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Heart Failure: What Actually Changes Practice

A new ESC guideline, a nurse-led trial that moved mortality, and the studies that quietly closed doors.

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Nurse Practitioner Regional Update · September 2026

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ROADMAP

Six findings worth your time

1	**The guideline rewrite**	HFmrEF is gone. GDMT is gone. New staging, new vocabulary.
2	**TIME-HF**	Nurse-coordinated care cut mortality 22%. This one is about us.
3	**EMAIL-HF**	A letter and a phone call doubled SGLT2i uptake.
4	**TRIC-I-HF**	Tricuspid repair finally moved death and hospitalization.
5	**Three neutral trials**	H-HeFT, Met-HeFT, CARDIO-TTRansform — what to stop expecting.
6	**Early signals**	Oral relaxin agonist and PA denervation in PH-LHD.

ESC Congress 2026 Hot Line sessions and Clinical Practice Guidelines, Munich, 28–31 August 2026.

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HEADLINE

The 2026 ESC Heart Failure Guideline

A full replacement of the 2021 document — not an update. First ESC guideline to use the new levels-of-evidence system.

2	4	39	<60%
phenotypes, not three	stages, A through D	new recommendations	alive at 5 years after diagnosis

Prevention first: the document is organized around treating earlier, in patients who are at risk or pre-symptomatic — not around what to add once someone is already congested.

Kitber L, Adamo M, et al. 2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehaq100.

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CHANGE 1 OF 4

HFmrEF has been eliminated

Patients with LVEF 41–49% behave like — and respond like — HFrEF. So they are now called HFrEF.

2021		2026	
HFrEF	LVEF ≤ 40%	**HFrEF**	**LVEF < 50%**
HFmrEF	LVEF 41–49%	**HFpEF**	**LVEF ≥ 50%**
HFpEF	LVEF ≥ 50%		

Practically: the patient you charted last month as HFmrEF at 45% is a full HFrEF patient with a full HFrEF drug list. No more hedging on the fourth pillar.

2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehag100.

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CHANGE 2 OF 4

A four-stage continuum, mirroring the US model

A	B	C	D
At risk	**Pre-HF**	**Symptomatic HF**	**Advanced HF**
Risk factors present. No symptoms, no structural abnormality.	Cardiac abnormality present. Still no signs or symptoms.	Cardiac abnormality plus current or prior signs/symptoms.	Severe, persistent symptoms despite optimal therapy.

Why this matters to an NP panel: stages A and B are where you already live — hypertension, diabetes, obesity, cardiotoxic chemo, a quiet 46% ejection fraction on an echo done for something else. The guideline now names that work as heart failure care.

2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehag100.

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CHANGE 3 OF 4

"Acute" heart failure is now "decompensated"

The problem with "acute"

It implies sudden onset. Most patients decline over days to weeks — gaining weight, sleeping upright, cutting their walk short — long before anyone calls it acute.

What "decompensated" captures

Gradual or sudden worsening severe enough to need urgent attention. Treatment is aimed at the trigger: diuretics for congestion, vasodilators for high pressures, rate control, ischemia, non-adherence.

The clinical point is not the word. It is that the window to intervene opens weeks before the emergency department does.

That window belongs almost entirely to outpatient teams: the weight log, the phone triage call, the two-day-early clinic slot.

2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehag100.

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CHANGE 4 OF 4

GDMT has been retired and split in three

"Guideline-directed medical therapy" was coined more than a decade ago and has since come to mean everything and nothing. The 2026 document replaces it.

FMT	AMT	GDIT
Foundational Medical Therapy	**Additional Medical Therapy**	**Guideline-Directed Interventional Therapy**
Every Class I therapy for the general HF population: beta-blocker, ACEi or ARNi, MRA, SGLT2 inhibitor. "Optimal FMT" = highest tolerated guideline doses.	Class IIa/IIb agents, Class I agents that improve only symptoms or quality of life, and Class I agents limited to a specific phenotype or subgroup.	All implantable electronic devices and interventional procedures carrying any level of recommendation.

