



HEART FAILURE FACT SHEET

Get With The Guidelines®-Heart Failure is the American Heart Association's collaborative quality improvement program, demonstrated to improve adherence to evidence-based care of patients hospitalized with heart failure.

The program provides hospitals with a web-based Patient Management Tool™ (powered by Outcome Sciences, Inc.), decision support, robust registry, real-time benchmarking capabilities and other performance improvement methodologies toward the goal of enhancing patient outcomes and saving lives.

Get With The Guidelines-HF is for patients in ICD-9 codes HF (402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9).

HF ACHIEVEMENT MEASURES

- **ACEI/ARB at discharge:** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD) and without both angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) contraindications who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular function (LVF) consistent with moderate or severe systolic dysfunction.*

TARGET: HEART FAILURE MEASURE

- **Evidence-based specific beta blockers:** Percent of heart failure patients who were prescribed with evidence-based specific beta blockers (Bisoprolol, Carvedilol, Metoprolol CR/XL) at discharge.
- **Measure LV function:** Percent of heart failure patients with documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge.*
- **Post-discharge appointment for heart failure patients:** Percent of eligible heart failure patients for whom a follow-up appointment was scheduled and documented including location, date, and time for follow up visits, or home health visit.

NEW MEASURE

HF QUALITY MEASURES

- **Aldosterone antagonist at discharge:** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD) with no contraindications or documented intolerance who were prescribed aldosterone antagonist at discharge.

TARGET: HEART FAILURE MEASURE

- **Anticoagulation for atrial fibrillation:** Percent of patients with chronic or recurrent atrial fibrillation prescribed anticoagulation therapy at discharge.
- **Hydralazine nitrate at discharge:** Percent of black heart failure patients with left ventricular systolic dysfunction (LVSD) with no contraindications or documented intolerance who were prescribed a combination of hydralazine and isosorbide dinitrate at discharge. Note: This treatment is recommended in addition to ACEI or ARB and beta blocker therapy at discharge.
- **DVT prophylaxis:** Percent of patients with heart failure and who are non-ambulatory who receive DVT prophylaxis by end of hospital day two.
- **CRT-D or CRT-P placed or prescribed at discharge:** Percent of heart failure patients with left ventricular ejection fraction less than or equal to 35% with a QRS duration of 120 ms or above with no contraindications, documented intolerance, or any other reason against who have CRT-D or CRT-P, had CRT-D or CRT-P placed, or were prescribed CRT-D or CRT-P at discharge.
- **ICD counseling, or ICD placed or prescribed at discharge:** Percent of heart failure patients with left ventricular ejection fraction less than or equal to 35% with no contraindications, documented intolerance, or any other reason against who had ICD counseling provided, who have ICD prior to hospitalization, had an ICD placed, or were prescribed an ICD at discharge.

NEW MEASURE

**Denotes TJC HF Core measures.*



- **Influenza vaccination during flu season:** Percent of patients that received an influenza vaccination prior to discharge during flu season.
- **Pneumococcal vaccination:** Percent of patients that received a pneumococcal vaccination prior to discharge.
- **Follow-up visit within 7 days or less:** Percent of eligible heart failure patients who underwent a follow-up visit within 7 days or less from time of hospital discharge.

