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Engaging Your Patient: Shared Decision-Making in HF With LVEF ≥40%

Announcer:
Welcome to CE on ReachMD. This activity, titled “Engaging Your Patient: Shared Decision-Making in Heart Failure With left ventricle ejection fraction greater than or equal to 40%” is provided by Medcon International.

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Dr. Solomon:
Hello, I'm Dr. Scott Solomon, the Edward Frolic chair and professor of medicine at Harvard Medical School and Brigham and Women's Hospital in Boston, Massachusetts. I'd like to welcome you to our Patient-Clinician Connection focused on shared decision-making in patients with heart failure with mildly reduced or preserved ejection fraction.

Today we'll address a challenge we face often in the clinic: how to engage patients with HFpEF in conversations about their treatment options. Now, these patients frequently struggle with symptoms that limit their daily life, and historically we've had very few therapies that could change their outcomes. That is no longer the case. With the advent of SGLT2 inhibitors and more recently finerenone, we now have therapies that can reduce hospitalizations, improve quality of life, and protect against future cardiovascular events. To effectively use these therapies, it's not enough to prescribe medication. We need to understand the patient's perspective, explain the risks and benefits clearly, and collaborate on a treatment plan that reflects both the science and the patient's goals.

Today I'll be illustrating my approach through a series of clinical vignettes where we'll explore how to communicate these options, address concerns, and make shared decisions that can truly optimize patient outcomes. Let's get started.

My patient is a 50-year-old woman attending clinic today. She has a history of hypertension, type 2 diabetes, atrial fibrillation, and obesity. She has a diagnosis of heart failure and her ejection fraction is 50%, so she's somewhere in between heart failure with mildly reduced ejection fraction and heart failure with preserved ejection fraction. She's currently taking diuretic, beta-blocker, and she's anticoagulated. Her symptoms include exertional dyspnea, fatigue, and a limited ability to do certain daily activities like gardening or climbing stairs. Our goals with her are to avoid hospitalization, allow her to regain her independence, and reduce her future cardiovascular risk.

Dr. Solomon:
Maria, it's nice to see you again. How have you been feeling since your last visit?

Maria:
Honestly, not so great. I feel short of breath. Even with simple things, walking up the stairs, carrying the groceries, I get tired so easily.

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Dr. Solomon:
That sounds very frustrating. What activities have been hardest for you to keep up with?

Maria:
I used to love gardening, but now even bending down and working outside wipes me out. I don't feel like myself anymore.

Dr. Solomon:
I'm sorry to hear that. It's difficult when symptoms interfere with the things you enjoy. Besides the fatigue, is there anything else that's worrying you?

Maria:
I really don't want to end up in the hospital again. That last admission was scary, and I don't want my family to go through that.

Dr. Solomon:
We're going to keep you out of the hospital. We want you active. We don't want you to be hospitalized again, and this is the goal that we're going to focus on today.

Dr. Solomon:
In talking to the patient, I used open-ended questions that validated her feelings. This allows her to define her own priorities, which sets the stage for shared decision-making. Let's return and continue our discussion with Maria and discuss next steps.

Dr. Solomon:
So based on what you've told me, I think there are 2 treatments that could potentially help. The first is a class of medications that are called SGLT2 inhibitors, and these are medicines that have been shown in large clinical trials to reduce hospitalization for heart failure and help people like you feel better and function better in daily life. The second is a newer medication called finerenone, and this is a medication that works in a different way in a very large study of patients just like you. It helped these patients stay out of the hospital and reduce the chance of serious heart complications, but because it's newer, not all patients have been offered it yet. I think it might be a very good option for you alongside an SGLT2 inhibitor.

Maria:
That sounds promising, but what about the side effects?

Dr. Solomon:
Important question. Well, SGLT2 inhibitors, the most common side effects are a bit more urination and, in some people, there can be genital infections or low blood pressure, but these are very, very rare and usually manageable. With finerenone, the main concern is a rise in potassium levels or changes in kidney function, and that's why we will do regular blood tests to make sure it's safe and effective for you.

