

Session 3

Keeping the Plan Working

Respond appropriately to medication-related warning symptoms and complete a named monitoring and follow-up handoff.

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 order is placed. Has the care happened?

- 72 years old; recently hospitalized with HF
- CKD, type 2 diabetes and multiple prescriptions
- Different teams own different parts of the list

Faculty facilitation

Use the fictional kitchen-table scene to introduce Teresa's confusion, not as evidence of a real patient outcome. She has a discharge list, pharmacy instructions and an upcoming appointment. Ask who is responsible for reconciling what she actually takes. Invite the audience to identify one failure that can occur even when every individual order is technically correct.

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 2 / 10

Three opening decisions

- Urgent symptoms during SGLT2 treatment
- Potassium and initiation eligibility
- Missing tests and accountable follow-up

Faculty facilitation

Use the three pre items before displaying the safety algorithms. Preserve first responses and count missing values separately. Explain that the cases test recognition and coordination, not memorization of every prescribing-table cell. The host should distinguish anonymous audience questions from learner assessment records and should never solicit identifiable patient cases in open chat.

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

Reconcile what she actually takes

- Discharge list, bottles and pharmacy information
- What was stopped, substituted or never obtained?
- Cost, transport, cognition and caregiver support

Faculty facilitation

Have the pharmacist ask Teresa to describe each medicine in her own words. Then have the primary-care clinician identify which discrepancies require same-day clarification. Avoid treating an electronic medication list as evidence that a medicine was obtained or taken. Include nonprescription products and newly prescribed interacting medicines. Identify the clinician responsible for resolving each unresolved discrepancy.

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 4 / 10

Reveal: vomiting, pain and breathlessness

- Recent SGLT2 initiation; poor oral intake
- Home glucose 146 mg/dL
- A reassuring glucose number does not resolve the danger

Faculty facilitation

Pause and ask the panel to state an action before naming the diagnosis. Explain that SGLT2-associated ketoacidosis may occur without marked hyperglycemia. Temporarily stop the medicine and arrange urgent assessment for ketoacidosis, depletion and other acute illness. Do not teach home observation or waiting for the routine panel as the default response to this symptom pattern.

Source: Empagliflozin US prescribing information.

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

FRAME 5 / 10

A different visit: baseline potassium is 5.3

- This result is before the first finerenone dose
- Do not initiate above potassium 5.0
- Review the result, contributing factors and full eligibility

Faculty facilitation

Emphasize the timing: initiation and continuation rules are not interchangeable. A clinician may remember a higher withholding threshold from a titration table and incorrectly use it to start therapy. Ask the pharmacist to explain the difference and how the team will communicate the change to Teresa and the pharmacy. The complete current label controls dose changes; this slide is a decision aid, not a substitute for it.

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

FRAME 6 / 10

When eligible, pair the dose with a monitoring task

- HF potassium/eGFR check at four weeks after starting or dose change
- Earlier assessment when clinical circumstances require
- Named reviewer and patient-contact plan

Faculty facilitation

Ask the audience to name the last step in the task. It is not ordering a laboratory panel. It includes completion, review, an action when needed and communication with the patient. Show how the planned date, location and responsible clinician fit into the discharge or outpatient note. Discuss how coverage is handled if the named clinician is unavailable.

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

FRAME 7 / 10

The result is missing

- Check whether testing occurred elsewhere
- Resolve transport, scheduling or cost barriers
- Keep the task open until reviewed and communicated

Faculty facilitation

Present three practical explanations: the patient did not attend, the result is at another system, or the result arrived but was not routed. Ask the panel for a specific response to each. An automated reminder can assist, but cannot establish that the test occurred. Explain escalation for a persistent missing result based on therapy and clinical risk; do not assign an arbitrary universal delay.

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 8 / 10

Use teach-back to test the plan

- Which medicine changed?
- When and where is the next test?
- Who will call, and which symptoms need immediate help?

Faculty facilitation

Invite a brief role-play between the moderator and pharmacist. Ask the audience which wording is easier to act on. The learner should leave able to describe a closed-loop handoff with a date and owner. Do not require a written assignment or patient disclosure. Include support for language, health literacy, disability and access as practical care-planning considerations.

