The Joint Commission

Prepublication Requirements

• Issued June 20, 2023 •

Joint Commission Requirement

Revisions to the Heart Failure Certification

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online *E-dition*®), accredited organizations and paid subscribers can also view them in the monthly periodical The *Joint Commission Perspectives*®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Please note: Where applicable, this report shows current standards and EPs first, with deleted language struck-through. Then, the revised requirement follows in bold text, with new language underlined.

APPLICABLE TO THE HEART FAILURE ADVANCED CERTIFICATION

Effective January 1, 2024

Program Management (DSPR) Chapter

DSPR.01

The program defines its leadership roles.

Element(s) of Performance for DSPR.01

1. The program identifies members of its leadership team.

~~Requirements Specific to Heart Failure Care Certification~~

~~a. The program identifies a leader(s).~~
~~b. The program leader(s) has the knowledge and experience in the care of patients with heart failure to provide administrative leadership and clinical guidance to the heart failure program.~~

Requirements Specific to Heart Failure Care Certification

a. The program appoints a medical director(s) who has knowledge and experience in the assessment, diagnosis, and treatment of acute heart failure, including new onset, acute-on-chronic heart failure, and decompensated heart failure. The medical director, in partnership with the program coordinator, defines, implements, and directs the heart failure program to make certain there is high quality, safe, evidenced-based patient care for both inpatient and outpatient care settings.
Note: The medical director's responsibilities include oversight of personnel, physician competency, physician privileging, physician availability, quality assurance, and case review conferences.
b. The program appoints a coordinator with knowledge and experience in managing heart failure patients who works with the medical director to define, implement, and direct the program and to provide clinical guidance and administrative responsibilities for both inpatient and outpatient care settings.

4. The program leader(s) identifies, in writing, the composition of the interdisciplinary team. (D)

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The program establishes an interdisciplinary team to collaborate in the care of heart failure patients.~~
~~b. The program documents the roles and responsibilities of the members of the interdisciplinary team.~~

Requirements Specific to Heart Failure Care Certification

a. Members of the interdisciplinary team have qualifications, training, and experience working with heart failure patients. The interdisciplinary team includes, but is not limited to, the following:
- Emergency room physician(s)
- Advanced practice provider(s) (if utilized by the program)
- Cardiologist(s)
- Heart Failure Specialist(s)
- Hospitalist(s)
- Nursing
- Pharmacist
- Physical therapist(s)
- Registered dietitian(s)
- Social work and/or case management
b. Based on patient and family needs, the interdisciplinary team also utilizes the following services, either on site or by referral:
- Palliative care
- Cardiac rehabilitation
- Occupational therapy
- Electrophysiology
- Interventional cardiology
- Cardiothoracic surgery
- Structural heart services
- Behavioral health
c. The program documents the roles and responsibilities for members of its interdisciplinary team.

6. The program leader(s) provides for the uniform performance of care, treatment, and services.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The program leader(s) has responsibility for overseeing the clinical and administrative aspects of inpatient and outpatient heart failure care, including care transitions.~~
~~b. The program leader(s) has the authority to advocate for resources with the hospital or organization administration.~~

7. The program leader(s) makes certain that practitioners practice within the scope of their licensure, certification, training, and current competency.

Requirement Specific to Heart Failure Care Certification

a. The program makes certain that licensed practitioners are trained, experienced, and privileged to diagnose and treat patients with acute heart failure, including new onset, acute-on-chronic heart failure, and decompensated heart failure. The practitioners maintain competency (such as through continuing medical education, skill-based training) according to their scope of practice and in accordance with laws and regulations and organizational procedure(s).

DSPR.02

The program is collaboratively designed, implemented, and evaluated.

Element(s) of Performance for DSPR.02

1. The interdisciplinary team designs the program.

Requirements Specific to Heart Failure Care Certification

a. The interdisciplinary team develops guideline-based, institution-specific written protocols for triaging and managing patients who present with or develop signs and symptoms of acute heart failure, including new onset, acute-on-chronic, and decompensated heart failure, that include, but are not limited to, the following:
- Developing criteria for rapidly identifying and treating patients in acute or decompensated heart failure
- Utilizing diagnostic imaging and laboratory testing for initial and serial evaluations
- Utilizing standardized definitions and criteria for assessing, diagnosing, classifying, and staging heart failure through the continuum of care (including use of New York Heart Association Functional Classification and/or American College of Cardiology/American Heart Association stages of heart failure for initial and serial evaluations)
- Assessing patient's health-related social needs
- Utilizing standardized tools for patient-reported outcomes throughout the continuum of care
- Utilizing structured medication titration plans to achieve maximally tolerated dosing
- Utilizing standardized protocols when determining referrals to advanced heart failure specialists
- Cardiogenic shock resuscitation and management with advance mechanical circulatory support devices
- Selecting device-based therapies (such as implantable cardioverter-defibrillator, cardiac resynchronization therapy, long-term ventricular assist device [VAD])
- Transferring patients for services not provided on site (such as advanced mechanical circulatory support or cardiac transplantation)
b. The program defines in writing, at a minimum, the mission, goals, services offered, target population, and accountabilities.
Note: The program can develop a charter or other similar document for this purpose.