Maria:
So neither of these cures heart failure, but they can help me stay well?

Dr. Solomon:
Exactly. Our goal is to reduce the chances that you're going to get hospitalized again, to help you feel better, do more, and protect you in the long term, and the best results usually come when we start therapies early.

Dr. Solomon:
My conversation with the patient allowed me to explain the risks and benefits in everyday language while linking treatment options back to the patient's stated goals. The treatment options for patients with heart failure with mildly reduced or preserved ejection fraction are based on several clinical trials. We have data from 2 large clinical trials with SGLT2 inhibitors, EMPEROR-Preserved and DELIVER, both of which show a consistent reduction in heart failure hospitalizations, heart failure events, and improved functional status. We also have data for the nonsteroidal mineralocorticoid receptor antagonist finerenone. This was based on the FINEARTS-HF trial. FINEARTS was a study of approximately 6,000 patients with heart failure with mildly reduced or preserved ejection fraction and showed a 16% reduction in a composite of cardiovascular death or heart failure events. We treated patients who were also on other therapies, including

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SGLT2 inhibitors, suggesting that these can be complementary therapies. We also found that the benefit of this therapy occurred very early, suggesting that we should treat patients as soon as we make the diagnosis.

Dr. Solomon:
So given that you're concerned about fatigue and the potential for additional hospitalizations, I'd like to start both an SGLT2 inhibitor and finerenone today. These drugs work in very different ways, so taken together, they should give you the strongest potential benefit.

Maria:
Starting both at once, is that safe?

Dr. Solomon:
It is as long as we monitor you closely. So we're going to check your blood pressure today. We're going to check your kidney function, and in a few weeks we'll check your potassium. If anything looks off, we can adjust the medications. The key really is that we get you on both medications as quickly as possible. That way you can get the maximum benefit.

Maria:
Oh, I like that. I don't want to wait until I get worse.

Dr. Solomon:
Neither do we. The earlier we act, the more likely we are to prevent future problems. So let's begin both today and I'll see you back in a month and see how you're feeling.

Dr. Solomon:
This vignette highlights collaborative decision-making. I make a clear recommendation, the patient's concerns are addressed, and a monitoring plan is agreed upon.

Dr. Solomon:
Welcome back, Maria. How have you been feeling since starting the new medicines?

Maria:
Much better. I still get tired sometimes, but I can climb the stairs without stopping and I've even gotten back to gardening.

Dr. Solomon:
Wow, that's great. Any new concerns?

Maria:
Just going to the bathroom a bit more, but nothing I can't handle.

Dr. Solomon:
Well, that's actually expected with one of your medicines, but importantly, your blood work looks really good. Kidney function and potassium are both stable. This tells me you're tolerating these medicines very well.

Maria:
That's a relief. I like that you explained why the newer medicine, finerenone, was important for me, especially because of my diabetes. I wasn't sure what to expect, but it feels reassuring knowing I'm on something that can help protect me long term. I feel more confident now. It helps to know we're using the latest treatments to keep me well.

Dr. Solomon:
This follow-up vignette demonstrates the importance of monitoring, ongoing dialogue with the patient, and reinforcing adherence. It shows how shared decision-making is not a one-time event but a continuous process.

Managing heart failure with preserved or mildly reduced ejection fraction has changed. SGLT2 inhibitors reduce hospitalizations, improve symptoms, and improve outcomes across the ejection fraction spectrum. Finerenone, which has recently been approved for patients with heart failure with mildly reduced or preserved ejection fraction, also reduces cardiovascular death and heart failure events.

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Together and initiated early, they represent a new potential standard of care. By eliciting patients' goals, explaining risks and benefits clearly, and engaging patients in collaborative and ongoing decision-making, we can improve both quality of life and long-term outcomes.

Thank you for joining this Patient-Clinician Connection on shared decision-making and heart failure with mildly reduced or preserved ejection fraction.

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