or feeling light-headed). Cough (dry, no mucus, production). Change in kidneys' ability to filter things out of the body. Increase in potassium. Allergic reaction (face, lips, tongue swelling)	Your doctor may change your dose over time. Lab tests will be monitored (potassium, and kidney function). **Seek medical attention if** swelling of the face, lips, or tongue occur.
Angiotensin Receptor Blocker (ARB)	Candesartan (Atacand) Losartan (Cozaar) Valsartan (Diovan)	• Relaxes blood vessels which causes a decrease in pressure on the heart. This results in a lowering of blood pressure.	Low blood pressure (dizziness or feeling light-headed). Change in kidneys' ability to filter things out of the body. Increase in potassium. Allergic reaction (face, lips, tongue swelling.	Similar to ACE inhibitor. Your doctor may change your dose over time. Lab tests will be monitored (potassium, and kidney function). **Seek medical attention if** swelling of the face, lips, or tongue occur.

Hosp Pharm, 2021; 56(4): 252-258

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Preparing for Hospital Discharge

Medication education

- Changes from prior to admission medication list
- New medication counseling
- Medications to avoid
- Teach-back method

Establish a plan for filling new prescriptions

Identifying barriers to adherence

Providing medication adherence aids

Adv Ther, 2018; 35:311-323

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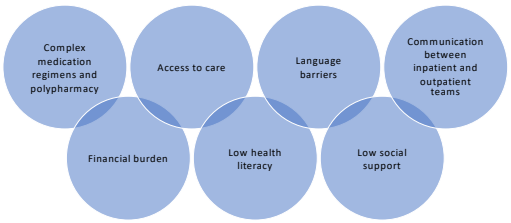
Barriers To Care



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Promoting Medication Adherence

- Simplified medication regimens
- Education and establishing expectations
  - Take your medications even if you are feeling well
  - Your dose may increase in the future
- Addressing cost barriers
- Pill organizers
- Medication reminder Apps

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Mobile Medication Reminder Apps **Available on Apple and Android devices

	CVS	Walgreens	MyMedSchedule	MediSafe	Mango Health	MyMeds	MedSimple
Free	✓	✓	✓	✓	✓	$9.99/year	$9.99/year (90-day free trial)
Medication Reminders	✓	✓	✓	✓	✓	✓	✓
Tracks Doses Taken/Missed	✓	✓	✗	✓	✓	✓	✗
Refill Reminders	✓	✓	✓	✓	✓	✓	✓
Ready for Pick Up Alert	✓	✓	✗	✗	✗	✗	✗
Offers Online Data Entry	✓	✓	✓	✓	✗	✓	✓
Share List of Medications	✗	Print, Email	Print	Print, Email	✗	Print, Email, Text	Print, Email
Extra Features	• Setup family profiles • Scan to refill prescription • Transfer prescriptions • Pharmacy locator	• Scan to refill prescription • Transfer prescriptions • Pharmacy locator	• Create and print wallet-size list of medications and schedule • *My Health Tracker* for lab results and vital signs	• Program family members to receive alerts if medication is not taken • Setup family profiles • Snooze reminder	• Earn points for taking medicine with the chance to win rewards (e.g., gift cards, charity donation) • Drug interaction warnings	• Setup family profiles • Record drug allergies, doctors, and pharmacies • Track immunization records	• Record drug allergies, doctors, and pharmacies • Cost savings – drug discount card, pharmacy programs (e.g., $4 lists, coupons)
Available Languages	English	English	English, Spanish	English, Spanish, Arabic, Chinese, French, Russian	English	English	English
HIPAA Compliant	✗	✓	✓	✓	✗	✓	✓
Website	cvs.com	walgreens.com	mymedschedule.com	medisafe.com	mangohealth.com	my-meds.com	medsimpleapp.com

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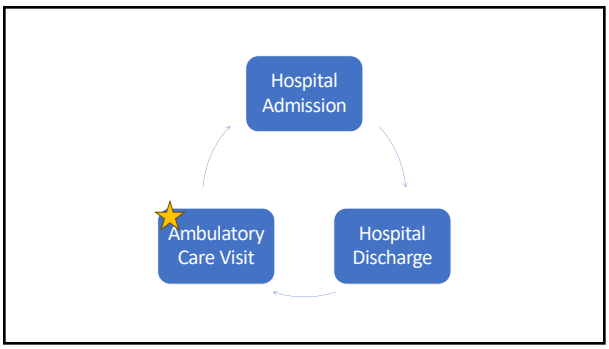

