

# HFpEF in Women: From the First Symptom to Coordinated Treatment

**Independent medical education | \$179,000 prospective planning request**

Lisa Zahakos, RPA-C | October 16, 2026

Three facilitated virtual conferences plus a conditional expanded enduring companion. Unquoted; no award or credit designated. Existing development is contributed, not reimbursed.

## Executive summary

Persistent breathlessness can be dismissed despite inconclusive resting findings, while confirmed HFpEF may not lead to an evidence-based treatment and monitoring plan. Published diagnostic research and a historical US registry showing 12.8% SGLT2-inhibitor use in the combined HFmrEF/HFpEF group by Q2 2023 support an educational response. These findings do not establish today's rate or that every untreated patient was eligible.

HEART RESERVE proposes three facilitated national virtual case conferences in 2027, each with a 60-minute design target, and a conditional three-module enduring companion. Renee, Angela and Teresa connect diagnostic uncertainty, evidence-based treatment selection and safe follow-through. The prepared companion contains 38 minutes 48 seconds of narration or equivalent written teaching, nine formative decisions and nine paired baseline/post concepts. Its 90-110-minute design estimate requires a timed pilot. Lisa Zahakos, RPA-C contributes the original case curriculum and PA educator/moderator perspective; independent faculty and delivery partners require confirmation.

The \$179,000 prospective request supports defined future clinical review, approved revisions, facilitated delivery, host adaptation, recruitment and outcomes; existing development and grant preparation are contributed. Proposed educator compensation is \$27,500 (15.36%). The primary endpoint is change in first-attempt case-application scores, analyzed separately for live and enduring formats, with nine reserved 60-day follow-up items and distinct self-report measures. BIPI's published HF priorities support topic alignment. The saved October HF call and November 3, 2026 deadline require current portal confirmation, including companion eligibility. No award, credit designation or verified practice improvement is claimed.

Source keys: rfp

## Why this education is needed

Treatment implementation: a 2025 US PINNACLE analysis included 759,915 HF patients at 191 cardiovascular practices, using July 2019-June 2023 records. In the combined HFmrEF/HFpEF population, SGLT2-inhibitor use increased from 4.5% to 12.8%. Female sex was associated with lower prescribing across the overall HF cohort (adjusted OR 0.79, 95% CI 0.77-0.81). These historical observational findings support an implementation gap; they are not a 2026 rate, a women-only HFpEF estimate or proof that every untreated patient was eligible.

Diagnostic recognition: in a selected prospective sample of 78 research volunteers with obesity and dyspnea, 65% women, 40 underwent invasive exercise testing and 24 were found to have HFpEF. That represents 31% of the full sample and 60% of those tested, not general-population prevalence. Resting assessments did not reliably separate the groups. This supports teaching how to resolve persistent symptoms when initial findings are inconclusive.

Clinical decision process: low peptides, preserved EF, trial composites and indication-specific safety tables can be misinterpreted. The educational inference is that clinicians need a reproducible sequence for evaluating uncertainty and completing treatment and monitoring decisions. Published gaps establish the rationale; the planned baseline responses will characterize the actual recruited audience. No needs-survey results have been invented.

The women-focused approach follows symptoms, comorbidities, history, function and access while preserving limits of sex-specific evidence. It does not presume that all women share a phenotype or that a treatment has greater HF efficacy in women. A practice barrier such as insurance or testing access may remain even after a learner demonstrates competence.

Source keys: gap, diagnostic, np, sex

## Audience and learning design

Primary learners are US primary-care/internal-medicine physicians and PAs/NPs caring for adults with cardiometabolic risk or possible HFpEF. Secondary learners include clinical pharmacists, general cardiologists, nephrologists, endocrinologists and hospitalists. Recruitment must document profession and practice setting rather than treating an entire mailing database as the target audience.

The format uses a recognizable patient problem, an independent baseline decision, a short evidence framework, progressive case reveals, panel reasoning and a parallel transfer decision. Short fictional lifestyle scenes introduce context; precise graphics, discussion and equivalent written material carry the teaching. Full teaching videos and equivalent written lessons provide alternative routes in the expanded enduring activity. No essay or additional video-completion requirement is added.

Public myCME listings provide a relevant benchmark for focused HFmrEF/HFpEF and obesity/HFpEF education. Their public course structure and topic coverage were reviewed; gated courses were not completed and their proprietary teaching was not copied. Their credit designations do not confer credit on HEART RESERVE.

