

**Worksheet 1. IMPLEMENTATION STRATEGY**  
**Guideline: The Pharmacologic Management of Chronic Heart Failure**

*Overall Implementation Strategy/Focus:*

<b>Key Guideline Element</b>	<b>Gaps in Current Practices (Planning Step 1)</b>	<b>Action Strategy (Planning Step 3)</b>
<b>INITIAL ASSESSMENT AND INTERVENTION</b> 1. Perform history, physical exam, laboratory and other diagnostic procedures.		
2. Classify patient according to stage of disease progression.		
3. Implement nonpharmacologic interventions and risk factor modification, manage concomitant cardiac conditions, address underlying causes.		
4. A diuretic should be used in patients with signs of fluid overload.		
5. Treat with an ACEI (unless contraindicated or not tolerated) if reduced LV function (with or without symptoms) or history of MI.		
6. A $\beta$ -adrenergic blocker should be used in conjunction with an ACEI in all patients with stable HF, and in patients with asymptomatic LV dysfunction or history MI, unless contraindicated or not tolerated.		

<b>Key Guideline Element</b>	<b>Gaps in Current Practices (Planning Step 1)</b>	<b>Action Strategy (Planning Step 3)</b>
7. Digoxin should be used in patients with moderate to severe HF whose symptoms persist despite treatment with an ACEI, a $\beta$ -blocker, and a diuretic.		
8. An AIIRA may be considered as an alternative for patients who cannot tolerate an ACEI due to cough.		
9. Hydralazine and isosorbide dinitrate may be considered in patients with contraindications to or who cannot tolerate an ACEI due to hypotension, renal insufficiency, or possibly, angioedema.		
10. Low dose spironolactone should be considered in patients with recent NYHA class IV HF and current class III or IV symptoms and LVEF $\leq$ 35%, unless contraindications exist.		
<b>General Principles for Management of HF</b> 11. Goals of therapy include improved symptoms, increased functional capacity, improved quality of life, slowed disease progression, decreased need for hospitalization, and prolonged survival.		
12. Educate patients and family on the etiology, prognosis, therapy, dietary restrictions, risk factor modification, activity, adherence, and signs and symptoms of recurrent HF.		

<b>Key Guideline Element</b>	<b>Gaps in Current Practices (Planning Step 1)</b>	<b>Action Strategy (Planning Step 3)</b>
13. Discuss nonpharmacologic therapy including abstaining from alcohol and tobacco, limiting dietary sodium, reducing weight if appropriate, and participating in exercise training programs.		
14. Increase pharmacologic therapy as tolerated in an effort to achieve target doses.		
15. Emphasize adherence to the medication regimen.		
16. Schedule regular follow-up and assess for change in functional status.		
17. Cardiology referral may be requested at any point in the care of the patient. Some facilities may have interdisciplinary HF disease management clinics to provide continuity of care for patients with HF.		

**Worksheet 2A. ACTION PLAN FOR GUIDELINE INTRODUCTION AND STAFF EDUCATION**  
**Guideline: The Pharmacologic Management of Chronic Heart Failure**

Identify actions for guideline introduction and education. (IN)	Designate someone to serve as <b>lead</b> for the action and <b>other staff</b> to be involved.		Identify the <b>tools</b> and <b>resources</b> for the action.	Specify the action timeline.	
Action #IN.__	Lead:	Other Staff:		Start	Complete
Action #IN.__	Lead:	Other Staff:		Start	Complete
Action #IN.__	Lead:	Other Staff:		Start	Complete
Action #IN.__	Lead:	Other Staff:		Start	Complete

