

Expanded assessment key

Staff review copy | 9 pre, 9 post and 9 formative decisions | October 16, 2026

E1-recognition-pre | pre

Renee, 58, has BMI 37, progressive exertional dyspnea, EF 63% and NT-proBNP 88 pg/mL. No acute warning symptoms are present. What is the best next step?

Correct: B - Review complete cardiac findings and competing causes; a low peptide does not exclude HFpEF.

Preserved EF and a low peptide are not sufficient to dismiss the syndrome in obesity. Evaluate cardiac and noncardiac explanations before establishing a diagnosis.

Source keys: acc, np

E1-confirmation-pre | pre

A complete HFA-PEFF assessment is 3 and exertional symptoms persist. Which step is most appropriate?

Correct: C - Arrange appropriate functional assessment or specialist evaluation.

An intermediate score organizes uncertainty. Functional evaluation may resolve what resting measurements cannot.

Source keys: hfa, acc

E1-alternatives-pre | pre

A woman with suspected HFpEF now reports new resting chest pressure and breathlessness. What should happen?

Correct: B - Arrange emergency assessment now.

New resting chest pressure with breathlessness requires urgent assessment, independent of an earlier reassuring EF.

Source keys: acc

E1-recognition-post | post

A 66-year-old woman with BMI 39 has declining walking tolerance, EF 61% and NT-proBNP 96 pg/mL. Which conclusion best guides care?

Correct: C - The findings remain inconclusive and require structured evaluation in context.

This is unresolved diagnostic probability, not a negative evaluation or a confirmed syndrome. Obtain the evidence that can explain her functional loss.

Source keys: acc, np

E1-confirmation-post | post

Resting testing is nondiagnostic. Exercise echocardiography is also inconclusive, and knowing whether HFpEF is present would change treatment. What should be considered?

Correct: A - Referral for invasive exercise hemodynamics at an experienced center.

In selected patients, specialist invasive exercise assessment can clarify unresolved hemodynamic uncertainty. This is not a routine test for every patient with obesity.

Source keys: hfa, acc

E1-alternatives-post | post

A woman awaiting outpatient HFpEF testing develops severe breathlessness at rest and chest pressure. What is the best next step?

Correct: B - Arrange emergency assessment now.

New severe resting symptoms require urgent assessment. A prior preserved EF and a planned outpatient evaluation do not provide reassurance about an acute change.

Source keys: acc

E2-sglT2-pre | pre

Angela has confirmed symptomatic HFpEF, no diabetes, adequate renal function and stable volume status. Which plan is best supported?

Correct: B - Discuss an eligible SGLT2 inhibitor with product-specific safety and access review.

SGLT2 HF benefit does not require diabetes. Eligibility, volume status, renal function, safety and access still need assessment.

Source keys: emperor, deliver, jardiance, farxiga

E2-endpoints-pre | pre

Angela asks whether SUMMIT proves tirzepatide prevents cardiovascular death in HFpEF. Which answer is most accurate?

Correct: C - The composite improved, driven by fewer worsening-HF events; isolated mortality reduction was not demonstrated.

Interpret the composite and its components separately. This was not a head-to-head comparison or proof of a mortality-alone benefit.

Source keys: step, summit, sema, tirz

E2-finerenone-pre | pre

For the HF indication, a stable patient has EF 55%, eGFR 45 mL/min/1.73 m² and potassium 4.8 mEq/L, without a contraindicated interaction. Which initial plan matches the label?

Correct: B - Start 10 mg daily and arrange potassium/eGFR review at four weeks.

At eGFR 25 to below 60 mL/min/1.73 m², the HF starting dose is 10 mg. The HF target is 20 mg if eligible; use current HF titration and laboratory instructions.

Source keys: kerendia, finearts

E2-sglit2-post | post

A woman without diabetes has confirmed HFpEF and asks why an SGLT2 inhibitor is being discussed. Which explanation is accurate?

Correct: C - Trials support HF benefit beyond glucose lowering; select a suitable agent and monitoring plan.

EMPEROR-Preserved and DELIVER support appropriate HF use beyond diabetes; avoid class-wide label assumptions or overstated mortality claims.

Source keys: emperor, deliver, jardiance, farxiga

E2-endpoints-post | post

Which explanation best distinguishes STEP-HFpEF from an HF mortality trial?

Correct: A - It demonstrated symptom, function and weight benefits; it was not designed to establish a mortality reduction.

Keep the claim tied to the measured outcomes, studied population and current indication. Avoid inferring mortality or cross-trial superiority.

Source keys: step, summit, sema, tirz

E2-finenone-post | post

A woman with EF 58%, eGFR 42 mL/min/1.73 m² and potassium 4.7 mEq/L is an appropriate finerenone HF candidate after full review. Which plan is correct?

Correct: C - Start 10 mg, check potassium/eGFR at four weeks, and consider the 20 mg HF target when eligible.

Starting dose and target dose are distinct. Monitoring includes both potassium and eGFR, with the full HF table governing adjustment.

Source keys: kerendia, finearts

E3-acute_safety-pre | pre

After SGLT2 initiation, Teresa has vomiting, poor intake, abdominal pain and breathlessness. Glucose is 146 mg/dL. What is the best action?

Correct: C - Temporarily stop the medicine and arrange urgent assessment for ketoacidosis, depletion and acute illness.

Ketoacidosis can occur without marked hyperglycemia. Urgent clinical evaluation is needed; a home glucose value cannot rule it out.

Source keys: jardiance, farxiga

E3-lab_action-pre | pre

Before planned finerenone initiation, potassium returns at 5.3 mEq/L. What is the best action?