2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehag100.

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PRESCRIBING

Two recommendation changes you will use

Class 1 — **Mineralocorticoid receptor antagonists in chronic heart failure — regardless of ejection fraction.**

Spironolactone and eplerenone are no longer an HFrEF-only conversation. That means potassium and creatinine surveillance becomes part of routine HFpEF follow-up too — a workflow question as much as a prescribing one.

Class 2a — **Semaglutide and tirzepatide in patients with preserved LVEF and obesity.**

Incretin therapy enters a heart failure guideline as heart failure treatment, not as diabetes or weight management. Expect questions about coverage, supply, and who owns the titration — cardiology, primary care, or endocrinology.

2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026;ehag100. US labeling and coverage differ from ESC recommendations.

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THE TRIAL ABOUT US

TIME-HF: nurse-coordinated care reduced death

1,507 adults with HFrEF (LVEF ≤ 40%) across 22 centres in India. Cluster-randomized to a nurse-led, mobile-health-supported collaborative care model versus usual care.

21.6%	26.7%	0.78	+4.5
died with the intervention	died with usual care	hazard ratio (0.63–0.95), p=0.028	percentage points alive and out of hospital

The intervention was not a new molecule. It was early intensive titration, trained nurses holding the follow-up, structured self-care education, and a phone in the patient's hand.

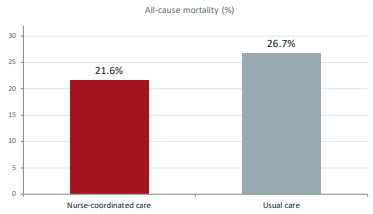
Investigators framed it as a blueprint for any setting where proven therapies are underused — which includes ours.

Joeman P, et al. TIME-HF. Presented ESC Congress 2026; published Circulation. doi:10.1161/CIRCULATIONAHA.126.082430

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TIME-HF

Mortality at two years



What was in the intervention

- Trained nurses as the care manager of record
- Early, intensive up-titration rather than deferred escalation
- Task sharing with the cardiologist, not referral back
- Mobile-health prompts and structured self-care teaching
- Sustained low-cost follow-up between visits

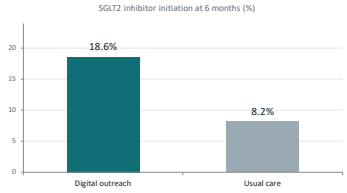
Jeemon P, et al. TIME-HF. Presented ESC Congress 2026; published Circulation.

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IMPLEMENTATION

EMAIL-HF: a letter, then a phone call

Denmark identified every heart failure patient in a two-million-person region who was not on an SGLT2 inhibitor, wrote to them, and offered a telephone consult with a specialist. 5,996 randomized.



Read the second number too

Uptake more than doubled and held at 24 months. But death or heart failure hospitalization was 13.0% versus 14.0% (p=0.28) — only a minority responded to the invitation, so the between-group difference in actual drug exposure stayed small.

The honest reading: outreach works on prescribing. Proving it works on outcomes needs a far larger trial.

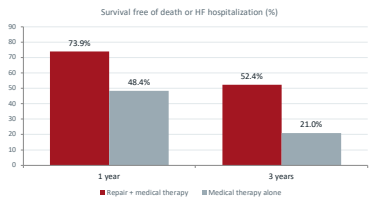
Elmegaard M, et al. EMAIL-HF. Presented ESC Congress 2026, Hot Line 5. Mean age 71 years; 60% of invited patients engaged.

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STRUCTURAL

TRIC-I-HF: tricuspid repair moved hard outcomes

Severe tricuspid regurgitation with heart failure and high event risk. Transcatheter tricuspid valve repair added to medical therapy versus medical therapy alone.



