

Session 2

What Changes After HFpEF Is Confirmed?

Select an evidence-based treatment discussion and monitoring plan without overstating trial or label claims.

Facilitator review manuscript | 60-minute design target | Not a scheduled or delivered event

Minutes	Teaching task
0-5	Three baseline decisions; first responses locked
5-15	Evidence framework
15-40	Progressive case reveal, polling and faculty reasoning
40-50	Audience questions and implementation barriers
50-55	Three parallel post-case decisions
55-60	Synthesis and evaluation

Use the prepared frames with clinical faculty discussion, not as a timed self-running narration. The baseline and post case decisions require secure host capture. Presenter previews do not collect authoritative learner records. Complete clinical review and rehearsal before release.

Faculty preparation

Review the enduring case, current sources and complete labels. Declare and mitigate financial relationships through the provider. Agree who teaches each frame, who monitors questions and who resolves unanswered clinical issues. Test poll capture, captions, accessible materials, technical support and recording consent. Keep answer keys separate from the learner’s baseline view.

FRAME 1 / 10

The swelling improved. The treatment decision remains.

- 67 years old; confirmed HFpEF; EF 58%
- Obesity and hypertension; no diabetes
- Stable after congestion treatment; renal function and medicines under review

Faculty facilitation

Open with Angela in her modern kitchen if the brief scene adds context. Her question is practical: if she does not have diabetes, why is a medicine commonly associated with diabetes being discussed? Ask learners to separate symptom relief from treatment intended to reduce HF events. Do not present a brand as the inevitable conclusion. Allow the panel to articulate the patient priorities, treatment burden and affordability questions.

Source: 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>

FRAME 2 / 10

Three opening decisions

- HF therapy without diabetes
- What a positive trial actually proves
- Starting dose, target dose and monitoring

Faculty facilitation

Collect the three independent pre responses before presenting efficacy data. Do not disclose correct choices through slide titles or sponsor logos. This activity compares decision quality, not willingness to prescribe. The accredited host must retain first responses, time stamps and item versions. The faculty will revisit all three concepts using new patients after discussion.

Source: 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>

FRAME 3 / 10

Use the evidence for the question it answered

- EMPEROR-Preserved and DELIVER: HF event composites
- Benefits did not require diabetes
- Separate trials do not establish a drug ranking

Faculty facilitation

Explain why a patient without diabetes can still be eligible for an appropriate SGLT2 inhibitor. Describe the study populations and outcomes without implying that every composite component showed the same effect. Ask the pharmacist to distinguish expected benefit from a guarantee. Do not rank empagliflozin and dapagliflozin using their separate hazard ratios. Present the decision within the complete HF and comorbidity plan.

Source: DELIVER primary report. <https://pubmed.ncbi.nlm.nih.gov/36027570/>

FRAME 4 / 10

Make initiation a usable plan

- Review renal function and volume status
- Check product-specific eligibility, safety and access
- Teach illness and procedure instructions

Faculty facilitation

Walk through what must happen before the first prescription: actual renal function, volume status, concurrent therapies, affordability and a realistic follow-up. Discuss genital or urinary symptoms and ketoacidosis warning symptoms. Product-specific renal instructions differ. Both labels include withholding at least three days before surgery or prolonged fasting when possible, and resuming after stability and oral intake return. Invite questions that clarify implementation rather than rehearsing a promotional benefit statement.

Source: Dapagliflozin US prescribing information, June 2026. <https://www.dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=72ad22ae-efe6-4cd6-a302-98aaee423d69&type=display>

FRAME 5 / 10

Obesity therapy: population and endpoint matter

- STEP-HFpEF: symptoms, function and weight
- SUMMIT: composite benefit driven by worsening-HF events
- Neither is a head-to-head comparison

Faculty facilitation

Ask Angela's question: does this mean I am less likely to die? Faculty should explain what was and was not demonstrated. Review symptom/function improvement and the difference between a composite and mortality alone. Discuss labeled obesity indications, tolerability, nutrition and physical function. The absence of an HFpEF indication in the current US obesity-product labels must remain clear when discussing the trial evidence.

Source: SUMMIT primary report. <https://pubmed.ncbi.nlm.nih.gov/39555826/>

FRAME 6 / 10

Mineralocorticoid antagonism: distinguish the evidence

- FINEARTS-HF enrolled EF at least 40%
- Finerenone has a current US HF indication
- Do not treat TOPCAT as a positive head-to-head comparison

Faculty facilitation

Connect the biological rationale to the clinical evidence, then stop short of claiming interchangeable results across all MRAs. FINEARTS-HF and TOPCAT were different trials. Introduce finerenone only within a balanced review of appropriate HF treatment, comorbidities and safety. Ask the independent reviewer to confirm the current label and guideline interpretation before release, including differences between European guidance and US prescribing authority.

Source: FINEARTS-HF primary report. <https://pubmed.ncbi.nlm.nih.gov/39225278/>

FRAME 7 / 10

Reveal: eGFR 42, potassium 4.7

- After full eligibility checks: HF start 10 mg daily
- HF target for that baseline renal category: 20 mg when eligible
- Potassium/eGFR at four weeks; use the complete HF adjustment table

Faculty facilitation

Ask learners to distinguish starting dose from target dose. A participant who remembers a CKD regimen may choose the wrong monitoring or titration rule. Have the pharmacist explain the indication-specific table and contraindications. Name the clinician who will review the result. Do not assume that a target dose must be reached regardless of laboratory changes, tolerability or clinical circumstances.

