For the Care Team
Patient Tool: *I Have Heart Failure with Reduced Ejection Fraction. Now What?* My Heart Failure Action Plan

Key Objective:

I Have Heart Failure with Reduced Ejection Fraction. Now What? is for patients with newly diagnosed Stage C HFrEF to guide them in initiating medical therapy during the first 6 to 12 months. This tool, which was developed with input from patients and a multidisciplinary team of clinicians, is available for download at *CardioSmart.org/MyHFActionPlan*.

Print this action plan and review it together with your patients at the point of care. It can be used at hospital discharge or in the outpatient setting to give patients a personalized roadmap of what to reasonably expect. There are also several worksheets to help facilitate optimal self-management in between follow-up appointments, such as a daily weight tracker, symptom and functional assessment and medication adherence tips.

Putting the Plan Into Action:

We hope that this tool can be used to engage patients in their care plans by educating them on how to do the following:

- Document individual treatment goals, challenges and priorities
- Recognize and report cardinal signs of worsening heart failure
- Understand the mechanism and management of heart failure medications
- Prioritize and start making key lifestyle changes
- Identify possible disease triggers
- Understand what they might expect in terms of medical follow-up and their own emotional journey

Tips For Communicating With Patients:

- Provide simple, meaningful explanations of the risks of HFrEF and its treatments when initiating new therapies and throughout the continuum of care.
- Be sensitive in explaining that HFrEF is a lifelong disease that requires ongoing follow-up and honest reporting of how they feel.
- Ask patients **"What matters most to you?"** Work to understand their preferences and values through shared decision-making.
- Explore potential barriers to receiving and/or adhering to medications, including prior authorization and cost.
- Assess patients' dietary and physical activity habits and their readiness to self-manage through sodium restriction, daily weight checks, symptoms tracking, etc. Provide relevant advice, materials and/or referrals.

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HF Management Checklist:

- ☐ Has the patient been educated about HFrEF and steps to manage it? Can they repeat back or reasonably explain:
  - o How the condition affects their health and function?
  - o Why each medication is being prescribed and how it helps the heart?
  - o Why repeat laboratory testing (every 1-3 weeks at first) and imaging tests will be needed to track their progress
- ☐ Can the patient articulate how they feel? What about how HFrEF affects their functional status?
- ☐ Does the patient understand the potential side effect(s) of each medication, as well as when and how to report them?
- ☐ Does the patient understand the circumstances under which medications may be adjusted over time and why?
- ☐ Does the patient have a way of tracking their medications each day?
- ☐ Have you or a member of your care team answered other common questions about:
  - o How to take each medication (how often, with or without food, etc.)
  - o Any contraindications, drug or food interactions
  - o What to do if they miss a dose
  - o The importance of automating refills, sharing concerns about cost or out-of-pocket expenses, etc.
- ☐ Have you addressed possible disruptions to therapy (e.g., travel, unexpected surgery) and how best to handle these issues?
- ☐ Is there a plan to help assure coordination with other care providers, especially for patients with co-morbidities?
- ☐ Does the patient understand that once optimal doses of guideline directed medical therapy (GDMT) have been achieved for 3-6 months, repeat imaging can be useful in making decisions regarding device therapy (ICD and/or CRT) or referral for advanced therapies (VAD or transplant)?
- ☐ Does the patient understand that repeat imaging may be needed if there are important changes in clinical status?

Additional Resources:

2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment
American College of Cardiology's Succeed in Managing Heart Failure (SIMHF) Initiative

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