Correct: B - Do not initiate; assess potassium and contributing factors and reassess eligibility.

The initiation threshold differs from continuation/adjustment rules. Do not initiate when potassium is above 5.0 mEq/L.

Source keys: kerendia

E3-ownership-pre | pre

Teresa's ordered four-week potassium/eGFR result is absent. What completes the monitoring task?

Correct: D - Find out whether testing occurred, resolve barriers and ensure clinician review and patient contact.

An order or reminder is not a reviewed result. Track completion and responsibility through to communication.

Source keys: acc, kerendia

E3-acute_safety-post | post

A patient on an SGLT2 inhibitor reports abdominal pain, vomiting and rapid breathing during an illness. Glucose is 158 mg/dL. Which plan is safest?

Correct: B - Withhold temporarily and obtain urgent clinical assessment.

The symptom pattern warrants urgent evaluation for ketoacidosis and other serious illness, even with modest glucose elevation.

Source keys: jardiance, farxiga

E3-lab_action-post | post

A new finerenone HF prescription is awaiting dispensing. Baseline potassium is 5.2 mEq/L. Which response matches the label?

Correct: A - Hold initiation, evaluate the result and contributing medicines, and reassess the plan.

Do not initiate with potassium above 5.0 mEq/L. Eligibility includes laboratory results and interactions, not EF alone.

Source keys: kerendia

E3-ownership-post | post

Which discharge-to-primary-care handoff is most actionable?

Correct: C - Specify medication/indication, test date, named result reviewer, contact plan and escalation instructions.

A complete handoff states what changed, what must happen next, who owns it and how the patient receives an answer.

Source keys: acc, kerendia

E1-practice-1 | practice

Renee can no longer finish her usual walk. She recalls being told that EF 63% was normal. Her symptoms remain stable. Which response best keeps the evaluation on track?

Correct: B - Connect her functional decline to the full examination, echo and differential.

A preserved pumping percentage does not explain the symptom or establish HFpEF. The next decision depends on the complete clinical picture.

Source keys: acc, acc26

E1-practice-2 | practice

A complete resting evaluation gives Renee an HFA-PEFF score of 3. Important alternatives have been assessed, but exertional limitation persists. What is the next diagnostic aim?

Correct: C - Resolve the intermediate probability with appropriate specialist functional assessment.

The score is intermediate. Select functional testing that can resolve the uncertainty; feasibility and specialist expertise matter. Inconclusive noninvasive assessment may lead to selected invasive exercise testing.

Source keys: hfa, np

E1-practice-3 | practice

Before the planned outpatient assessment, Renee develops chest pressure and severe breathlessness at rest. What changes?

Correct: A - The new symptoms require urgent assessment.

The new presentation takes priority over a stable outpatient pathway. Prior reassuring measurements must not delay urgent evaluation.

Source keys: acc

E2-practice-1 | practice

Angela has confirmed HFpEF and asks why a medicine often associated with diabetes is being considered when her A1c is 5.8%. Which explanation is appropriate?

Correct: B - Discuss HF trial evidence and individual eligibility even without diabetes.

The HF evidence is not restricted to diabetes. Review product-specific eligibility, renal function, volume, precautions and access, and explain the relevant HF outcomes.

Source keys: emperor, deliver, jardiance, farxiga

E2-practice-2 | practice

Angela reads that a positive composite outcome in SUMMIT means tirzepatide was proven to prevent cardiovascular death in HFpEF. How should you respond?

Correct: C - Explain the composite benefit and its components without asserting a proven cardiovascular-mortality benefit.

Separate symptoms, function, weight and clinical-event outcomes. The positive composite does not establish benefit for every component, and separate trials are not a head-to-head comparison.

Source keys: summit, step

E2-practice-3 | practice

For an otherwise eligible finerenone HF candidate with EF 58%, baseline eGFR 42 mL/min/1.73 m² and potassium 4.7 mEq/L, which plan matches the current HF label?

Correct: A - Start 10 mg daily and check potassium/eGFR at four weeks; use the full HF table for adjustment.

For this baseline renal category the start is 10 mg and the HF target is 20 mg when eligible. Review interactions and contraindications and reassess potassium/eGFR four weeks after initiation or a dose change; earlier review may be needed clinically.

Source keys: kerendia

E3-practice-1 | practice

After starting an SGLT2 inhibitor, Teresa has vomiting, poor intake, abdominal pain and breathlessness. Her glucose is 146 mg/dL. Which response is safest?

Correct: B - Hold the SGLT2 inhibitor and arrange urgent assessment for possible ketoacidosis and other acute causes.

Ketoacidosis may occur without marked hyperglycemia. Concerning symptoms and poor intake require urgent assessment; a routine monitoring schedule is not the appropriate pathway.

Source keys: jardiance, farxiga

E3-practice-2 | practice

At a later stable visit, a baseline potassium result of 5.3 mEq/L returns before Teresa has taken her first finerenone dose. What should happen?

Correct: C - Do not initiate; review the result, contributing factors and complete eligibility.

The current label says not to initiate when baseline potassium is above 5.0 mEq/L. This is an initiation decision, not a maintenance-dose adjustment.

Source keys: kerendia

E3-practice-3 | practice

After a subsequent eligible start, the ordered potassium/eGFR result is absent. Teresa could not arrange transportation. What closes the gap?

Correct: A - Assign a reviewer and backup, resolve access, obtain/retrieve the test and communicate the reviewed plan.

A named owner must track the test through interpretation and communication. Resolve the practical barrier and retain responsibility until the receiving clinician or team accepts it.

Source keys: acc26, kerendia