3. The interdisciplinary team evaluates the program.

Requirement Specific to Heart Failure Care Certification

a. At least quarterly, representatives of the interdisciplinary team participate in meetings to review the assessment, diagnosis, and treatment provided to patients with acute heart failure, including new onset and acute-on-chronic heart failure. Documentation includes attendance records and meeting minutes.

DSPR.03

The program meets the needs of the target population.

Element(s) of Performance for DSPR.03

1. The leader(s) defines, in writing, the program's mission and scope of service. (D)

~~Requirement Specific to Heart Failure Care Certification~~

~~a. Services provided to patients with heart failure include, at a minimum, the following:~~
~~- Acute inpatient care, including intensive care~~
~~- Outpatient heart failure services~~
~~- Advanced cardiac imaging (such as cardiac MRI)~~
~~- Cardiac pulmonary exercise~~
~~- On-site pharmacy, nutrition services, occupational therapy/physical therapy~~
~~- Ability to utilize organizational resources for underserved groups (transportation assistance, pharmacy support)~~
~~- Transitional care services (such as referrals to home care, outpatient heart failure clinic, palliative care)~~
~~- Device implantation~~
~~- Access to a ventricular assist device (VAD) either on site or via referral~~
~~- Access to genetic services either on site or via referral~~
~~- Referral to transplant services, if needed~~

3. The program identifies its target population.

Requirements Specific to Heart Failure Care Certification

a. The program develops a minimum of two community outreach activities per year that include populations that are at higher risk for health care disparities.
b. The program has structured and regularly scheduled heart failure support group meetings or provides referrals to this service for patients and families of patients with heart failure.

4. The services provided by the program are relevant to the target population.

~~Requirements Specific to Heart Failure Care Certification~~

~~a. The program conducts at least one heart failure public education activity per year.~~
~~b. The program hosts regular support group meetings for patients and families of patients with heart failure; if interest is generally low for a program-sponsored support group, patients and families are referred to heart failure support groups as needed.~~

Requirements Specific to Heart Failure Care Certification

a. The program performs the following services 24 hours a day, 7 days a week:
- 12-lead electrocardiogram (ECG)
- Chest radiography (X-ray)
- Computed tomography (CT) and/or coronary computed tomography angiography (CCTA)
- Laboratory testing
- Advanced circulatory support (ACS)/mechanical circulatory support (MCS)
Note: The program determines the types of ACS or MCS devices that will be utilized, such as intra-aortic balloon pump (IABP), extracorporeal membrane oxygenation (ECMO), percutaneous ventricular assist device (for example Impella), or ventricular assist device (VAD).
b. The program performs the following advanced imaging when indicated by patient need:
- Diagnostic and interventional cardiac catheterization (on site or by referral)
- Transesophageal echocardiography (TEE)
- Transthoracic echocardiography (TTE/Echo)
- Diagnostic cardiac stress testing (exercise or pharmacologic)
- Cardiovascular magnetic resonance imaging (CMR or cardiac MRI)
- Cardiopulmonary exercise testing (CPET), 6-minute walk test
- Nuclear imaging (such as single-photon emission computed tomography (SPECT), positron emission tomography (PET))
c. The program has a cardiac step-down unit, cardiac telemetry unit, or designated beds available 24 hours a day, 7 days a week for the management of acute heart failure patients.
d. The program has a cardiac intensive care unit or designated intensive care beds available 24 hours a day, 7 days a week for the management of critical cardiac or critical heart failure patients.

DSPR.05

The program determines the care, treatment, and services it provides.

Element(s) of Performance for DSPR.05

1. The program defines in writing the care, treatment, and services it provides. (D)

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The scope of the program includes both inpatient and outpatient services, including transitions.~~
~~b. The program provides care coordination services across inpatient and outpatient settings.~~
~~c. The program provides services for patients with heart failure, including those with preserved ejection fraction (HFpEF) and those with reduced ejection fraction (HFrEF).~~

5. The program informs the patient and family about how to access care, treatment, and services, including after hours (if applicable).

