PMT FORM SELECTION	**Legend: Elements in bold are required**
HF	**Patient ID:**

ARRIVAL AND ADMISSION INFORMATION

Internal Tracking ID:		Physician/Provider NPI:	
Arrival Date and Time:	___/___/_____ ___: ____	☐ MM/DD/YYYY only ☐ Unknown/Date UTD	
Admit Date:	___/___/_____	Transferred in (from another ED)?	O Yes O No

Point of Origin for Admission or Visit:	O 1 Non-Health Care Facility Point of Origin O 2 Clinic O 4 Transfer From a Hospital (Different Facility) O 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	O 6 Transfer from another Health Care Facility O 7 Emergency room O 9 Information not available O F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program

DEMOGRAPHIC DATA

Date of Birth:	___/___/_____	**Race:**	☐ American Indian or Alaska Native ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐Other Pacific Islander ☐ White ☐ UTD
Gender:	O Male O Female OUnknown	**Hispanic Ethnicity** If yes,	**:** O Yes O No/UTD ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino or Spanish Origin
Payment Source:	☐ Medicaid (Title 19) ☐ Medicare (Title 18) ☐ Medicare – Private/HMO/Other	☐ No Insurance/Not Documented/UTD ☐ Private/HMO/Other	
External Tracking ID**:**	_____	**Patient Postal Code:**	_____ - _____

MEDICAL HISTORY

Medical History (Select all that apply)	☐ None	☐ Anemia	☐ Atrial Fib (Chronic or Recurrent)
	☐ Atrial Flutter (Chronic or Recurrent)	☐ CAD	☐ CardioMEMS (implantable hemodynamic monitor)
	☐ CRT-D (cardiac resynchronization therapy with ICD)	☐ CRT-P (cardiac resynchronization therapy-pacing only)	☐ COPD or Asthma
	☐ CVA/TIA	☐ Depression	☐ Diabetes - Insulin treated
	☐ Diabetes - Non-insulin treated	☐ Dialysis (chronic)	☐ Heart failure
	☐ Hyperlipidemia	☐ Hypertension	☐ ICD only
	☐ Pacemaker	☐ Peripheral Vascular Disease	☐ Prior CABG
	☐ Prior MI	☐ Prior PCI	☐ Renal insufficiency - chronic (SCr>2.0)
	☐ Valvular Heart Disease	☐ Ventricular assist device	

History of Cigarette Smoking? (in past 12 months): O Yes O No

Heart Failure History	Etiology: Check if history of:	☐ Ischemic/CAD	☐ Non-Ischemic ☐ Hypertensive ☐ Alcohol/other drug ☐ Chemotherapy ☐ Viral ☐ Familial ☐ Other Etiology ☐ Unknown/ Idiopathic

	Known history of HF prior to this admission?	O Yes O No
	# hospital admissions in past 6 mo. for HF:	O 0 O 1 O 2 O >2 O Unknown
	☐ Patient listed for transplant	

DIAGNOSIS

Heart Failure Diagnosis	☐ Heart Failure, primary diagnosis, with CAD ☐ Heart Failure, primary diagnosis, no CAD ☐ Heart Failure, secondary diagnosis		
Atrial Fibrillation (At presentation or during hospitalization)	O Yes O No	Documented New Onset?	☐
Atrial Flutter (At presentation or during hospitalization)	O Yes O No	Documented New Onset?	☐

New Diagnosis of Diabetes	O Yes O No O Not Documented	
Basis for Diagnosis	☐ HbA1c ☐ Oral Glucose Tolerance	☐ Fasting Blood Sugar ☐Test Other
Characterization of HF at admission or when first recognized	O Acute pulmonary edema O Dizziness/syncope O Dyspnea O ICD Shock/Sustained Ventricular Arrhythmia	O Pulmonary congestion O Volume overload/Weight Gain O Worsening fatigue O Other
Other Conditions Contributing to HF Exacerbation *Select all that apply*	☐ Arrhythmia ☐ Pneumonia/respiratory process ☐ Worsening renal failure ☐ Noncompliance – medication	☐ Ischemia/ACS ☐ Uncontrolled HTN ☐ Noncompliance – dietary ☐ Other