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>

Questions from the transition home

- What if the receiving clinician has not accepted the handoff?
- What if a medicine is unaffordable?
- Which symptoms bypass routine follow-up?

Faculty facilitation

Reserve ten minutes for audience barriers and questions. Discuss respectful escalation across teams rather than transferring responsibility through an unacknowledged message. For new resting chest pressure, severe dyspnea, syncope or other instability, urgent assessment supersedes the routine pathway. Keep individualized treatment advice out of the public session; teach the reasoning and referral threshold.

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 10 / 10

Make the next step happen

- Complete the three parallel post cases
- Choose one feasible workflow change
- At 60 days, reassess competence and implementation barriers

Faculty facilitation

Collect the post cases before showing the key. Distinguish competence from self-reported behavior: a correct case response demonstrates application in an assessment, while a later report of practice change is not verified patient care. Invite consent for the host follow-up under its privacy policy. Summarize the task: test, date, owner, action and patient communication.

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>

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

S3-acute_safety-pre

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

- A. Reassure her because glucose is below 200.
- B. Wait for her scheduled four-week panel.
- C. Temporarily stop the medicine and arrange urgent assessment for ketoacidosis, depletion and acute illness.
- D. Increase the dose to improve glucose control.

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

S3-lab_action-pre

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

- A. Start because the value is below 5.5.
- B. Do not initiate; assess potassium and contributing factors and reassess eligibility.
- C. Start at the target dose with no further checks.
- D. Use a different indication table to permit initiation.

Best answer: B. The initiation threshold differs from continuation/adjustment rules. Do not initiate when potassium is above 5.0.

S3-ownership-pre

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

- A. Leave the order active.
- B. Send a reminder and close the task.
- C. Wait until the next refill.
- D. Find out whether testing occurred, resolve barriers and ensure clinician review and patient contact.

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

Post cases

S3-acute_safety-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?

- A. Continue treatment until glucose exceeds 250 mg/dL.
- B. Withhold temporarily and obtain urgent clinical assessment.
- C. Arrange a routine appointment in two weeks.
- D. Treat the symptoms as an expected adjustment effect.

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

S3-lab_action-post

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

- A. Hold initiation, evaluate the result and contributing medicines, and reassess the plan.
- B. Start 10 mg because that avoids hyperkalemia.
- C. Start and repeat potassium in six months.
- D. Treat the result as irrelevant because EF is preserved.

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

S3-ownership-post

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

- A. Medication changed; follow up as needed.
- B. Check labs sometime next month.
- C. Specify medication/indication, test date, named result reviewer, contact plan and escalation instructions.
- D. Ask the patient to decide which clinician should manage the results.

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

Followup cases

S3-acute_safety-followup

A patient on SGLT2 therapy cannot maintain oral intake and develops abdominal pain and breathlessness. What should the team do?

- A. Use normal-range glucose to exclude ketoacidosis.
- B. Wait for a home ketone result before any referral.
- C. Advise exercise and reassess tomorrow.
- D. Withhold the medicine temporarily and arrange urgent assessment.

Best answer: D. Escalate concerning illness promptly. A routine monitoring plan does not replace acute assessment.

S3-lab_action-followup

A potential finerenone HF candidate has eGFR 43 but potassium 5.4 before the first dose. What should happen?

- A. Begin immediately because renal function permits treatment.
- B. Apply a continuation threshold to authorize the first dose.
- C. Do not initiate; investigate and manage the elevated potassium before reassessing eligibility.
- D. Start a larger dose to achieve the target sooner.

Best answer: C. Check all initiation criteria. A qualifying eGFR does not override the potassium restriction.

S3-ownership-followup

A patient missed monitoring because transportation fell through. What best addresses the care gap?

- A. Close the order because the patient was reminded.
- B. Arrange a feasible testing route and confirm a responsible clinician reviews and communicates the result.
- C. Wait until the annual visit.
- D. Transfer responsibility without contacting the receiving team.

Best answer: B. Address the practical barrier and track the whole task. Responsibility cannot be assumed from a forwarded order.