The choice of interactive virtual cases is a design hypothesis about learner needs, not a measured preference result from this audience. The provider/host must supply activity-specific preference and recruitment evidence, or use a brief prelaunch preference check covering session time, format, testing access and care barriers. That check refines delivery; it is not represented as completed evidence or a large paid survey.

Source keys: mycme, mycme2

## Gap, clinical decision and measurable response

Renee: persistent exertional limitation despite reassuring or inconclusive resting findings leads to three assessable decisions: recognize that preserved EF is not exclusionary, choose a justified confirmation pathway and reassess competing diagnoses or new urgency. The E1 concept map links each opening response to a formative decision, a parallel first post response and its reserved follow-up case.

Angela: treatment selection requires separating population, endpoint and individual eligibility. The E2 concept map tests an SGLT2 treatment discussion, interpretation of obesity/HFpEF trial endpoints and indication-specific finerenone initiation/monitoring. The grant seeks better evidence application and safety reasoning; product uptake is not an outcome.

Teresa: a plan is incomplete until results and responsibility reach the patient and receiving team. The E3 map tests acute safety escalation, laboratory action and ownership of missing results. Follow-up asks about eligible encounters, reported actions and barriers; it does not equate a selected case answer with observed clinical performance.

Each module has three baseline, three formative and three parallel post items. Report first-response paired scores and denominators, item-level changes, missingness and retry results separately. The same constructs are revisited with the nine reserved 60-day items. Parallel forms require independent adjudication and a pilot; their scores are not assumed psychometrically equivalent. Keep the live S-prefixed bank separate from the enduring E-prefixed bank and record prior exposure.

## Curriculum and objectives

Session 1: Breathlessness With a Preserved EF. Renee's persistent functional loss, obesity, low NT-proBNP and preserved EF create a diagnostic problem. Learners select an appropriate next test or referral, interpret intermediate probability and keep important alternatives and urgent symptoms visible.

Session 2: What Changes After HFpEF Is Confirmed? Angela's case connects HF treatment without diabetes, obesity-trial interpretation and HF-specific finerenone initiation/monitoring. Learners distinguish studied populations, symptom outcomes, composite clinical events, mortality claims, guideline recommendations and current US indications.

Session 3: Keeping the Plan Working. Teresa's transition home tests response to concerning illness during SGLT2 therapy, potassium-based initiation eligibility and ownership of missing laboratory results. Learners create a feasible handoff and recognize when urgent assessment takes priority.

Each live session has a 60-minute design target: baseline decisions 5 minutes; evidence framework 10; progressive case discussion 25; audience questions/barriers 10; parallel post cases 5;

synthesis/evaluation 5. The prepared materials support facilitated dialogue, not 60 minutes of prerecorded narration. Rehearsal and a timed pilot must validate the duration.

The expanded enduring companion comprises three separately assessed modules: Renee, Angela and Teresa. Each has three baseline questions, a complete narrated or equivalent written lesson, three formative case decisions, three parallel post questions and an evaluation. There are 38 minutes 48 seconds of measured narration, 9 baseline items, 9 formative decisions and 9 post items. The 90-110-minute total design estimate includes decision work, feedback and evidence review; it is not measured learner time or a credit designation. A timed pilot and provider approval must validate duration, passing rules, distinct content and repeat-credit policies.

## Content independence and validation

The accredited provider and independent clinical chair control objectives, faculty, content, assessments and release. Supporters do not choose the answers, require product preference, control faculty selection or receive learner-level marketing leads. Commercial support is acknowledged only using provider-approved language after agreement.

Collect relevant financial relationships, determine their relevance, mitigate as required, document resolution and disclose to learners before participation. An independent reviewer checks the full manuscript, slides, polls, answers, current labels and all claims. Any discussion outside an approved indication must be identified and placed in context. Maintain a dated claim-to-source and issue-resolution log.

Teach both empagliflozin and dapagliflozin as appropriate evidence-based options, alongside congestion management, comorbidity care, MRA evidence and obesity therapies when relevant. Include diagnostic alternatives, treatment limitations, adverse effects and nonpharmacologic care. Do not select a correct answer because it favors the prospective supporter.