MEDICATIONS AT ADMISSION

Medications Used Prior to Admission *Select all that apply*	☐ Patient on no meds prior to admission ☐ ACE inhibitor ☐ Aldosterone antagonist ☐ Angiotensin receptor blocker (ARB) ☐ Angiotensin receptor neprilysin inhibitor (ARNI) ☐ Antiarrhythmic ☐ Anticoagulation Therapy ☐ Warfarin ☐ Direct Thrombin Inhibitor ☐ Factor Xa Inhibitor ☐ Other ☐ Antiplatelet agent (excluding aspirin) ☐ Aspirin ☐ Beta Blocker ☐ Ca channel blocker ☐ Diabetic Medications (Any) ☐ Digoxin	☐ Diuretic ☐ Thiazide/Thiazide-like ☐ Loop ☐ Hydralazine ☐ Ivabradine ☐ Lipid lowering agent (Any) ☐ Statin ☐ Other lipid lowering agent ☐ Nitrate ☐ Omega-3 fatty acid supplement ☐ Renin Inhibitor ☐ Other

EXAM/LABS AT ADMISSION

Symptoms (closest to admission) *Check all that apply*	☐ Chest pain ☐ Dyspnea at rest ☐ Orthopnea	☐ Decreased appetite/early satiety ☐ Dyspnea on exertion ☐ Palpitations	☐Dizziness/lightheadedness/syncope ☐ Fatigue ☐ PND

Vital Signs (closest to admission)	Height	_____ O inches O cm	☐ Not documented
	Weight	_____ O lbs O kg	☐ Not documented
	Waist Circumference	_____ O inches O cm	☐ Not documented
	BMI	_____ (automatically calculated)	
	Heart Rate	_____ bpm	☐ ND
	BP-Supine	_____ / _____ mmHg (systolic/diastolic)	☐ ND

	Respiratory Rate	_____ breaths per minute
Exam (closest to admission)	JVP:	O Yes O No O Unknown If yes, _____cm
	Rales:	O Yes O No O Unknown If yes, O <1/3 O ≥1/3 O N/A
	Lower extremity edema:	O Yes O No O Unknown If yes, O trace O 1+ O 2+ O 3+ O 4+ O N/A
Lipids	TC: _____ mg/dL HDL: _____ mg/dL LDL: _____ mg/dL TG: _____ mg/dL	☐ Lipids Not Available
Labs (closest to admission)	**Na**	_____ O mEq/L O mmol/L O mg/dL ☐ Not Available
	Hgb	_____ O g/dL O g/L ☐ Not Available
	Albumin	_____ O g/dL O g/L ☐ Not Available
	BNP	_____ O pg/mL O pmol/L O ng/L ☐ Not Available
	NBNP	_____ O pg/mL O ng/L ☐ Not Available
	SCr	_____ O mg/dL O µmol/L ☐ Not Available
	BUN	_____ O mg/dL O µmol/L ☐ Not Available
	Troponin (Peak)	_____ O ng/mL O ug/L O T O I O Normal O Abnormal ☐ Not Available
	K	_____ O mEq/L O mmol/L O mg/dL ☐ Not Available
	HbA1C	_____ % ☐ Not Available
	Fasting Blood Glucose (mg/dL)	_____ ☐ Not Available
	EKG QRS Duration (ms)	_____ ☐ Not Available
	EKG QRS Morphology	O Normal O LBBB O RBBB O NS-IVCD O Paced O Not Available

