2026 CHF Clinical Pathway

Case Studies, Handouts & Talking Points

Catalyst
HEALTH NETWORK

CHF Clinical Pathway

Based on my current knowledge and understanding, I am aligned to the clinical need, benefit, and intended outcome of the 2026 CHF Clinical Pathway.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Agree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Board Question

A 68-year-old woman with heart failure and an ejection fraction of 58% presents for medication optimization.

Which of the following statements regarding pharmacologic therapy for heart failure with preserved ejection fraction (HFpEF) is most accurate?

A. Beta-blockers have demonstrated significant mortality reduction in randomized controlled trials of HFpEF and should be first-line therapy

B. SGLT2 inhibitors reduce heart failure hospitalizations but have not demonstrated clear mortality reduction in HFpEF

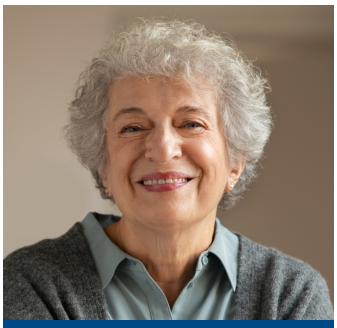
C. ACE inhibitors are preferred over angiotensin receptor blockers (ARBs) based on superior outcomes in older adults with HFpEF

D. Steroidal mineralocorticoid receptor antagonists (MRAs) significantly reduce the composite endpoint of cardiovascular mortality and heart failure hospitalizations in all HFpEF patients

E. Sacubitril-valsartan demonstrates greater mortality benefit in HFpEF than in heart failure with reduced ejection fraction

Case 1A

Mrs. Smith is a 75 y/o Medicare Advantage patient (capitated RBE patient) who presents to establish care with you. She has no new complaints or new symptoms.



Mrs. Smith

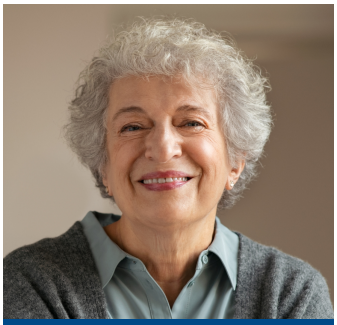
- **Problems:** HTN, DMII, CKD3a, RA, Obesity
- **Meds:** Amlodipine 10mg, Valsartan 160 mg, and Hydroxychloroquine 400 mg
- **Vitals: BP:** 118/78 **HR:** 86 **BMI:** 38
- **Exam:** CV RRR without murmurs. Extremities: trace edema.
- **Labs:** HbA1c 8.5%

1. What is the pre-test probability that this patient has Heart Failure?

2. What would you do if this was a traditional Medicare or ACO REACH patient?

3. How would you discuss getting an echocardiogram screening with the patient (the how, the why, the cost, and the intended outcome)?

Case 1B HFpEF (I50.9 HF Unspecified)



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Mrs. Smith undergoes a screening echo that shows "Mild LVH with grade II diastolic dysfunction" but is otherwise normal with an EF of 60%.

She comes in for a follow-up to discuss the echo results. Her ROS is negative for CHF symptoms.

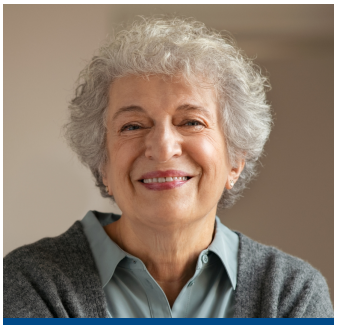
1. How would you explain the echo findings?

2. What medication adjustments would you consider?

3. How long would you take to titrate GDMT, how many patient touchpoints to accomplish, and by whom?

4. Stellus consult vs. PCP GDMT Optimization?

Case 1B HFrEF (I50.9 HF Unspecified)



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- **Labs:** HbA1c 8.5%

Mrs. Smith undergoes screening, but with different echo findings showing "Mild LVH with grade II diastolic dysfunction with an EF of 40%."

She comes in for a follow-up to discuss the echo results. Her KCCQ is negative for symptoms despite the reduced EF. You're concerned about the low EF.