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Patient Case - DB

Seen 1 week post-discharge

Weight stable, reports some mild fatigue

Key labs and vitals:

- SCr 1.1
- K 5.0
- BP 118/72
- HR 62

Admits to some missed doses of medications

Current Medication List:

- Sacubitril/valsartan 24/26 mg BID
- Metoprolol succinate 25 mg daily
- Spironolactone 25 mg daily
- Empagliflozin 10 mg daily
- Torsemide 20 mg daily
- Metformin 1000 mg BID
- Atorvastatin 10 mg daily

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STRONG-HF

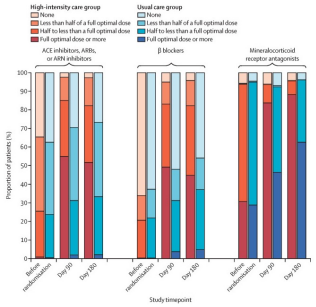
"Usual Care" vs "High-intensity" titration

Primary Endpoint: 6-month HF readmission or all cause mortality
15.2% vs 23.3% favoring high-intensity group (p 0.0021)

Also significantly less:
- NT pro-BNP
- Edema
- HF readmission or death at 3 months

However, high-intensity group experienced more adverse events:
- Hypotension (5% vs 1%)
- Hyperkalemia (3% vs 0%)
- AKI (3% vs <1%)

Lacet, 2022; 400: 1938-52



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Practical Titration Schedule

Drug Class	Day 1	Day 7-14	Day 14-28	Day 21-42	> Day 42
ARNI	Initiate (low dose)	Continue	Titrate as able	Titrate as able	Maintain or titrate all 4 classes
B-Blocker	Initiate (low dose)	Titrate as able	Titrate as able	Titrate as able	Consider EP device
MRA	Initiate (low dose)	Continue	Titrate as able	Continue	MVR if indicated
SGLT2i	Initiate	Continue	Continue	Continue	Add-on therapies if refractory
					Manage comorbidities

JAMA Cardiol, 2021; 6(7): 743-744

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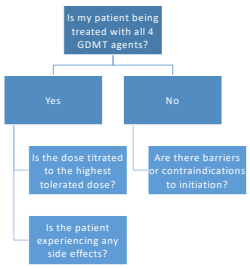

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Patient Case - DB

What changes do you recommend for DB's regimen while he is in clinic?

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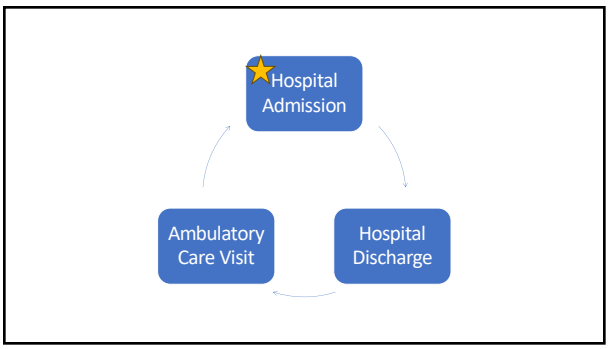

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Patient Case - DB

6 weeks later, DB presents to the ED with worsening dyspnea and 10 lb weight gain in past 3 days

Key Vitals and Labs

- BP 150/88
- HR 110
- SCr 1.8
- NT-pro BNP 8,446 pg/mL

Admitted for acute decompensated heart failure

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Patient Case - DB

What is the reason for decompensation, and could a problem with a medication be contributing?

What medications should we continue on admission, and what medications should be held?

Prior To Admission Medication List:

- Sacubitril/valsartan 24/26 mg BID
- Metoprolol succinate 25 mg daily
- Spironolactone 25 mg daily
- Empagliflozin 10 mg daily
- Torsemide 20 mg daily
- Metformin 1000 mg BID
- Atorvastatin 10 mg daily

DB tells you that he ran out of his HF medications ~10 days ago

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Clinical Inertia

Lack of treatment initiation or intensification in a patient not at evidence-based goals for care

- Includes delays in starting, titrating, or optimizing GDMT
- Significantly increases risk of poor outcomes (mortality, hospitalization rates) and increases healthcare costs
- Multifactorial
  - System-related factors
  - Patient-related factors
  - Physician-related factors

Heart Fail Rev, 2020; 26(6): 1359-1370.