Current primary trials, prescribing information and ACC/ESC materials inform this review edition. A qualified clinical lead must adjudicate applicable US guidance and all release-date changes. Source checking by this development workflow is not independent faculty approval.

Source keys: acc26, esc, emperor, deliver, finearts, kerendia, step, summit

## Recruitment, reach and access

Planning targets are 300 verified attendees per virtual session, 1,200 unique enduring starters and 1,500 unique learners across all formats. This implies 2,100 activity participations and approximately 600 repeat participations; the counts are not additive unique reach. Targets are assumptions awaiting a named distribution partner's activity-specific quote, channel plan and overlap model.

The recruitment plan should itemize permission-based email segments, professional education placements, partner calendar/listing activity and reminders, with profession/setting criteria,

deliverability reporting and attributable costs. Monitor registrations, verified attendance, starts and completion separately. Do not equate delivered invitations, impressions, registrations, clicks or a publisher database with learners.

Provide accessible captions, transcripts, readable mobile layouts, keyboard operation and a nonvideo route. The host must test iPhone/Safari, Android/Chrome, desktop and screen readers. Faculty and users should review the full media for pronunciation and clinical meaning. Make the event schedule and assistance route clear; do not publish fabricated dates or an active registration claim before contracting.

A previous myCME offer concerns a different pregnancy/cardiovascular activity and does not establish this program's fee, audience guarantee or live-event scope. Obtain a separate HF-specific proposal covering all three conferences, the companion, hosting, reports, follow-up and certificate responsibilities. Reconcile bundled services before finalizing the grant amount.

## Outcomes and analysis

Primary endpoint: within each module or live session, change in first-attempt correct responses on three matched clinical concepts among learners with usable baseline and first post responses. Both formats use parallel case variants. Report live and enduring results separately, and record prior exposure because the enduring questions adapt the same live item bank. Do not count repeated exposure as independent evidence. Preserve first attempts; report retries and eventual passing separately.

Report item-level and participant-level paired scores, sample sizes, percentage-point changes and 95% confidence intervals. The analysis plan prespecifies participant-level resampling for the paired score change and appropriate paired item summaries. Missing responses are reported, not converted into incorrect answers or silently dropped from participation denominators. Retry success is reported separately from learning.

Planning success targets are at least 15 percentage-point matched improvement, 70% usable paired participation per live session, 70% enduring completion among starts and 30% response to delivered follow-up invitations. These are provisional targets, not predicted results or a power calculation. Pilot data and partner benchmarks should determine whether they are feasible.

At 60 days, invite consenting eligible participants to the three parallel follow-up application cases corresponding to each completed module/session and brief selections about encounters, actions and barriers. Nine reserved follow-up items cover the full series; these are not used as formative exercises. Coordinate invitations and prior exposure across live/enduring participation. Report retained competence separately from self-reported practice, with delivered-invitation denominators and bounce counts. No patient outcome or verified-performance claim is planned.

Use a stable pseudonymous identifier for analysis, with the identity linkage retained securely by the host. Deduplicate people across sessions and the companion. Provide course-specific results first; a

series total must not double-count people or costs. Suppress small subgroup cells under the approved privacy policy and treat exploratory comparisons as such.

The proposed Moore level 4 assessment requires independent review of each parallel case, a defensible scoring key, pilot evidence and a prespecified analysis before release. The prepared items are not yet a validated instrument. Evaluate the live and enduring formats separately and interpret any 60-day application score within its response and equivalence limitations.

## Faculty, partner roles and delivery schedule

Proposed contributions include an HF specialist chair; women's preventive cardiologist; clinical pharmacist/cardiorenal specialist; primary-care PA/NP educator; independent clinical/assessment reviewers; accredited provider; host/distribution partner; and outcomes specialist. Lisa Zahakos, RPA-C is the proposed PA educator/moderator. Other names, credentials, contracts and conflicts must be verified before submission or release as required.

Where one qualified person performs two roles, combine hours and remove duplication. Faculty compensation requires documented work, reasonable rates and review. The organizational applicant must satisfy the current RFP rules; prior provider discussions, an EIN or a website do not establish applicant eligibility or accreditation.

Working schedule: October 2026 applicant, faculty and quote confirmation; provisional internal submission target November 2, subject to confirming the saved November 3, 2026 deadline in the current portal. After any award and executed agreement: first-quarter 2027 clinical review, platform adaptation and pilot; proposed live sessions April, May and June 2027; enduring companion from April 2027 for up to 12 months; rolling 60-day follow-up and final reporting after the last eligible follow-up. All dates require provider/funder acceptance and are not booked events.