1. Would you revisit the KCCQ?

2. How would you explain the findings?

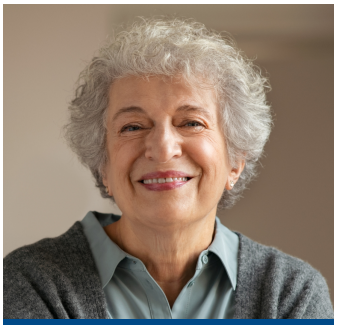
3. What additional evaluation would you consider?

4. What medication adjustments would you consider? Anything different based on low EF?

5. What if the patient was on diltiazem?

6. Stellus consult vs. PCP GDMT Optimization?

Case 1C (I50.20 – I50.43)



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- **Vitals: BP:** 118/78 **HR:** 86 **BMI:** 38
- **Exam:** CV RRR without murmurs. Extremities: trace edema.
- **Labs:** HbA1c 8.5%

During your follow up visit with Mrs. Smith, she now screens positive for HF symptoms. She is limiting her activities due to shortness of breath.

1. How would you discuss the diagnosis of Stage C HF with your patient?

2. What data points would you convey when discussing benefits to morbidity and mortality?

Mrs. Smith is compliant with lifestyle changes and with medications. However, she now describes having worsening symptoms including significant reduction in activities due to DOE. She has 2 pillow orthopnea and 2+ LE edema.

3. When is a cardiology referral part of your treatment plan?

You find out that Mrs. Smith has been taking ibuprofen, OTC decongestants, and talked a Doc-In-Box physician into prescribing phentermine for weight loss.

4. Do any of these medications give you pause?

5. What changes would you make to accommodate pain, upper respiratory infections, and weight loss?

6. Stellus consult vs. PCP GDMT Optimization?

Cardiology Handouts and Talking Points

HFrEF Initial Work Up

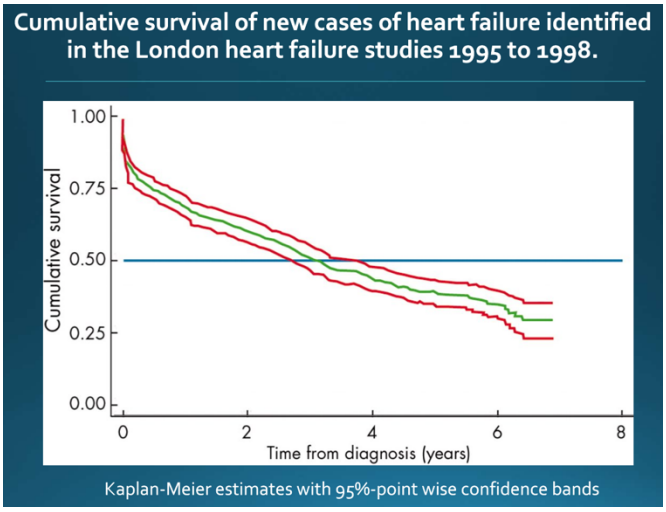
Imaging:

- Chest x-ray
- 12-lead ECG
- Ischemic testing
- Laboratory Testing:
- Complete blood count
- CMP
- BNP
- Iron studies (serum iron, ferritin, transferrin saturation)
- Thyroid-stimulating hormone
- HIV for at risk patients

Red Flags to Consider Cardiology Consult

- Worsening symptoms
- Syncope
- Signs of decompensation- weight gain, volume overload
- Elevated troponin, markedly elevated BNP/NT-pro BNP
- Concerns for CAD
- Family history of sudden cardiac death or cardiomyopathies
- Structural cardiac abnormalities
- Significant LVH, chamber enlargement (LV dilation), wall motion abnormalities, valvular heart disease
- Left Bundle Branch Block