**Denotes TJC HF Core measures.*

HF REPORTING MEASURES

- **Blood pressure control at discharge:** Percent of heart failure patients with a last recorded systolic pressure <140 mmHg and diastolic pressure <90 mmHg blood pressure.
- **Beta blocker at discharge:** Percent of heart failure patients on beta blockers at discharge.
- **Lipid-lowering medications at discharge:** Percent of heart failure patients with either CAD, PVD, CVA, or diabetes who were prescribed lipid lowering medications at discharge.
- **Omega-3 fatty acid supplement use at discharge:** Percent of heart failure patients without contraindication who are prescribed omega-3 fatty acid supplement at hospital discharge.
- **Diabetes treatment:** Percent of diabetic patients or newly diagnosed diabetics receiving diabetes treatment in the form of glycemic control (diet and/or medication) at discharge.
- **Diabetes teaching:** Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes teaching at discharge.
- **Smoking cessation:** Percent of heart failure patients with a history of smoking cigarettes, who are given smoking-cessation advice or counseling during hospital stay. Note: for purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.*
- **Discharge instructions:** Percent of heart failure patients discharged home with a copy of written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, what to do if symptoms worsen.*
- **ICD placed or prescribed at discharge:** Percent of heart failure patients with left ventricular ejection fraction less than or equal to 35% with no contraindications, documented intolerance, or any other reason against who have ICD prior to hospitalization, had ICD placed, or were prescribed ICD at discharge.
- **Advanced care plan:** Percent of heart failure patients who have an advanced care plan or surrogate decision maker document in the medical record.
NEW MEASURE
- **QRS duration documented:** Percent of heart failure patients for whom QRS duration is documented.
NEW MEASURE
- **Heart failure disease management program referral:** Percent of heart failure patients referred to disease management program.
NEW MEASURE
- **60 minutes of heart failure education:** Percent of heart failure patients who received 60 minutes of heart failure education by a qualified heart failure educator.
NEW MEASURE
- **Referral to AHA heart failure interactive workbook:** Percent of heart failure patients who received an AHA heart failure interactive workbook.
NEW MEASURE
- **Referral to HF disease management, 60 minutes patient education or HF interactive workbook:** Percent of heart failure patients who were referred to heart failure disease management, received 60 minutes of patient education by a qualified educator, or received an AHA heart failure interactive workbook.
NEW MEASURE; TARGET: HEART FAILURE MEASURE
- **Follow-up visit or contact within 48 hours of discharge scheduled:** Percent of heart failure patients who had a follow-up visit or phone call scheduled to take place within 48 hours or less of hospital discharge.
NEW MEASURE; TARGET: HEART FAILURE MEASURE
- **Follow-up visit or contact within 72 hours of discharge scheduled:** Percent of heart failure patients who had a follow-up visit or phone call scheduled to take place within 72 hours or less of hospital discharge.
NEW MEASURE
- **Activity-level instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing activity level.
- **Diet instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing diet.
- **Follow-up instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing follow-up appointment.

- **Medication instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing discharge medications.
- **Weight instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing weight monitoring.
- **Symptoms worsening instruction:** Percent of heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing what to do if symptoms worsen.
- **LOS:** Length of stay.
- **In-hospital mortality**
- **Risk-adjusted mortality ratio:** A ratio comparing the actual in-hospital mortality rate to the risk-adjusted expected mortality rate. A ratio greater than 1 indicated that the hospital's mortality rate is higher than expected rate. A ratio equal to 1 is interpreted as no difference between the hospital's mortality rate and the expected rate.

**Denotes TJC HF Core measures.*

HF DESCRIPTIVE MEASURES

- **Age:** Patients grouped by age.
- **Diagnosis:** Patients grouped by diagnosis.
- **Gender:** Patients grouped by gender.
- **Race:** Patients grouped by race and Hispanic ethnicity.
- **HF Composite Measure:** The composite quality of care measure indicates how well your hospital does to provide appropriate, evidence-based interventions for each patient.
- **HF Defect-free Measure:** The defect-free measure gauges how well your hospital did in providing all the appropriate interventions to every patient.
- **JC/CMS HF Defect-free Measure:** The defect-free measure gauges how well your hospital did in providing all the appropriate interventions to every patient.

