

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 Quintiles Real-World & Late Phase Research), 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) or

ICD-10 codes HF: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9)

HF ACHIEVEMENT MEASURES

- **ACEI/ARB or ARNi at discharge:** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) contraindications or angiotensin-receptor/neprilysin inhibitor (ARNi) contraindications who are prescribed an ACEI, ARB or ARNi 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 Succinate CR/XL) at discharge.
TARGET: HEART FAILURE MEASURE
 - **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 location and
- **Angiotensin Receptor–Neprilysin Inhibitor (ARNi) at Discharge:** Percent of eligible patients with heart failure who are prescribed an ARNi at hospital 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%, QRS duration of 120ms or above and Left Bundle Branch Block or QRS 150ms or above regardless of QRS morphology, 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.
 - **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.
TARGET: HEART FAILURE 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 or atrial flutter:** Percent of patients with chronic or recurrent atrial fibrillation or atrial flutter at high risk for thromboembolism, according to CHA2DS2-VASc risk stratification, prescribed anticoagulation therapy at discharge.

HF REPORTING MEASURES

- **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.
- **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.
- **Advanced care plan:** Percent of heart failure patients who have an advanced care plan or surrogate decision maker document in the medical record.
- **Advance directive executed:** Percent of patients who have documentation in the medical record that an advance directive was executed.
- **Beta blocker at discharge:** Percent of heart failure patients on beta blockers at discharge.
- **Beta blocker medication at discharge (all patients):** A histogram of all patients grouped by specific beta blocker medication prescribed at hospital discharge.
- **Beta blocker medication at discharge (eligible patients):** A histogram of eligible patients grouped by specific beta blocker medication prescribed at hospital discharge.
- **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. **Care transition record transmitted:** A care transition record is transmitted to a next level of care provider within 7 days of discharge containing all of the following: reason for hospitalization, procedures performed during this hospitalization, treatment(s)/service(s) provided during this hospitalization, discharge medications, including dosage and indication for use, and follow-up treatment and services needed (e.g., post-discharge therapy, oxygen therapy, durable medical equipment).
- **Diabetes teaching:** Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes teaching at 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.
- **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.
- **Discharge disposition:** Patients grouped by discharge disposition.
- **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.
- **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.
- **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.
- **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.
- **Heart failure disease management program referral:** Percent of heart failure patients referred to disease management program.
- **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.
- **Ivabradine at Discharge:** Percent of eligible heart failure patients who are prescribed ivabradine at hospital 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.
- **LOS:** Length of stay, defined as Arrival Date – Discharge Date (or Admission Date – Discharge Date if Arrival Date is missing).

HF REPORTING MEASURES

- **In-hospital mortality:** Percent of patients who expired grouped by diagnosis.
- **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.
- **Outpatient cardiac rehab program referral:** Percent of heart failure patients referred to outpatient cardiac rehab program.
- **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.
- **QRS duration documented:** Percent of heart failure patients for whom QRS duration is documented.
- **Referral to AHA heart failure interactive workbook:** Percent of heart failure patients who received an AHA heart failure interactive workbook.
- **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.
TARGET: HEART FAILURE MEASURE
- **Risk adjusted mortality ratio:** A ratio comparing the actual in-hospital mortality rate to the risk-adjusted expected mortality rate. A ratio equal to 1 is interpreted as no difference between the hospital's mortality rate and the expected rate. A ratio greater than 1 indicates that the hospital's mortality rate is higher than the expected rate. A ratio of less than 1 indicates that the hospital's mortality rate is lower than the expected rate.
- **Smoking cessation:** Percent of heart failure patients with a history of smoking cigarettes, who are given smoking-cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.
- **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.

- **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.

HF DATA QUALITY MEASURES

- **HF Achievement Award Qualified:** Percent of patients who have the minimum necessary data elements complete to be included in GWTG Achievement Measures for award calculation. NOTE: This does not mean the patient is compliant with the measure just that they meet the minimum criteria for measure inclusion.
- **HF Quality Award Qualified:** Percent of patients who have the minimum necessary data elements complete to be included in GWTG Quality Measures for award calculation. NOTE: This does not mean the patient is compliant with the measure just that they meet the minimum criteria for measure inclusion.
- **Missing HF Achievement Award Qualified:** Histogram of missing data for key elements needed for appropriate inclusion in GWTG Achievement Measures.
- **Missing HF Quality Award Qualified:** Histogram of missing data for key elements needed for appropriate inclusion in GWTG Quality Measures.
- **Record completion rate:** Percent of patient records

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.

COMPOSITE MEASURES

- **HF Composite:** The composite quality of care measure indicates how well your hospital does to provide appropriate, evidence-based interventions for each patient.

DEFECT FREE MEASURES

- **HF Defect-Free:** The Defect-free measure gauges how well your hospital did in providing all the appropriate interventions to every patient.
- **Target Heart Failure Recognition (or Defect-free) Measure:** >Percent of heart failure patients who received ACEI/ARB or ARNi, Evidenced Based Beta Blockers, Aldosterone Antagonist medications at discharge (if eligible), for whom a follow-up visit or contact within 7 days of discharge scheduled, and who was referred to one or more enhanced education (referral to disease management program, 60 minutes of patient education, or HF interactive workbook).

30 DAY FOLLOW-UP

- **30 Day ACEI/ARBs or ARNi (Heart Failure):** Heart failure patients with left ventricular systolic dysfunction (LVSD) and without ACEI/ARBs or ARNi contra- indications who are on ACEI/ARBs or ARNi 30 days post discharge.
- **30 Day Aldosterone Antagonist:** Heart failure patients with LVSD with no contraindications or documented intolerance who were prescribed Aldosterone Antagonist 30 days post discharge.
- **30 Day Beta-Blocker for LVSD (Heart Failure):** Percent of heart failure patients on Beta-Blocker 30 days post discharge.
- **30 Day Hydralazine Nitrate for LVSD:** Black heart failure patients with LVSD with no contraindications or documented intolerance who were prescribed a Hydralazine Nitrate 30 days post discharge.
- **30 Day Lipid Lowering Medication:** Percent of Heart Failure patients with either CAD, PVD, CVA or diabetes who were prescribed lipid lowering medications 30 days post discharge.
- **30 Day Diabetic Tx:** Percent of patients receiving diabetic treatment 30 days post discharge.
- **30 Day Re-hospitalization (Heart Failure):** Percent of heart failure patients (unadjusted) with one or more re-hospitalization in the first 30 days post discharge.
- **30 Day Mortality Post Discharge (Heart Failure):** Percent of heart failure patients who died in the first 30 days post discharge.
- **30 Day Mortality (Heart Failure):** Percent of heart failure patients (unadjusted) who died in the first 30 days since admission, including in-hospital deaths.

NOTE: The GWTG Readmission Measures are not equivalent to the CMS 30-Day Risk Standardized Readmission Measure. They are not risk adjusted, do not represent all cause readmission, and do not capture readmission to other hospitals.

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-Heart Failure 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-Heart Failure 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 Quintiles Real-World & Late Phase Research