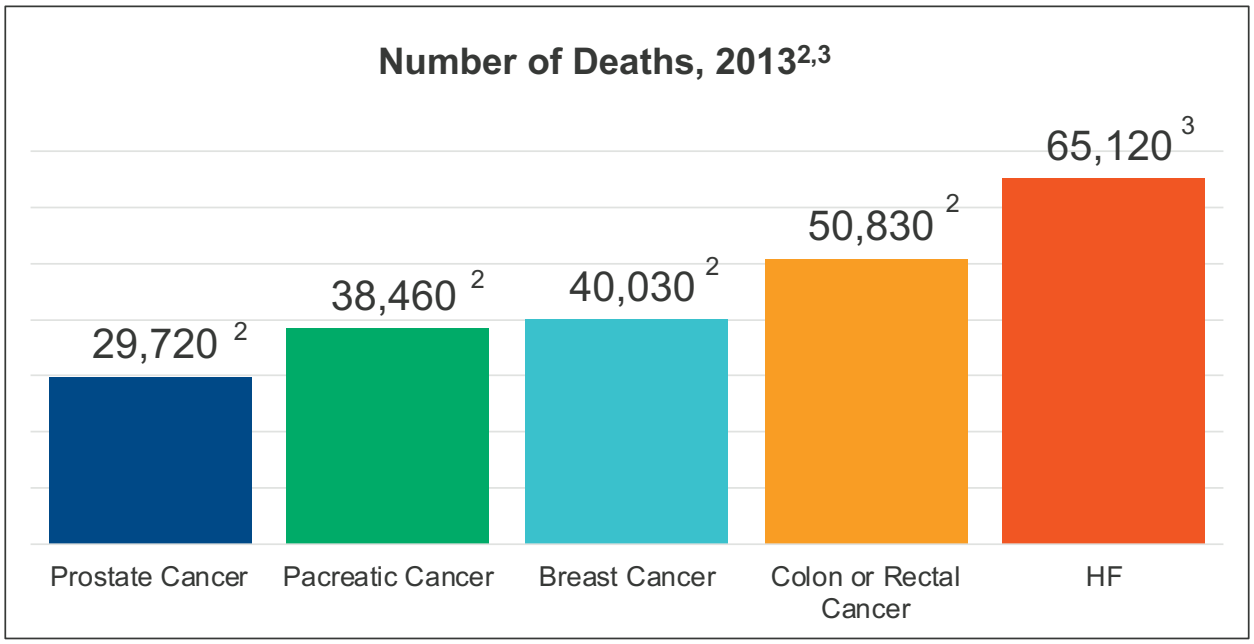
Stage C Review



- Lifetime incidence of stage C/D in large community sample = 26%
- Once symptomatic, there is a 40% to 50% mortality in 5 years.
- Stage C HFrEF absolute 2 yr mortality 35% → 9% w/ GDMT alone

Annual Mortality for HF is Higher than That of Some Common Cancers

Approximately 50% of patients with HF have HFrEF[1]



**Cancer data are forecasted estimates for 2013.*

1. Gerber Y, et al. *JAMA Intern Med.* 2015;175(6):996-1004.
2. Diegel R, er al. *CA Cancer J Clin.* 2013;63(1):11-30
3. Mozaffarian D, et al. *Circulation*. 2016;133(4):e38-60

Case 2D (I50.84 End Stage HF)

Mr. Johnson

Another patient, Mr. Johnson, is a 76 y/o Stage C HF patient with worsening symptoms after an acute MI. He's been hospitalized multiple times for HF in the past year despite having an LVAD placed.

He sees the cardiologist frequently and he continues to ask for all his refills from you, despite being long overdue for a visit. His most recent echo showed an EF = 20%.

He finally makes it to your office for a follow-up visit, and this time he is in a wheelchair. Minimal activity causes him to have significant shortness of breath and fatigue.

His MIP shows that Stage C HF was captured earlier in the year.

1. What's the most appropriate condition to document for this patient?

2. What other condition or status would you consider documenting?

3. What other resources would you consider for this patient?

Answers Key

Board Question (page 2)

A 68-year-old woman with heart failure and an ejection fraction of 58% presents for medication optimization.

Which of the following statements regarding pharmacologic therapy for heart failure with preserved ejection fraction (HFpEF) is most accurate?

B. SGLT2 inhibitors reduce heart failure hospitalizations but have not demonstrated clear mortality reduction in HFpEF

Case 1A (page 3)

1. What is the pre-test probability that this patient has Heart Failure? ~40%

2. What would you do if this was a traditional Medicare or ACO REACH patient? The economics of ACO REACH do not allow for the same RBE subsidized pathway we have for MA. In this case, consider ordering a BNP and/or sending for an echocardiogram via the traditional pathway. Note the patient might have some out of pocket cost.