HF ACHIEVEMENT DATA ELEMENTS

- Principle diagnosis
- Cardiac diagnosis
- Date of birth
- Discharge status
- Discharge disposition
- Discharge date
- Comfort measures only
- Ejection fraction
- Ejection fraction qualitative moderate or severe dysfunction
- Ejection fraction qualitative planned after discharge

- LVF assessment
- ACEI prescribed at discharge
- ARB prescribed at discharge
- Contraindications to ACEI at discharge
- Contraindications or other documented reasons for not providing ACEI
- Contraindications to ARB at discharge
- Contraindications or other documented reasons for not providing ARB
- Beta blockers at discharge (Bisoprolol, Carvedilol, Metoprolol CR/XL)
- Contraindications to beta blockers at discharge (Bisoprolol, Carvedilol, Metoprolol CR/XL)
- Contraindications or other documented reasons for not providing beta blocker (Bisoprolol, Carvedilol, Metoprolol CR/XL)
- Follow-up visit scheduled
- Date of first follow-up visit
- Time of first follow-up visit
- Location of first follow-up visit

HF QUALITY DATA ELEMENTS

- Principle diagnosis
- Cardiac diagnosis
- Discharge status
- Discharge disposition
- Discharge date
- Date of birth
- Medical history
- Atrial fibrillation during this admission
- Known history of HF prior to this admission
- Race
- Comfort measures only
- QRS duration
- Ejection fraction
- Ejection fraction qualitative moderate or severe dysfunction
- Aldosterone antagonist prescribed at discharge
- Contraindication to aldosterone antagonist at discharge
- Contraindications or other documented reasons for not providing aldosterone antagonist at discharge
- Anticoagulation prescribed at discharge
- Contraindications to anticoagulation therapy
- Hydralazine nitrate prescribed
- Contraindications to hydralazine nitrate
- DVT prophylaxis initiated by end of hospital day two
- Patient ambulating at end of hospital day 2
- Earliest physician/APN/PA documentation of comfort measure only
- Medical history of CRT-D or CRT-P
- CRT-D placed
- CRT-P placed

- CRT placed or prescribed at discharge
- Reason for not prescribing CRT therapy
- Medical history ICD or CRT-D
- ICD counseling prior to discharge
- ICD therapy prescribed at discharge
- Documented medical reasons for no counseling
- Reasons for not prescribing ICD therapy at discharge
- ICD placed
- Influenza vaccine prior to admission
- Influenza vaccine given during this hospitalization during the current flu season
- Documentation of patient's refusal of influenza vaccine
- Allergy/sensitivity to influenza vaccine or medically contraindicated
- Vaccine not available
- Pneumococcal vaccine received in the past year
- Pneumococcal vaccine was given during hospitalization
- Documentation of patient's refusal of pneumococcal vaccine
- Allergy/sensitivity to pneumococcal vaccine
- Date of follow-up visit within 7 days

HF REPORTING DATA ELEMENTS

- Principle diagnosis
- Cardiac diagnosis
- Medical history
- Arrival date/time
- Discharge status
- Discharge disposition
- Discharge date
- Admit date
- Admission source
- Known history of HF prior to this admission
- Age
- In-hospital death
- Procedures during this hospitalization
- Comfort measures only
- Discharge status
- Blood pressure closest to discharge
- Discharge blood pressure: systolic
- Discharge blood pressure: diastolic
- Left ventricular assessment
- Ejection fraction
- Ejection fraction qualitative moderate or severe dysfunction
- Beta blockers prescribed at discharge
- Contraindications to beta blockers at discharge
- Contraindications or other documented reasons for not providing beta blockers
- Lipid-lowering medication prescribed at discharge
- Contraindications to lipid-lowering medication at discharge
- Omega-3 fatty acid supplement prescribed
- Omega-3 fatty acid supplement contraindicated

