Central to the ACC's strategic plan is the generation of actionable knowledge—a concept that places emphasis on making clinical information easier to consume, share, integrate, and update. To this end, the ACC has shifted from developing isolated documents to creating integrated "solution sets." These are groups of closely related activities, policies, mobile applications, decision-support tools, and other resources necessary to transform care and/or improve heart health. Solution sets address key questions facing care teams and attempt to provide practical guidance to be applied at the point of care. They use both established and emerging methods to disseminate information for cardiovascular conditions and their related management. The success of solution sets rests firmly on their ability to have a measurable impact on the delivery of care. Because solution sets reflect current evidence and ongoing gaps in care, the associated tools will be refined over time to match changing evidence and member needs.

Expert Consensus Decision Pathways (ECDPs) represent a key component of solution sets. Standard methodology for developing an ECDP is as follows: for a high-value topic that has been selected by the Science and Quality Committee and prioritized by the Solution Set Oversight Committee (SSOC), a group of clinical experts is assembled to develop content that addresses key questions facing our members.[1] This content is used to inform the development of various tools that accelerate real-time use of clinical policy at the point of care. ECDPs are not intended to provide single correct answers to clinical questions; rather, they encourage clinicians to consider a range of important factors as they define treatment plans for their patients. Whenever appropriate, ECDPs seek to provide unified articulation of clinical practice guidelines, appropriate use criteria, and other related ACC clinical policy. In some cases, covered topics will be addressed in subsequent clinical practice guidelines as the evidence base evolves. In other cases, these will serve as standalone policy.

Nicole M. Bhave, MD, FACC
Chair, ACC Solution Set Oversight Committee

1. INTRODUCTION

1.1. The Scope of the Problem

Despite advances in therapy, heart failure (HF) continues to be a major cause of morbidity and mortality worldwide with a lifetime risk at age 40 years of approximately 20%.[2] Although the incidence of overall HF in the United States appears to be stable or even declining, the incidence of heart failure with preserved ejection fraction (HFpEF) continues to rise.[3,4] HFpEF now accounts for more than 50% of cases of HF,[5] with outcomes comparable to heart failure with reduced ejection fraction (HFrEF).[6] HFpEF is often under-recognized and results in substantial resource utilization.

Historically, treatment options were limited to managing comorbidities; however, revolutionary advances in the past decade regarding the pathophysiology of HFpEF, improved methods of diagnosis, and insights into prognostic predictions now yield novel, effective management strategies. With recent favorable clinical trial results, there is increasing urgency for accurate diagnosis and timely implementation of guideline-directed medical therapy (GDMT). These advances motivate the creation of this ECDP to address pivotal issues pertinent to HFpEF:

1. How to approach a person with shortness of breath
2. How to overcome diagnostic dilemma and identify a need for further testing
3. How to rule out mimics to avoid missed diagnosis
4. How to manage comorbidities and address complexities in care
5. How to initiate and optimize GDMTs
6. When and why to refer to a cardiologist or HF specialist
7. How to improve access to care
8. How to recognize sex-specific differences in diagnosis and care management

1.2. Challenges in the Diagnosis of HFpEF

The Universal Definition of HF requires symptoms and/or signs of HF caused by structural/functional cardiac abnormalities *and* at least 1 of the following: 1) elevated natriuretic peptides; or 2) objective evidence of cardiogenic pulmonary or systemic congestion.[7] While these criteria are clear, there are nuances and challenges to be considered in the diagnosis of HFpEF.

The first challenge in the diagnosis of HFpEF is what ejection fraction (EF) threshold constitutes HFpEF. Based on consensus from the U.S. Heart Failure Collaboratory and Academic Research Consortium,[8] as supported by the Universal Definition of HF,[7] HFpEF is defined as a clinical diagnosis of HF with left ventricular ejection fraction (LVEF) ≥50%. Those individuals with EFs between 40% and 50% are noted to have HF with mildly reduced ejection fraction (HFmrEF). Individuals with HFmrEF comprise a diverse group, including those with improving HFrEF or worsening HFpEF. The separation of HFmrEF and HFpEF is useful because it provides a distinct category for those individuals with stable preserved EF and because EF measurement may vary depending on the imaging modality and interpretation method.

Another challenge in the diagnosis of HFpEF is using the correct terminology. HFpEF is not synonymous with