IN-HOSPITAL CARE

Procedures	☐ No Procedures	☐ Atrial Fibrillation Ablation or Surgery	☐ Cardiac Cath/Coronary angiography
	☐ Cardioversion	☐ CardioMEMS (implantable hemodynamic monitor)	☐ Coronary artery bypass graft
	☐ CRT-D (cardiac resynchronization therapy with ICD)	☐ CRT-P (cardiac resynchronization therapy-pacing only)	☐ Dialysis
	☐ Dialysis or Ultrafiltration unspecified	☐ ICD only	☐ Intra-aortic balloon pump
	☐ Left Ventricular assist device	☐ Mechanical ventilation	☐ Pacemaker
	☐ PCI	☐ PCI with Stent	☐ Right Cardiac Catheterization
	☐ Stress Testing	☐ Transplant (Heart)	☐ Ultrafiltration

EF – Quantitative	_____ %	Obtained:	O This Admission O W/in the last year O > 1 year ago
EF – Qualitative	O Not applicable O Normal or mild dysfunction O Qualitative moderate/severe dysfunction O Performed/results not available O Planned after discharge O Not performed	Obtained:	O This Admission O W/in the last year O > 1 year ago
Documented LVSD?	O Yes O No		
LVF Assessment?	O Yes O No O Not done, reason documented		

Oral Medications during hospitalization ***Select all that apply***	☐ None	☐ ACE inhibitor	☐ ARB
	☐ ARNI	☐ Aldosterone antagonist	☐ Beta Blocker
	☐ Hydralazine nitrate		

Parenteral Therapies during hospitalization *Select all that apply*	☐ None ☐ Dopamine ☐ Milrinone ☐ Nesiritide ☐ Nitroglycerine ☐ Vasopressin antagonist ☐ Dobutamine ☐ Loop diuretics ☐ Intermittent bolus ☐ Continuous infusion ☐ Other IV vasodilator
Was the patient ambulating at the end of hospital day 2?	O Yes O No O Not Documented
Was DVT prophylaxis initiated by the end of hospital day 2?	O Yes O No/Not Documented O Contraindicated
If yes,	O Low dose unfractionated heparin (LDUH) O Low molecular weight heparin (LMWH) O Warfarin O Intermittent pneumatic compression devices (IPC) O Factor Xa Inhibitor O Direct thrombin inhibitor O Venous foot pumps (VFP) O Other
Was DVT or PE (pulmonary embolus) documented?	O Yes O No/Not Documented
Influenza Vaccination	O Influenza vaccine was given during this hospitalization during the current flu season O Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization O Documentation of patient's refusal of influenza vaccine O Allergy/sensitivity to influenza vaccine or if medically contraindicated O Vaccine not available O None of the above/Not documented/UTD.
Pneumococcal Vaccination	O Pneumococcal vaccine was given during this hospitalization O Pneumococcal vaccine was received in the past, not during this hospitalization O Documentation of patient's refusal of pneumococcal vaccine O Allergy/sensitivity to pneumococcal vaccine O None of the above/Not documented/UTD

DISCHARGE INFORMATION

Discharge Date/Time	___/___/_____ ___:____ ☐ MM/DD/YYYY only
Get With The Guidelines® HF Mortality Risk Score	[Calculated in the PMT]
For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?	1 – Home 2 – Hospice – Home 3 – Hospice – Health Care facility 4 – Acute Care Facility 5 – Other Health Care facility 6 – Expired 7 – Left Against Medical Advise/AMA 8 – Not Documented or Unable to Determine (UTD)
If Other Health Care Facility	O Skilled Nursing Facility (SNF) O Inpatient Rehabilitation Facility (IRF) O Long Term Care Hospital (LTCH) O Intermediate Care facility (ICF) O Other
If Home, special discharge circumstances	O Home Health O Homeless O International O Prison/Incarcerated O None/UTD
Primary Cause of Death	O Cardiovascular O Non-cardiovascular O Unknown If cardiovascular: O Acute coronary syndrome O Worsening heart failure O Sudden death O Other cardiovascular
When is the earliest physician/APN/PA documentation of comfort measures only?	O Day 0 or 1 O Day 2 or after O Timing unclear O Not Documented/UTD