3. How would you discuss getting an echocardiogram screening with the patient (the how, the why, the cost, and the intended outcome)? Educate patient briefly on stages of heart failure with Stage B and then early symptomatic Stage C often being present for years before diagnosis.
   We are trying to identify it and treat it upstream to mitigate progression. 40% to 50% diagnosed much later in the acute setting = increased pain & suffering
   Metabolic diseases are the most significant cause of HF today.
   Educate on how simple the u/s is, minimally invasive
   No cost to you.

Case 1B HFpEF (I50.9 HF Unspecified) (pages 3-4)

1. How would you explain the echo findings? Your heart muscle is thickened, likely in response to longstanding HTN. This makes it where the heart cannot relax the way it needs to, so it doesn't pump as well.

2. What medication adjustments would you consider? Start SGLT-2. Discontinue hydroxychloroquine given its cardiotoxicity.

3. How long would you take to titrate GDMT, how many patient touchpoints to accomplish, and by whom? Please do not slow roll this. Needs to be done within 90-120 days at most for the patient to receive the benefit.

4. Stellus consult vs. PCP GDMT Optimization? Stellus, Stellus, Stellus!!!

   Stellus consult:

   - SGLT-2 inhibitor: Initiate empagliflozin (Jardiance) 10 mg tablet once daily since SBP>90 and renal function stable (eGFR>30). Check BMP in 4 weeks after initiation. Target dose: 10 mg once daily, with the option to increase to 25mg once daily if needed for additional glycemic control. Counsel patient on importance of close monitoring of BP, blood glucose, and urinary symptoms.
   - Initiate tirzepatide (Mounjaro) 2.5 mg injection SQ once weekly for 4 weeks then titrate further based on patient tolerability given A1c > 7 and BMI 38. Counsel patient on importance of close monitoring of blood glucose, weight, and GI symptoms.
   - Decrease amlodipine to 5mg once daily with the goal of potentially discontinuing amlodipine all together if BP remains controlled on above agents given patient's trace edema.
   - Discontinue hydroxychloroquine 400mg and depending on RA disease severity, can consider starting either sulfasalazine or methotrexate.

Case 1B HFrEF (I50.9 HF Unspecified) (page 4)

1. Would you revisit the KCCQ? Yes, need to determine if patient is having symptoms. Would also ask if patient has changed lifestyle at all or reduced activities.

2. How would you explain the findings? Your heart isn't pumping as well as it should. We can put on different medications to improve the pump function as well as your quanity and quality of life. The treatment can slow the progression of the disease.

3. What additional evaluation would you consider? CXR, ECG, Ischemic testing. Labs: CBC, CMP, BNP, Iron studies, TSH, HIV for at risk patients

4. What medication adjustments would you consider? Anything different based on low EF? Discontinue valsartan and add sacubitril/valsartan, add metoprolol succinate, discontinue diltiazam.

5. What if the patient was on diltiazem? Stop diltiazam.

6. Stellus consult vs. PCP GDMT Optimization? Stellus, Stellus, Stellus!!! See below.

Case 1C (I50.20 – I50.43) (page 5)

1. How would you discuss the diagnosis of Stage C HF with your patient? It is vital to get on GDMT in a timely manner to add quality and quantity of life to the patient.

2. What data points would you convey when discussing benefits to morbidity and mortality? Stage C has a 40-50% mortality rate of 5 yrs. Stage C HEFrEF has an absolute 2-year mortality rate of 35%. GDMT alone can reduce that to 9%! 1 in 3 down to 1 in 10 mortality rates. Titration to GDMT in 90-120 days can add 8 years of life to the patient. Add in the comparisons to prominent cancer mortality rates.
3. When is a cardiology referral part of your treatment plan? Advancing Stage C and Stage D for sure. See the attached handout of red flags that indicate referral is needed.
4. Do any of these medications give you pause? Yes, all NSAIDs, OTC decongestants, and phterermine. Stop them all.