Source: Finerenone US prescribing information, September 2026.
https://labeling.bayerhealthcare.com/html/products/pi/Kerendia_PI.pdf

FRAME 8 / 10

Build a complete plan with Angela

- HF therapy and congestion management have different purposes
- Address BP, rhythm, kidney health, function and sleep
- Decide together what is feasible and affordable

Faculty facilitation

Invite the primary-care faculty member to explain how the plan fits into a typical visit and subsequent contact. Ask Angela's fictional question about cost, pill burden or laboratory access, and have the panel work through a response. Do not imply that choosing a medication resolves food access, transportation or referral delays. Document the decision and the reason when treatment is deferred.

Source: 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>

FRAME 9 / 10

Questions that test the evidence

- Does a positive composite prove a mortality benefit?
- Can obesity treatment replace all HF-directed care?
- How does European guidance differ from a US indication?

Faculty facilitation

Use ten minutes for audience discussion. Correct overstatements without implying that a therapy lacks value simply because one outcome was not established. Explain that sex subgroup evidence supports relevant female cases but not a universal claim of greater drug benefit in women. Note unanswered questions for source-checked faculty follow-up.

Source: STEP-HFpEF prespecified pooled sex analysis. <https://pubmed.ncbi.nlm.nih.gov/38913003/>

FRAME 10 / 10

Apply the evidence to a new patient

- Three parallel post cases
- Choose the next treatment and monitoring step
- Explain the expected benefit and the limit

Faculty facilitation

Collect the three first post responses and then debrief. Ask the audience to state one trial claim they would now explain more carefully. Finish with an action that can be implemented: connect every treatment choice to the patient, evidence, current label, safety plan and access. Complete the evaluation without an essay or a media-watching requirement.

Source: 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>

Assessment and rationale key

Host/faculty use. Preserve independent first baseline and post responses before feedback. Parallel variants assess the same concept; validate their clarity and difficulty in the pilot.

Pre cases

S2-sglt2-pre

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

- A. Wait for diabetes before considering an SGLT2 inhibitor.
- B. Discuss an eligible SGLT2 inhibitor with product-specific safety and access review.
- C. Increase diuretic therapy despite euvolemia as the only treatment.
- D. Use a beta-blocker solely to reproduce HFrEF therapy.

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

S2-endpoints-pre

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

- A. Yes; every component of a positive composite must improve.
- B. It proves superiority over semaglutide.
- C. The composite improved, driven by fewer worsening-HF events; isolated mortality reduction was not demonstrated.
- D. The study assessed weight only.

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

S2-finerenone-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?

- A. Start 40 mg and check labs at the annual visit.
- B. Start 10 mg daily and arrange potassium/eGFR review at four weeks.
- C. Start the 20 mg target immediately for every patient.
- D. Use only the CKD dose-adjustment table.

Best answer: B. At eGFR 25 to below 60, the HF starting dose is 10 mg. The HF target is 20 mg if eligible; use current HF titration and laboratory instructions.

Post cases

S2-sgl2-post

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

- A. It is required only to prevent future diabetes.
- B. All SGLT2 agents have interchangeable HF labels.
- C. Trials support HF benefit beyond glucose lowering; select a suitable agent and monitoring plan.
- D. A standalone cardiovascular mortality benefit was proven in every HFpEF trial.

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

S2-endpoints-post

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

- A. It demonstrated symptom, function and weight benefits; it was not designed to establish a mortality reduction.
- B. Its weight effect proves longer survival.
- C. Its findings establish superiority over tirzepatide.
- D. The result means all obesity drugs treat HFpEF identically.

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

S2-finenone-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?

- A. Start 20 mg because that is her target.
- B. Start 10 mg and check potassium only after symptoms develop.
- C. Start 10 mg, check potassium/eGFR at four weeks, and consider the 20 mg HF target when eligible.
- D. Start 40 mg because the HF label differs from CKD.

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

Followup cases

S2-sglt2-followup

A euvolemic woman with HFpEF declines therapy because she does not have diabetes. Which response supports shared decision-making?

- A. Explain the HF evidence and review her eligibility, preferences, safety and coverage.
- B. Defer the discussion until another HF hospitalization establishes the need for treatment.
- C. Explain that the principal expected benefit is a proven reduction in cardiovascular death alone.
- D. Increase loop-diuretic treatment first and reassess whether another HF medicine is needed.

Best answer: A. Discuss expected benefit and limitations without making guarantees or ignoring treatment burden.

S2-endpoints-followup

A colleague ranks semaglutide and tirzepatide by comparing their separate HFpEF trial effect sizes. What is the best response?

- A. Agree because both trials included obesity.
- B. Choose the larger numerical effect without considering endpoints.
- C. Treat guideline recommendations as equivalent to US approval.
- D. Explain that different designs and endpoints do not establish head-to-head superiority.

Best answer: D. Trial evidence, guidelines and labels are related but distinct. Neither separate trials nor a European recommendation establishes a US HFpEF indication.

S2-finerenone-followup

Baseline eGFR is 48 and potassium is 4.6 before finerenone for HF. Which instruction is appropriate?

- A. Use the HF 10 mg starting dose, review potassium/eGFR at four weeks and titrate only if eligible.
- B. Use the HF 40 mg target as the starting dose.
- C. Avoid all mineralocorticoid antagonists because EF is preserved.
- D. Omit follow-up labs because baseline potassium is normal.

Best answer: A. The HF-specific plan links eligibility, starting dose, renal-category target and monitoring. Baseline normality does not replace reassessment.