The host supplies secure learner identification, authoritative attendance/attempt records and account-based certificate retrieval. Existing browser-local certificates remain noncredit records. The shared HEART RESERVE certificate design can be used with approved provider wording only after approval.

Source keys: rfp

## Budget justification and funding controls

The \$179,000 direct planning estimate funds future defined work. It contains no added indirect charge, learner honoraria, unspecified contingency, proposal-preparation fee or reimbursement for the existing course, scenes, code, branding, draft slides or assessments. Future expert-requested changes must be distinguishable from this completed development.

Replace all estimates with documented scopes and reasonable rates before submission. Clinical chair, faculty, reviewer, editorial, pilot and outcomes lines use hours or defined units. Live

production, hosting, recruitment and provider allowances require itemized vendor quotes. Direct delivery coordination covers actual rehearsal/scheduling tasks and cannot be used to relabel general overhead.

BIPI's general policy permits eligible indirect costs up to 30% of direct costs, subject to its conditions. This program does not automatically add that allowance. The RFP's general \$350,000 request guidance is not an entitlement or a reason to enlarge the budget. No costs of preparing the RFP response are requested.

The companion's incremental scope must be confirmed under this live/virtual call. If it is ineligible, remove its update line and the attributable shares of hosting, recruitment, media, provider work and outcomes; identify separate funding rather than concealing those costs inside the live scope. Use one ledger to allocate every invoice across supporters and contributed resources, with total allocations never exceeding eligible actual cost.

At the proposed reach target, \$179,000 corresponds to about \$119 per unique learner and \$85 per activity participation. These are planning ratios based on unconfirmed reach, not quoted acquisition prices or observed value. If quotes do not support the reach and scope, resize the request. Partial funding requires a revised approved scope rather than underdelivering the original promise.

The proposed educator fee totals \$27,500 (15.36% of \$179,000), across moderation, faculty-directed educational revisions, conditional enduring updates, educational host adaptation and narration. All other services have separate payees. Aggregate every payment to Lisa Zahakos before approval and keep the total below 20% of the final funded amount.

Source keys: policy, rfp

## Submission attachments and release gates

The reviewer package supplies the curriculum, objective map, live/retention items, facilitator notes, outcomes protocol, itemized budget, allocation ledger, partner-scope questions and readiness checklist. The authorized applicant must add authentic legal/tax documents, accreditation or content-control evidence, faculty CVs/disclosures/commitments, accepted provider and distribution scopes, final schedule and any additional portal-required fields.

Before submission, obtain current portal requirements and confirm the applicant, format and companion eligibility directly through the BIPI grants office. Before release, complete independent clinical signoff, assessment/passing-rule approval, timed pilot, real-device/accessibility QA, human listening, record/certificate integration and provider release. Reviewer access must be arranged before sharing the private Site.

The application has not been submitted. No grant is awarded until a formal agreement is fully executed. No messages, faculty invitations or registration campaigns have been sent by this work.

Source keys: rfp

# Budget and compensation

All values are prospective planning estimates. Every line needs a confirmed scope, allowable rate and accepted future deliverable.

| Line  | Future work                                             | USD       |
|-------|---------------------------------------------------------|-----------|
| B01   | Clinical chair                                          | \$9,000   |
| B02   | Specialist faculty                                      | \$13,500  |
| B03   | PA educator and moderator                               | \$6,000   |
| B04   | Independent clinical and assessment reviewers           | \$4,800   |
| B05   | Faculty-directed revision of three session packages     | \$9,000   |
| B06   | Future enduring evidence updates                        | \$4,000   |
| B07   | Live interaction and host adaptation                    | \$4,000   |
| B08   | New faculty-requested clinical graphics                 | \$1,800   |
| B09   | Accessibility and revised-media verification            | \$3,000   |
| B10   | Educator narration revisions for three session packages | \$4,500   |
| B11   | Assessment pilot and validation                         | \$4,500   |
| B12   | Live technical production                               | \$19,500  |
| B13   | Hosting, registration and data integration              | \$15,000  |
| B14   | Clinician recruitment and distribution                  | \$40,000  |
| B15   | Accreditation and required provider records             | \$18,000  |
| B16   | Outcomes management and analysis                        | \$12,000  |
| B17   | Final outcomes report and reconciliation evidence       | \$4,000   |
| B18   | Direct session-delivery coordination                    | \$6,400   |
| Total | Prospective request                                     | \$179,000 |

Lisa’s aggregate proposed compensation is \$27,500 (15.36%). Apply the 20% user-directed ceiling to the final funded total across all roles. This is a planning constraint, not a claim of a universal funder rule.