~~Requirement Specific to Heart Failure Care Certification~~

~~a. The organization provides patients with access to a practitioner who can provide care for heart failure 24 hours a day, 7 days a week.~~
~~Note: In addition to office visits, means of access may include use of telemedicine, the telephone, or the Internet, and/or being directed to urgent/emergent care settings.~~

6. The program has a process to provide emergency/urgent care.

Requirement Specific to Heart Failure Care Certification

a. The program implements standardized processes for the timely triage, diagnosis, and treatment of patients who present with or develop signs and symptoms of acute or decompensated heart failure that include, but are not limited to, the following:
- Identifying patients with increased volume status and clinical congestion to rapidly assess and determine treatment interventions in accordance with protocol
- Acquiring a 12-lead ECG for patients who have or develop chest pain/anginal equivalent
- Initiates interventions for patients in cardiogenic shock in accordance with protocol
- Discharging and/or referring stable heart failure patients from the emergency department

7. The program provides the number and types of practitioners needed to deliver or facilitate the delivery of care, treatment, and services.

Requirement Specific to Heart Failure Care Certification

a. The program maintains on-call schedules for cardiovascular services and access to heart failure expertise 24 hours a day, 7 days a week.
Note: On-call requirements and response times are determined by the program. Access to expertise may be in person, via telehealth, or phone consultation.

DSPR.06

The program has current reference and resource materials.

Element(s) of Performance for DSPR.06

Key: (D) indicates that documentation is required; R indicates an identified risk area;

1. Practitioners have access to reference materials, including clinical practice guidelines, in either hard copy or electronic format.

~~Requirement Specific to Heart Failure Care Certification~~

~~a. Protocols and pathways (either preprinted or electronic documents) for the care of individuals with heart failure are available in all areas where patient care is provided.~~

Delivering or Facilitating Clinical Care (DSDF) Chapter

DSDF.01

Practitioners are qualified and competent.

Element(s) of Performance for DSDF.01

1. Practitioners have education, experience, training, and/or certification consistent with the program's scope of services, goals and objectives, and the care provided. (D)

~~Requirement Specific to Heart Failure Care Certification~~

~~a. Staff who coordinate the care of individuals with heart failure have the education, experience, and knowledge to perform this function. (Refer to DSDF.5, EP 1)~~

Requirement Specific to Heart Failure Care Certification

a. Practitioners demonstrate knowledge and understanding of the program's protocols related to care, treatment, and services for heart failure patients.

4. Orientation provides information and necessary training pertinent to the practitioner's responsibilities. Completion of the orientation is documented. (D)

Requirements Specific to Heart Failure Care Certification

a. Nurses who care for heart failure patients complete required education and training pertinent to the patient population they serve, including, but not limited to, the following:
- Rhythm recognition
- Telemetry monitoring systems
- 12-lead electrocardiogram (ECG)
- Assessments and interventions related to volume status and clinical congestion
- Advanced circulatory support (ACS)/ mechanical circulatory support (MCS) devices utilized by the program
b. Other staff who interact with heart failure patients receive training on clinical signs and symptoms that require timely notification to the appropriately licensed practitioner.

7. Ongoing in-service and other education and training activities are relevant to the program's scope of services.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. The program supports practitioner continuing education or certification related to heart failure care.~~
~~Note: The organization may provide access to continuing education units (CEUs), accommodate training attendance by modifying work schedules, or offer continuing education.~~

Requirement Specific to Heart Failure Care Certification

a. The program provides ongoing education and training to staff involved in the care of heart failure patients. The education and training are provided according to the program's defined intervals, but at a minimum, when staff responsibilities change and/or when new policies, procedures, or guidelines are implemented.
Note: The format and content of education and training are determined by the program.

DSDF.02

The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practice to deliver or facilitate the delivery of clinical care.

Element(s) of Performance for DSDF.02

2. The selected clinical practice guidelines are based on evidence that is determined to be current by the clinical leaders.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. The program follows current American College of Cardiology/American Heart Association/Heart Failure Society of America heart failure guidelines.~~
~~Note: Individual patient needs or newly published evidence may warrant the use of additional or alternate evidence-based guidelines.~~

Requirements Specific to Heart Failure Care Certification

a. The program (inpatient and outpatient settings) utilizes current clinical practice guidelines for acute heart failure, including new onset, acute-on-chronic, and decompensated heart failure, based on recommendations from professional organizations such as the American College of Cardiology (ACC), American Heart Association (AHA), Heart Failure Society of America (HFSA) and other guidelines as determined by program need.
b. The clinical practice guidelines selected by the program address care, treatment, and services, including, but not limited to, the following:
- Staging of heart failure
- Classification by type and cause of heart failure
- Heart failure risk scoring tool(s)
- Titration of medications to achieve maximum target dosing
- Nonpharmacological interventions
- Genetic screening and counseling
- Cardiac imaging
- Surgical and nonsurgical interventions
- Device-based therapies
- Cardiac rehabilitation

3. The program leader(s) and practitioners review and approve clinical practice guidelines prior to implementation. | | Ⓓ |

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. The program reviews its order sets and pathways for relevancy and current evidence at least annually and updates them as necessary using an interdisciplinary approach.~~

Requirements Specific to Heart Failure Care Certification

a. The program leaders review and approve the clinical practice guidelines used by the program at least annually.
b. The program revises protocols based on the clinical practice guidelines approved by the program leaders.