Symptoms (closest to discharge)		O Worse O Unchanged O Better, symptomatic O Better, asymptomatic O Unable to determine	
Vital Signs (closest to discharge)	Weight	_____ O lbs O kg ☐ Not well documented	
	Heart Rate	_____ bpm ☐ ND	
	BP-Supine	_____ / _____ mmHg (systolic/diastolic) ☐ ND	
Exam (closest to discharge)	JVP	_____ O Yes O No O Unknown If yes, _____ cm	
	Rales	_____ O Yes O No O Unknown If yes, O <1/3 O ≥1/3 O N/A	
	Lower extremity edema	_____ O Yes O No O Unknown If yes, O trace O 1+ O 2+ O 3+ O 4+ O N/A	
Labs (closest to discharge)	Na	_____ O mEq/L O mmol/L O mg/dL ☐ Not well documented	
	BNP	_____ O pg/mL O pmol/L O ng/L ☐ Not well documented	
	SCr	_____ O mg/dL O µmol/L ☐ Not well documented	
	BUN	_____ O mg/dL O µmol/L ☐ Not well documented	
	NT-BNP (pg/mL)	_____ O pg/mL ☐ Not well documented	
	K	_____ O mEq/L O mmol/L O mg/dL ☐ Not well documented	

DISCHARGE MEDICATIONS

ACEI	**Prescribed?**	O Yes O No
	If yes,	Medication: Dosage: Frequency:
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reason(s) For Not Providing ACEI:	☐ Hypotensive patient who was at immediate risk of cardiogenic shock ☐ Hospitalized patient who experienced marked azotemia ☐ Other ☐ Patient Reason ☐ System Reason
ARB	**Prescribed?**	O Yes O No
	If yes,	Medication: Dosage: Frequency:
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reason(s) For Not Providing ARB:	☐ Hypotensive patient who was at immediate risk of cardiogenic shock ☐ Hospitalized patient who experienced marked azotemia ☐ Other ☐ Patient Reason ☐ System Reason
ARNI	**Prescribed?**	O Yes O No
	If yes,	Medication: Dosage: Frequency:
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reason(s) For Not Providing ARNI:	☐ Ace inhibitor use within the prior 36 hours ☐ Allergy ☐ Hyperkalemia ☐ Hypotension ☐ Other Medical reasons ☐ Patient reason ☐ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women ☐ System reason
	Reasons for not switching to ARNI at discharge:	O Yes O No O ARNI was prescribed at discharge
	If yes,	☐ New onset heart failure ☐ NYHA Class I ☐ NYHA Class IV ☐ Not previously tolerating ACEI or ARB
ASA	Prescribed?	O Yes O No
	If yes,	Dosage: Frequency:

	Contraindicated?	O Yes O No
Anticoagulation Therapy	**Prescribed?**	O Yes O No
	If yes,	**Class:** Medication: Dosage: Frequency: O Warfarin O Direct thrombin inhibitor O Factor Xa Inhibitor O Other
	Contraindicated?	O Yes O No
	If yes,	Contraindication(s): ☐ Allergy to or complication r/t anticoagulation therapy (hx or current) ☐ Patient/Family refused ☐ Risk for bleeding or discontinued due to bleeding ☐ Serious side effect to medication ☐ Terminal illness/Comfort Measures Only
Clopidogrel	Prescribed?	O Yes O No
	If yes,	Dosage: Frequency:
	Contraindicated?	O Yes O No
Other Antiplatelet(s)	Prescribed?	O Yes O No
	If yes,	Medication: Dosage: Frequency:
Beta Blocker	**Prescribed?**	O Yes O No
	If yes, Class of Beta Blocker	O Evidence-Based Beta Blocker O Non Evidence-Based Beta Blocker O Unknown Class
	If yes,	**Medication:** Dosage: Frequency:
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	☐ Low blood pressure ☐ Fluid overload ☐ Asthma ☐ Patient recently treated with an intravenous positive inotropic agent ☐ Other ☐ Patient Reason ☐ System Reason
Aldosterone Antagonist	**Prescribed?**	O Yes O No
	If yes,	Medication: Dosage: Frequency:
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reasons(s) for Not Providing Aldosterone Antagonist at Discharge	☐ Allergy due to aldosterone receptor antagonist ☐ Hyperkalemia ☐ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women ☐ Other medical reasons ☐ Other contraindications ☐ Patient Reason ☐ System Reason
Diabetic Tx:	☐ None prescribed/ND ☐ None – contraindicated ☐ Insulin ☐ Oral agents ☐ Other subcutaneous/injectable agents	
Lipid Lowering Medication(s)	Prescribed?	O Yes O No
	If yes,	Class: Medication: Dosage: Frequency: Class: Medication: Dosage: Frequency: Class: Medication: Dosage: Frequency:
	Contraindicated?	O Yes O No
Omega-3 fatty acid supplement	Prescribed?	O Yes O No
	Contraindicated?	O Yes O No
Hydralazine Nitrate	**Prescribed?**	O Yes O No
	Contraindicated?	O Yes O No
	Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	☐ Medical Reason ☐ Patient Reason