# Source register

## **rfp | Boehringer Ingelheim HF IME RFP, October 7, 2026**

[https://www.acehp.org/Portals/0/RFPs/2026/Request%20for%20Proposal\\_HF%20October%202026.pdf?ver=L4kWl\\_Y4lc1eAwA\\_o-klwA%3D%3D](https://www.acehp.org/Portals/0/RFPs/2026/Request%20for%20Proposal_HF%20October%202026.pdf?ver=L4kWl_Y4lc1eAwA_o-klwA%3D%3D)

## **policy | Boehringer Ingelheim US independent medical education grants**

<https://pro.boehringer-ingelheim.com/us/medinfo/medical-research-funding/independent-medical-education-grants>

## **gap | El Rafei et al. US ambulatory HF SGLT2 prescribing. JAMA Cardiology 2025.**

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12242822/>

## **diagnostic | Kosyakovsky et al. Unrecognized HFpEF in obesity and dyspnea. 2024.**

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11214582/>

## **np | Reddy et al. Natriuretic peptides in ambulatory HFpEF assessment. Circulation 2025.**

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12021425/>

## **acc | ACC HFpEF consensus: practical diagnostic and management framework.**

<https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2023/04/17/16/40/2023-acc-expert-consensus-on-hfpef>

## **acc26 | ACC summary of the 2026 HFpEF consensus update.**

<https://www.acc.org/latest-in-cardiology/journal-scans/2026/07/22/17/25/updated-acc-eudp-addresses-management-of-hfpef>

## **esc | ESC 2026 Heart Failure guideline and official materials.**

<https://www.escardio.org/guidelines/clinical-practice-guidelines/all-esc-practice-guidelines/heart-failure/>

## **hfa | Pieske et al. HFA-PEFF diagnostic algorithm.**

<https://pubmed.ncbi.nlm.nih.gov/31504452/>

## **emperor | EMPEROR-Preserved primary report.**

<https://pubmed.ncbi.nlm.nih.gov/34449189/>

## **deliver | DELIVER primary report.**

<https://pubmed.ncbi.nlm.nih.gov/36027570/>

**finearts | FINEARTS-HF primary report.**

<https://pubmed.ncbi.nlm.nih.gov/39225278/>

**kerendia | Finerenone US prescribing information, September 2026.**

[https://labeling.bayerhealthcare.com/html/products/pi/Kerendia\\_PI.pdf](https://labeling.bayerhealthcare.com/html/products/pi/Kerendia_PI.pdf)

**jardiance | Empagliflozin US prescribing information.**

<https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=5777b8a8-ada6-4950-8548-43a1de11f075>

**farxiga | Dapagliflozin US prescribing information, June 2026.**

<https://www.dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=72ad22ae-efe6-4cd6-a302-98aaee423d69&type=display>

**step | STEP-HFpEF primary report.**

<https://pubmed.ncbi.nlm.nih.gov/37622681/>

**summit | SUMMIT primary report.**

<https://pubmed.ncbi.nlm.nih.gov/39555826/>

**sema | Wegovy US prescribing information.**

<https://www.novo-pi.com/wegovy.pdf>

**tirz | Zepbound US prescribing information.**

<https://pi.lilly.com/us/zepbound-uspi.pdf>

**sex | STEP-HFpEF prespecified pooled sex analysis.**

<https://pubmed.ncbi.nlm.nih.gov/38913003/>

**mycme | myCME public listing: From Gaps to Gains-Guiding HFmrEF and HFpEF Care.**

<https://www.mycme.com/courses/from-gaps-to-gains-guiding-hfmrEF-and-hfpEF-care-10820>

**mycme2 | myCME public listing: Obesity Management in a Patient With HFpEF.**

<https://www.mycme.com/courses/obesity-management-in-a-patient-with-hfpEF-10572>