

determining what constitutes a relevant relationship, with additional vetting by the SSOC.

ECDP writing groups must be chaired or cochaired by an individual with no relevant RWI. Although vice chairs and writing group members may have relevant RWI, they must constitute less than 50% of the writing group. Relevant disclosures for the writing group and comprehensive disclosures for external peer reviewers can be found in [Appendixes 1 and 2](#). To ensure complete transparency, a comprehensive list of disclosure information for the writing group, including relationships not pertinent to this document, is available in a [Supplemental Appendix](#). Writing group members are discouraged from acquiring relevant RWI throughout the writing process.

Every ECDP undergoes a formal peer review process consistent with ACC policy and includes a public comment period to obtain further feedback. Following reconciliation of all comments, ECDPs are then vetted and approved for publication by the Clinical Policy Approval Committee.

3. ASSUMPTIONS AND DEFINITIONS

3.1. General Clinical Assumptions

1. The principal focus of this effort, including ECDP considerations, applies to individuals with HFpEF.
2. The writing committee endorses the evidence-based approach to HF diagnosis and management recommended in the 2022 American Heart Association (AHA)/ACC/Heart Failure Society of American (HFSA) Guideline for the Management of HF.¹⁴
3. Optimal care decisions should properly reflect the individual's preferences and priorities as well as those of the managing clinician. A shared-decision model regarding care decisions is appropriate, particularly when clinical equipoise exists in areas of treatment uncertainty.
4. This ECDP is not intended to supersede good clinical judgement as, especially for HFpEF care, many questions remain unanswered. The treating clinician should seek input as needed from relevant experts (eg, pharmacists, cardiologists, HF specialists, endocrinologists, nephrologists, palliative care specialists).
5. This ECDP is based on the best data currently available. As new discoveries emerge, (eg, trials of additional agents and devices and including other populations), these data will affect the considerations made here. Clinicians should be careful to incorporate relevant information published after this ECDP.
6. Although implementing relevant portions of these recommendations in the acute inpatient hospital setting may be reasonable, this ECDP is primarily focused on management in the ambulatory setting.

3.2. Definitions

GDMT: Treatment options supported for use by clinical practice guidelines.

HF: defined as per the Universal Definition of Heart Failure⁷: symptoms and/or signs of HF caused by structural/functional cardiac abnormalities *and* at least 1 of: 1) elevated natriuretic peptides; *or* 2) objective evidence of cardiogenic pulmonary or systemic congestion. An HF event, including hospitalization, is defined by the criteria outlined by the 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials.¹⁵

HF_rEF: Clinical diagnosis of HF and LVEF ≤40%.¹⁴

HF_{mr}EF: Clinical diagnosis of HF and LVEF 41% to 49%.¹⁴

HF with improved EF: previous LVEF ≤40% and a follow-up measurement >40%.

HF_pEF: Clinical diagnosis of HF and LVEF ≥50%¹⁴ not attributable to an underlying cause such as an infiltrative cardiomyopathy, hypertrophic cardiomyopathy, valvular disease, pericardial disease, or high-output HF.

HF_pEF mimics: Clinical diagnosis of HF and LVEF ≥50% with a primary noncardiac cause (kidney or liver disease) or an underlying cardiac cause (infiltrative cardiomyopathy, hypertrophic cardiomyopathy, valvular disease, pericardial disease, or high-output HF).

New York Heart Association (NYHA) functional classification:

- Class I: No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.
- Class II: Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in symptoms of HF.
- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms of HF.
- Class IV: Unable to perform any physical activity without symptoms of HF, or symptoms of HF at rest.

4. PATHWAY SUMMARY GRAPHIC

Many individuals present first to their primary care clinicians with symptoms of dyspnea and exercise intolerance and/or signs of congestion. The primary care clinician should be aware of HFpEF in the differential diagnosis of dyspnea, exercise intolerance, and edema; order relevant testing; be able to initiate GDMT; and recognize when a cardiology referral may be useful. The role of the cardiology specialist (cardiologist or cardiology advanced practice professional) is to exclude the presence of an alternative diagnosis to explain the individual's presentation of dyspnea, edema, and preserved EF; optimize GDMT; encourage clinical trials; and identify