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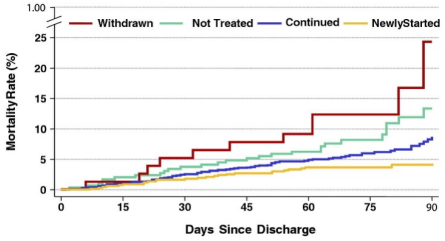
Post-Discharge Survival Related to Beta-Blocker Treatment



JACC, 2008; 52(3): 190-199.

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Consequences of withholding GDMT while inpatient

- Increased risk of readmission and short-, intermediate-, and long-term mortality
- Decreased medication adherence
- Increased likelihood of never being initiated or switched to GDMT as outpatient
- Missed opportunity for teaching moment during hospitalization

JACC HF, 2019; 7(1): 1-12

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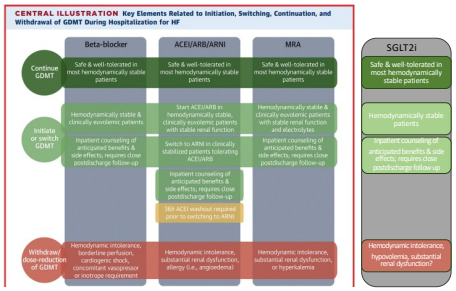

JACC HF, 2019; 7(1): 1-12

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Is your patient…

Hypotensive? Requiring vasopressors?
- Hold ACE/ARB/ARNI, BB

In cardiogenic shock? Requiring inotropes?
- Hold beta-blocker
- Consider holding ACE/ARB/ARNI, SGLT2, MRA

Hypovolemic?
- Hold SGLT2
- Consider holding ARNI, MRA

Experiencing severe renal impairment?
- Hold ACE/ARB/ARNI, MRA

Hyperkalemic?
- Hold ACE/ARB/ARNI, MRA

JACC HF, 2019; 7(1): 1-12

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Patient Case - DB

6 weeks later, DB presents to the ED with worsening dyspnea and 10 lb weight gain in past 3 days

Key Vitals and Labs

- BP 150/88
- HR 110
- SCr 1.8
- NT-pro BNP 8,446 pg/mL

Do any of DB's HF medications need to be held at this time?

Admitted for acute decompensated heart failure

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Closing Thoughts

- GDMT significantly improves survival and reduces hospitalization
- Timely initiation and titration of GDMT are critical to optimizing patient outcomes
- Every patient interaction is an opportunity for GDMT optimization
- Transitions of care are high-risk periods where pharmacist interventions can significantly improve outcomes

Proactive, pharmacist-driven GDMT optimization across transitions of care is key to improving heart failure outcomes

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Post-Test Question #1

Which of the following is true regarding initiation of GDMT?

a) SGLT2-inhibitors frequently cause urinary tract infections and should be avoided in women
b) A patient with a history of angioedema while taking lisinopril can be cautiously initiated on ARNI
c) MRA's have strong blood pressure lowering effects, and should only be initiated in patients with a SBP > 110
d) MRA's can cause hyperkalemia and should not be initiated in patients with eGFR < 30 or K > 5.0

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Post-Test Question #2

Which of the following are potential barriers to medication adherence in the heart failure population?

a) Complex pharmacotherapy regimens

b) Medication cost

c) Low health literacy

d) All of the above

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Post-Test Question #3

DB is a 68 year old male who has been admitted to the hospital for new onset heart failure. Prior to presentation, he had gained about 30 lbs over the past 6 months and noted a progressive loss of exercise tolerance over time. So far this admission, DB has received several doses of IV furosemide. His SCr today is 1.5 (baseline ~1.1). Today, the medical team would like to start GDMT and reach out to you for your recommendations. You tell them:

a) Initiation of GDMT in the hospital setting has been associated with poor outcomes and should be delayed until stable post-discharge.

b) Due to the patient's AKI, initiation of ARNI, MRA, and SGLT2i should be delayed until the SCr returns to baseline.

c) The addition of ARNI, MRA, and SGLT2i may help augment diuresis and can be safely started concomitantly at this time.

d) Metoprolol succinate should be initiated and up-titrated daily with the goal to reach target dose by day of discharge.

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GDMT Without Gaps: Building and Maintaining Optimal Therapy Across the Patient Journey

2026 OSHP Annual Seminar

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Advanced Heart Failure and Transplant Pharmacist
Oregon Health & Science University
April 25, 2026

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