5. What changes would you make to accommodate pain, upper respiratory infections, and weight loss? Discontinue ibuprofen and initiate acetaminophen 1000 mg three times daily around the clock. Discontinue phentermine since patient is receiving a GLP-1 agonist for DM and potential weight loss. Discontinue pseudoephedrine product and initiate either oral phenylephrine 10 mg every 4 hours or, if allergy-related, fluticasone nasal spray and/or antihistamine (cetirizine, loratadine)

6. Stellus consult vs. PCP GDMT Optimization? Stellus, Stellus, Stellus!!! See below.

Case 2D (I50.84 End Stage HF) (page 6)

1. What's the most appropriate condition to document for this patient?
   Stage D Heart Failure I50.84

2. What other condition or status would you consider documenting?
   Frailty, Advanced care planning
3. What other resources would you consider for this patient?
   Palliative/Hospice care

Stellus RX Case Study GDMT Recommendations

Slide 14 – HFpEF (EF 60%, no CHF symptoms)

1. SGLT2 inhibitor – Initiate empagliflozin (Jardiance) 10 mg tablet once daily since SBP > 90 and renal function stable (eGFR > 30). Check BMP in 4 weeks after initiation. Target dose: empagliflozin (Jardiance) 10 mg once daily, with the option to increase to 25 mg once daily if needed for additional glycemic control. Counsel patient on importance of close monitoring of BP, blood glucose, and urinary symptoms.
2. Decrease amlodipine to 5 mg once daily with the goal of potentially discontinuing amlodipine altogether if BP remains controlled, given patient's trace LE edema.
3. Initiate tirzepatide (Mounjaro) 2.5 mg injection SQ once weekly for 4 weeks, then titrate further based on patient tolerability given A1c > 7 and BMI 38. Counsel patient on importance of close monitoring of blood glucose, weight, and GI symptoms.
4. Discontinue hydroxychloroquine 400 mg and, depending on RA disease severity, consider starting either sulfasalazine or methotrexate.

Slide 15 – HFrEF (EF 40%, no CHF symptoms)

Assuming GFR 45–59 mL/min, potassium is WNL, vitals stable:

1. RASi – Discontinue valsartan 160 mg and initiate sacubitril/valsartan (Entresto) 24/26 mg BID since SBP > 90, K ≤ 5, and stable SCr within baseline. Check BMP 2–4 weeks after initiation/titration. Dose can be doubled every 2 weeks if GFR hasn't decreased by more than 30%, K ≤ 5, and SBP > 95. Target dose: sacubitril/valsartan (Entresto) 97/103 mg BID. Counsel patient on close monitoring of BP.
2. Beta-blocker – Initiate metoprolol succinate (Toprol XL) 25 mg daily since SBP > 90 and HR > 60. Dose can be doubled every 1–2 weeks if SBP > 95 and HR > 50. Target dose: metoprolol succinate (Toprol XL) 200 mg daily. Counsel patient on daily monitoring of BP and HR.
3. Discontinue diltiazem and optimize rate control with metoprolol succinate.

At the 2–4 week follow-up, if repeat labs WNL and vitals stable:

1. Titrate sacubitril/valsartan (Entresto), metoprolol succinate (Toprol XL), tirzepatide (Mounjaro), and empagliflozin (Jardiance) as appropriate based on vitals and lab values.

Slide 25 – HFrEF (EF 40%, CHF symptoms)

1. Titrate sacubitril/valsartan (Entresto), metoprolol succinate (Toprol XL), tirzepatide (Mounjaro), and empagliflozin (Jardiance) as appropriate based on vitals and lab values.
2. MRA – Initiate spironolactone 12.5 mg once daily if renal function and potassium trends are WNL (K < 5). Check BMP in 1–2 weeks after initiation, then monthly for 3 months, then every 3 months thereafter. Target dose: spironolactone 25 mg once daily. Counsel patient on importance of daily BP monitoring and follow-up labs.
3. Discontinue ibuprofen and initiate acetaminophen 1000 mg three times daily around the clock. Discontinue phentermine since patient is receiving a GLP-1 agonist for DM and potential weight loss.
4. Discontinue pseudoephedrine product and initiate either oral phenylephrine 10 mg every 4 hours or, if allergy-related, fluticasone nasal spray and/or antihistamine (cetirizine, loratadine).