- New diagnosis of diabetes
- Diabetic treatment at discharge
- Diabetes treatment contraindicated
- TLC diet at discharge
- Diabetes teaching provided
- Cigarette smoking within past year
- Smoking-cessation counseling/advice given at discharge
- Discharge instructions addressing activity level
- Discharge instructions addressing diet
- Discharge instructions addressing follow-up
- Discharge instructions addressing medications
- Discharge instructions addressing symptoms worsening
- Discharge instructions addressing weight monitoring
- Medical history of ICD or CRT-D
- ICD placed
- CRT-D placed
- ICD therapy prescribed at discharge
- CRT-D therapy prescribed at discharge
- Reason for not prescribing ICD therapy at discharge
- Advance care plan or surrogate decision maker
- Advance care plan/surrogate decision maker documented
- EKG QRS duration
- Referral to outpatient heart failure management program
- Provision of at least 60 minutes of heart failure education by a qualified educator
- Referral to AHA heart failure interactive workbook
- Follow-up visit scheduled
- Date of follow-up visit
- Date/time of first follow-up visit less than 48 hours
- Date of first follow-up phone call less than 48 hours
- Date/time of first follow-up visit less than 72 hours
- Date of first follow-up phone call less than 72 hours
- Risk interventions that address activity level
- Risk interventions that address diet
- Risk interventions that address follow-up instructions
- Risk interventions that address medications
- Risk interventions that address weight monitoring
- Risk interventions that address symptoms worsening
- Length of stay
- GWTG HF mortality risk score

HF DESCRIPTIVE DATA ELEMENTS

- Age
- Cardiac diagnosis
- Gender
- Race
- Hispanic ethnicity
- Discharge status
- Receipt of risk interventions at discharge

HOW ACHIEVEMENT AND QUALITY MEASURES ARE DETERMINED

Achievement and quality measures provide the basis for evaluating and improving treatment of HF patients. Formulating those measures begins with a detailed review of HF guidelines.

When evidence for a process or aspect of care is so strong that failure to act on it reduces the likelihood of an optimal patient outcome, an achievement measure may be developed regarding that process or aspect of care. Achievement measure data are continually collected and results are monitored over time to determine when new initiatives or revised processes should be incorporated. As such, achievement measures help speed the translation of strong clinical evidence into practice.

In order for participating hospitals to earn recognition for their achievement in the program, they must adhere to achievement measures.

Quality measures apply to processes and aspects of care that are strongly supported by science. Application of quality measures may not, however, be as universally indicated as achievement measures.

The Get With The Guidelines team follows a strict set of criteria in creating achievement and quality measures. We make every effort to ensure compatibility with existing performance measures from other organizations.

Note: Measures previously referred to as Performance Measures will now be referred to as Achievement Measures by Get With The Guidelines.

GET WITH THE GUIDELINES-HEART FAILURE AWARDS: RECOGNITION FOR YOUR PERFORMANCE

Hospitals teams that participate actively and consistently in Get With The Guidelines-HF get more than a pat on the back. They're rewarded with public recognition that helps hospitals hone a competitive edge in the marketplace by providing patients and stakeholders with tangible evidence of their commitment to improving quality care.

Silver, Gold, Silver Plus and Gold Plus award-winning Get With The Guidelines-HF hospitals are honored at national recognition events during Scientific Sessions and listed by name in advertisements that appear annually in *Circulation* and in the "Best Hospitals" issue of *U.S. News & World Report*. Moreover, all award-winning hospitals are provided with customizable marketing materials they can use to announce their achievements local.

TARGET: HEART FAILURESM

Target: Heart Failure draws from the American Heart Association's vast collection of content-rich resources for patients and healthcare professionals, including educational tools, prevention programs, treatment guidelines, quality initiatives and outcome-based programs.

Among the most important of those resources is Get With The Guidelines-Heart Failure, a hospital-based performance improvement tool that helps ensure up-to-date, evidence-based care for heart failure patients. Strategies deployed in Get With The Guidelines-Heart Failure have proven successful in lowering 30-day mortality rates and readmissions in heart failure patients, making it central to Target: Heart Failure.

To learn more about Target: Heart Failure, go to heart.org/targethf.

Visit heart.org/quality for more information.

Web-based Patient Management Tool™ provided by Outcome, Cambridge, Mass.