ECHO Idaho: Managing Heart Failure in Primary Care
CASE RECOMMENDATION FORM

ECHO Session Date: 12/4/25 **Presenter Credential**: MD

Thank you for presenting your patient at ECHO Idaho –Managing Heart Failure in Primary Care session.

Summary: A 67-year-old man with Medicare presents for guidance on whether he needs GDMT—specifically SGLT2 inhibitors or MRAs—for HFpEF management. He is currently asymptomatic (NYHA I) with preserved EF (57%) and has been stable since severe CAD and NYHA IV HFpEF resolved after CABG ×3 in 2019. His heart failure appears to be recovered, but his stage (formerly D) is unclear, raising questions about when GDMT should be initiated in patients labeled with HFpEF but clinically stable under cardiology care. Comorbidities include prediabetes, chronic back pain on buprenorphine, emphysema, hypertension, CAD, hyperlipidemia, hypothyroidism, and recurrent major depression. Vitals and labs are stable, he is on a beta blocker and ACEI/ARB, but not on MRA or SGLT2i. Social history is stable with significant depression burden but no substance use or access issues.

Question: Does this patient need to be on GDMT i.e. SGLT2i & MRA?

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Heart Failure Diagnosis & Staging

- The panel agreed the patient continues to have HFpEF—he previously had symptomatic HF (NYHA IV) and now has structural heart disease without symptoms, placing him in Stage C, Class I, not Stage A or D.
- Despite being asymptomatic, he remains Stage C because of his history of symptomatic HF and structural heart disease.
- **A success story:** This case may represent a successful heart failure management story, as current medications and consistent follow up care may have prevented progression to HFrEF.

GDMT Recommendations

- **SGLT2 Inhibitor: YES (Start)**
  - Start with empagliflozin 10 mg daily
  - SGLT2 inhibitors have the strongest evidence in HFpEF and may soon become Class I recommendations
- **MRA (Spironolactone/Eplerenone): MAYBE (Conditional)**
  - Evidence for MRAs in HFpEF is weaker (Class 2B)
  - Consider only if additional BP lowering is needed and kidney function and potassium allow

A1C & Diabetes-related recommendations

- The patient's A1C is 6.1; while the chart lists prediabetes, the patient may technically be diabetic, especially since he is on 1–2 grams of metformin.
- Due to this, starting an SGLT2 inhibitor (empagliflozin 10 mg daily) is even more appropriate, as it benefits HFpEF, blood pressure, glycemic control, and renal protection

Other clinical considerations

- Beta blocker and ARB doses are already optimal and may have helped prevent HF progression.
- Review echo details (E/e', LA size, pulmonary arterial systolic pressure estimate, TR, LV wall thickness) to determine whether diastolic dysfunction persists.
- No loop diuretic is needed because the patient is euvolemic.

Medication adherence considerations

- Cost is the largest barrier to SGLT2 inhibitor use, as well as other HF medications such as sacubitril/valsartan.
- Recommended strategies include:
    - Using system-based financial assistance programs
    - Coupons and specialty pharmacy resources
    - Ensuring the patient is enrolled in all eligible programs, including Medicare supplements and assistance programs like NeedyMeds
    - Using a clinic financial advocate when available
- Keep in mind that depression significantly affects medication adherence and needs ongoing support.

Social & Advanced Care Planning

- Continue assessing social support needs, including counseling, community resources, and assistance with financial or transportation needs.
- Encourage completion of advance directives, framed as a helpful "gift to family."
- IDHW Advance Directive and Registry info: https://healthandwelfare.idaho.gov/services-programs/birth-marriage-death-records/advance-directives-and-registry-services

Diet/Lifestyle

- Dietary recommendations for HFpEF and HFrEF are the same.
- Recommend a low-sodium diet and the Mediterranean diet, emphasizing eating more whole foods, reducing processed foods, and incorporating lifestyle elements such as activity and shared meals, which support social connection.
- Note that discussions about food often lead to conversations about depression, creating an opening for a larger conversation; whole-food eating patterns and the Mediterranean lifestyle can support people experiencing depressive symptoms.