**Worksheet 2B. PLANNING WORKSHEET FOR PRACTICE CHANGE IMPLEMENTATION**

**Guideline: The Pharmacologic Management of Chronic Heart Failure**

**Key Guideline Element: \_\_\_\_\_**

Identify actions in the strategy for this guideline element.	Designate someone to serve as <b>lead</b> for the action and <b>other staff</b> to be involved.		Identify the <b>tools</b> and <b>resources</b> for the action.	Specify the action timeline.	
<b>Action #</b> __	<b>Lead:</b>	<b>Other Staff:</b>		<b>Start</b>	<b>Complete</b>
<b>Action #</b> __	<b>Lead:</b>	<b>Other Staff:</b>		<b>Start</b>	<b>Complete</b>
<b>Action #</b> __	<b>Lead:</b>	<b>Other Staff:</b>		<b>Start</b>	<b>Complete</b>
<b>Action #</b> __	<b>Lead:</b>	<b>Other Staff:</b>		<b>Start</b>	<b>Complete</b>
<b>Action #</b> __	<b>Lead:</b>	<b>Other Staff:</b>		<b>Start</b>	<b>Complete</b>

**Worksheet 3. GANTT CHART OF TIMELINE FOR GUIDELINE IMPLEMENTATION**  
**Guideline: The Pharmacologic Management of Chronic Heart Failure**

Actions	MONTH OF WORK											
	1	2	3	4	5	6	7	8	9	10	11	12
<i>Introduction &amp; Education</i>												
#IN. __												
#IN. __												
#IN. __												
#IN. __												
<i>Practice Changes</i>												
# __												
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**Worksheet 4. METRICS AND MONITORING**  
**Guideline: The Pharmacologic Management of Chronic Heart Failure**

Key Guideline Element	Metric	Data Sources	Monitoring Schedule
<b>INITIAL ASSESSMENT AND INTERVENTION</b> 1. Perform history, physical exam, laboratory and other diagnostic procedures.			
2. Classify patient according to stage of disease progression.			
3. Implement nonpharmacologic interventions and risk factor modification, manage concomitant cardiac conditions, address underlying causes.			
4. A diuretic should be used in patients with signs of fluid overload.			
5. Treat with an ACEI (unless contraindicated or not tolerated) if reduced LV function (with or without symptoms) or history of MI.			
6. A $\beta$ -adrenergic blocker should be used in conjunction with an ACEI in all patients with stable HF, and in patients with asymptomatic LV dysfunction or history MI, unless contraindicated or not tolerated.			
7. Digoxin should be used in patients with moderate to severe HF whose symptoms persist despite treatment with an ACEI, a $\beta$ -blocker, and a diuretic.			
8. An AIIRA may be considered as an alternative for patients who cannot tolerate an ACEI due to cough.			
9. Hydralazine and isosorbide dinitrate may be considered in patients with contraindications to or who cannot tolerate an ACEI due to hypotension, renal insufficiency, or possibly, angioedema.			
10. Low dose spironolactone should be considered in patients with recent NYHA class IV HF and current class III or IV symptoms and LVEF $\leq 35\%$ , unless contraindications exist.			

Key Guideline Element	Metric	Data Sources	Monitoring Schedule
<p><b>General Principles for Management of HF</b></p> <p>11. Goals of therapy include improved symptoms, increased functional capacity, improved quality of life, slowed disease progression, decreased need for hospitalization, and prolonged survival.</p>			
<p>12. Educate patients and family on the etiology, prognosis, therapy, dietary restrictions, risk factor modification, activity, adherence, and signs and symptoms of recurrent HF.</p>			
<p>13. Discuss nonpharmacologic therapy including abstaining from alcohol and tobacco, limiting dietary sodium, reducing weight if appropriate, and participating in exercise training programs.</p>			
<p>14. Increase pharmacologic therapy as tolerated in an effort to achieve target doses.</p>			
<p>15. Emphasize adherence to the medication regimen.</p>			
<p>16. Schedule regular follow-up and assess for change in functional status.</p>			
<p>17. Cardiology referral may be requested at any point in the care of the patient. Some facilities may have interdisciplinary HF disease management clinics to provide continuity of care for patients with HF.</p>			