			☐ System Reason
Ivabradine	**Prescribed?**	**O** Yes **O** No	
	Contraindicated?	**O** Yes **O** No	
	Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:		☐ Allergy to Ivabradine ☐ NYHA class I or IV ☐ Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated ☐ New Onset HF ☐ Not in sinus rhythm ☐ Patient 100% atrial or ventricular paced ☐ Other medical reasons ☐ Patient reasons ☐ System reasons
Other Medications at Discharge	☐ Antiarrhythmic ☐ Amiodarone ☐ Dofetilide ☐ Sotalol ☐ Other ☐ Ca Channel blocker ☐ Digoxin		☐ Diuretic ☐ Loop Diuretic ☐ Thiazide Diuretic Nitrate ☐ Nitrate ☐ Ranolazine ☐ Renin inhibitor ☐ Other anti-hypertensive ☐ Other
OTHER THERAPIES			
ICD Therapy	**Counseling?**	**O** Yes **O** No	
	Reason for not counseling?	**O** Yes **O** No	
	Documented Medical Reason(s) for Not Counseling?		☐ ICD or CRT-D device in patient ☐ Multiple or significant comorbidities ☐ Limited life expectancy ☐ other reasons not eligible for ICD (e.g. EF > 35%, new onset HF) ☐ other reasons for not counseling
	Placed or Prescribed?	**O** Yes **O** No	
	Reason for not Placing or Prescribing?	**O** Yes **O** No	
	Documented Reason(s) for Not Placing or Prescribing ICD Therapy?		☐ Contraindications ☐ Not receiving optimal medical therapy ☐ Any other physician documented reason including, AMI in prior 40 days, recent revascularization, recent onset of HF ☐ Patient Reason ☐ System Reason
CRT Therapy	**CRT-D Placed or Prescribed?**	**O** Yes **O** No	
	CRT-P Placed or Prescribed	**O** Yes **O** No	
	Reason for not Placing or Prescribing?	**O** Yes **O** No	
	Documented Medical Reason(s) for Not Placing or Prescribing CRT Therapy?		☐ Contraindications ☐ Not receiving optimal medical therapy ☐ Not NYHA functional Class III or ambulatory Class IV ☐ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF ☐ QRS duration <120 ms ☐ Patient Reason ☐ System Reason
RISK INTERVENTIONS			