HR 0.40

for death or HF hospitalization (0.29–0.55), p<0.0001

Win ratio 2.42

hierarchical composite of death, HF hospitalization and quality of life at 1 year (1.76–3.33)

NNT 4

at one year

Hausleiter J, et al. TRIC-I-HF. Presented ESC Congress 2026; published NEJM. First randomized evidence of hard-outcome benefit for transcatheter tricuspid repair.

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EQUALLY IMPORTANT

Three trials that should change what you expect

H-HeFT

Hydralazine + isosorbide dinitrate in a broad HFrEF population (n=592, Denmark). 8.6 vs 9.3 events per 100 patient-years; HR 0.90, not significant. Discontinuation was high.

Do not add H-ISDN reflexively in contemporary HFrEF. Black patients were excluded — the A-HeFT evidence in that population stands.

Met-HeFT

Metformin in chronic heart failure with diabetes or prediabetes. No cardiovascular benefit.

Continue metformin for metabolic indications. Do not add it to improve heart failure outcomes.

CARDIO-TTRansform

Eplontersen in ATTR cardiomyopathy (n=1,422). Rate ratio 0.89 (0.73–1.09), p=0.277, despite deep TTR suppression. 57% were already on a stabilizer.

Neutral overall; a benefit signal appeared only in patients not on a stabilizer. Do not assume additive benefit on top of tafamidis.

Kabur L (H-HeFT), Wiggers H (Met-HeFT), Maurer MS (CARDIO-TTRansform). Presented ESC Congress 2026, Munich.

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WATCH THIS SPACE

Two early signals worth tracking

LUMINARA

AZD5462 — a once-daily oral relaxin receptor agonist

Phase 2b, 375 patients across both ejection fraction cohorts on top of maximally tolerated therapy. Reverse remodeling in the reduced-EF cohort (end-systolic volume index −5.4 mL/m² versus placebo, p=0.054) and clear vasodilation in the 41–55% cohort. No unacceptable hypotension or volume overload.

Counterintuitively, the lowest dose performed best. Proof of concept only — outcome trials are the next step.

PADN-HF-PH

Pulmonary artery denervation for PH from left heart disease

264 patients with group 2 pulmonary hypertension randomized to denervation plus medical therapy or medical therapy alone. Reported 51% lower risk of clinical worsening, 35.5% fewer recurrent clinical events, and sustained functional gains.

This is the first randomized outcome signal in a group with no approved PH-specific therapy. Single-country trial; US investigational-device work has only just begun.

Jonuzzi JL, et al. LUMINARA, published Circulation. Chen S-L, Han Y, Stone GW, et al. PADN-HF-PH, published NEJM. Both presented ESC Congress 2026.

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TAKEAWAYS

What this means in our clinics

Stop calling 41–49% a gray zone	Treat those patients as HFrEF: four foundational drugs, titrated to the highest tolerated dose.
Learn the new vocabulary	FMT, optimal FMT, AMT, GDIT. "On GDMT" was never an auditable statement. "On optimal FMT" is.
Expect MRAs across the EF spectrum	And build the potassium and renal monitoring workflow before the prescriptions go out.
Own the decompensation window	Weight logs, early phone triage, and a same-week slot beat a bed. That window is outpatient territory.
Take TIME-HF seriously	A nurse-led, structured, titration-focused model reduced death by roughly a fifth. Nothing about it requires a new drug.
Refer severe TR	After TRIC-I-HF, severe tricuspid regurgitation warrants a structural heart conversation, not more diuretic.

Reminder: these are European recommendations. US labeling, coverage, and the AHA/ACC/HFSA guideline have not moved in lockstep — the science travels faster than the paperwork.

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The most effective heart failure intervention presented in Munich was a care model.

Not a molecule. Not a device. A trained nurse, an early titration schedule, and someone who called the patient back.

Questions and discussion

Joel Fernandez, MD · Heart Failure Service Line, Lakeland Regional Health
Primary sources: Eur Heart J 2026;ehag100 · NEJM · Circulation · ESC Congress 2026 Hot Line sessions, Munich, 28–31 August 2026

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