Smoking Cessation Counseling Given	O Yes O No
Activity Level	O Yes O No
Follow-Up	O Yes O No
Symptoms Worsening	O Yes O No
Diet (Salt restricted)	O Yes O No
Medications	O Yes O No
Weight Monitoring	O Yes O No
Follow-Up Visit Scheduled	O Yes O No
Date/Time of first follow-up visit:	___/___/_____ ___:___ ☐ MM/DD/YYYY only ☐ Unknown
Location of first follow-up visit:	O Office Visit O Home Health Visit O Not Documented
Medical or Patient Reason for no follow-up appointment being scheduled?	O Yes O No
Follow up Phone Call Scheduled O Yes O No	**Date of first follow-up phone call:** ___/___/_____ ☐ Unknown
TLC (Therapeutic Lifestyle Change) Diet	O Yes O No O Not Documented O Not Applicable
Obesity Weight Management	O Yes O No O Not Documented O Not Applicable
Activity Level/Recommendation	O Yes O No O Not Documented O Not Applicable
Referred to Outpatient Cardiac Rehab Program	O Yes O No O Not Documented O Not Applicable
Anticoagulation Therapy Education	O Yes O No O Not Documented O Not Applicable
Was Diabetes Teaching Provided?	O Yes O No O Not Documented O Not Applicable
PT/INR Planned follow-up	O Yes O No O Not Documented O Not Applicable
Referral to Outpatient HF Management Program	O Yes O No O Not Documented O Not Applicable
If Yes,	☐ Telemanagement ☐ Home Visit ☐ Clinic-based
Referral to AHA Heart Failure Interactive Workbook	O Yes O No O Not Documented O Not Applicable
Provision of at least 60 minutes of Heart Failure Education by a qualified educator	O Yes O No O Not Documented O Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	O Yes O No O Not Documented O Not Applicable
Advance Directive Executed	O Yes O No
POST DISCHARGE TRANSITION	
Care Transition Record Transmitted	O By the seventh post-discharge day O Exists, but not transmitted by the seventh post-discharge day O No Care Transition Record/UTD
Care Transition Record Includes	☐ All were included *(Check all yes)* Discharge Medications O Yes O No Follow-up Treatment(s) and Service(s) Needed O Yes O No Procedures Performed During Hospitalization O Yes O No Reason for Hospitalization O Yes O No Treatment(s)/Service(s) Provided O Yes O No

OPTIONAL FIELDS				
Field 1	Field 2	Field 3	Field 4	Field 5
Field 6	Field 7	Field 8	Field 9	Field 10
Field 11		Field 12		
Additional Comments				

ADMIN/JOINT COMMISSION			
ICD-9 Principal Diagnosis Code	_____		
ICD-9 Other Diagnoses Codes	1.	2.	3.
	4.	5.	6.
	7.	8.	9.
	10.	11.	12.
	13.	14.	15.
	16.	17.	18.
	19.	20.	21.
	22.	23.	24.
ICD-9-CM Principal Procedure Code	_____ Date:___/___/_____ ☐ Date UTD		
ICD-9 Other Procedure Codes	1. _____ Date:___/___/_____ ☐ Date UTD		
	2. _____ Date:___/___/_____ ☐ Date UTD		
	3. _____ Date:___/___/_____ ☐ Date UTD		
	4. _____ Date:___/___/_____ ☐ Date UTD		
	5. _____ Date:___/___/_____ ☐ Date UTD		
ICD-10-CM Principal Diagnosis Code	_____		
ICD-10-CM Other Diagnoses Codes	1.	2.	3.
	4.	5.	6.
	7.	8.	9.
	10.	11.	12.
	13.	14.	15.
	16.	17.	18.
	19.	20.	21.
	22.	23.	24.
ICD-10-PCS Principal Procedure Code	_____ Date:___/___/_____ ☐ Date UTD		
ICD-10-PCS Principal Procedure Code	1. _____ Date:___/___/_____ ☐ Date UTD		
	2. _____ Date:___/___/_____ ☐ Date UTD		
	3. _____ Date:___/___/_____ ☐ Date UTD		
	4. _____ Date:___/___/_____ ☐ Date UTD		
	5. _____ Date:___/___/_____ ☐ Date UTD		
CPT Code			
CPT Code Date	___/___/_____ ☐ Unknown		
What is the patient's source of payment for this episode of care?	**O** Medicare **O** Non-Medicare		
Was this Case Sampled?	**O** Yes **O** No		
During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, PR, SCIP)?	**O** Yes **O** No		
PMT used concurrently or retrospectively or combination?	O Concurrently O Retrospectively O Combination		
Standardized order sets used?	O Yes O No		
Patient adherence contract/compact used?	O Yes O No		
Discharge checklist used?	O Yes O No		