4. Practitioners are educated about clinical practice guidelines and their use. | |

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. Practitioners providing heart failure care can demonstrate knowledge of the program resources, which are based on clinical practice guidelines and evidence-based care practices.~~

5. The program demonstrates evidence that it is following the clinical practice guidelines when providing care, treatment, and services.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. Medical record documentation of the care provided to patients with heart failure reflects the use of clinical practice guidelines and/or evidence-based care practices.~~

DSDF.03

The program is implemented through the use of clinical practice guidelines selected to meet the patient's needs.

Element(s) of Performance for DSDF.03

2. The assessment(s) and reassessment(s) are completed according to the patient's needs and clinical practice guidelines.

Requirements Specific to Heart Failure Care Certification

a. Assessments of patients are completed in accordance with the clinical practice guidelines or evidence-based care practices in a time frame that meets the patient's needs.
b. Volume status and vital signs (such as weight, jugular venous pressure estimate, the presence of edema or orthopnea) are assessed at each patient encounter.
c. Diagnostic testing for patients with heart failure includes the following:
- Laboratory tests (including complete blood count, urinalysis, serum electrolytes, blood urea nitrate, serum creatinine, glucose, fasting lipid profile, liver function tests, thyroid stimulating hormone)
- Serial monitoring (including serum electrolytes and renal function)
- Twelve-lead electrocardiogram (ECG)
d. Noninvasive cardiac imaging for patients includes the following:
- Chest x-ray for suspected, new onset, or acute decompensated heart failure
- Two-dimensional echocardiogram (2D echo) with Doppler during initial evaluation of patients with heart failure to assess ventricular function, size, wall thickness, wall motion, and valve function
- Repeat ejection fraction measurement for patients with heart failure who have experienced a significant change in clinical status, a clinical event, received therapy (including guideline-directed medical therapy [GDMT]), or a change in status making them possible candidates for device therapy
e. B-type natriuretic peptide (BNP) or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) is used to support clinical decision making regarding heart failure diagnosis for ambulatory patients with dyspnea.
f. B-type natriuretic peptide (BNP) or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) and/or cardiac troponin is used to support the diagnosis of a newly decompensated heart failure patient who is hospitalized.
g. Functional capacity of the patient is assessed in accordance with the clinical practice guidelines or evidence-based care practices.
h. Practitioners providing care within their scope of practice to program patients are able to recognize and assess symptoms of heart failure and implement interventions based on the clinical practice guidelines and evidence-based care practices followed by the program.
i. Patients who are hospitalized are assessed for venous thromboembolism and treated with venous thromboembolism prophylaxis as indicated.
j. The patient is reevaluated, or arrangements are made for reevaluation, within 72 hours after inpatient discharge.
Note: The reevaluation may be conducted via phone call, home visit, or scheduled office appointment.
k. A follow-up echocardiogram is obtained 90–180 days after the initial diagnosis of heart failure with a reduced ejection fraction (HFrEF) in order to assess the need for an implantable cardioverter defibrillator (ICD) placement for primary prevention of sudden cardiac death.

Requirement Specific to Heart Failure Care Certification

a. The program has a process to classify patients' heart failure according to the severity of their symptoms utilizing the New York Heart Association Functional Classification and/or the American College of Cardiology/American Heart Association stages of heart failure.

3. The program implements care, treatment, and services based on the patient's assessed needs.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. Based on priority and risk, the heart failure care team implements interventions across inpatient and outpatient settings that address the following:~~
~~- Assistance with self-management activities~~
~~- Fluid management~~
~~- Symptom management~~
~~- Nutrition/diet~~
~~- Medications~~
~~- Exercise~~
~~- Stress reduction~~
~~- Support in coping with progressive, chronic illness~~
~~- Immunizations and vaccinations~~
~~- Risk reduction~~
~~- Palliative care~~
~~b. Guideline-directed medical therapy (GDMT) considerations and contraindications are documented in the medical record for patients with stage C and D heart failure. Note: GDMT includes all FDA-approved medications for the treatment of heart failure.~~
~~c. Chronic anticoagulant therapy is used in patients with permanent/persistent/paroxysmal atrial fibrillation, and heart failure, and a risk factor for cardioembolic stroke.~~
~~d. Device therapy such as an implantable cardioverter defibrillator (ICD), cardiac resynchronization therapy (CRT), or ventricular assist device (VAD) is considered when appropriate for the patient.~~
~~e. In addition to guideline-directed medical therapy (GDMT), the following treatment considerations and contraindications for patients with stage D heart failure are documented in the medical record:~~
~~- IV inotropic support is used for patients with cardiogenic shock until definitive therapy is used.~~
~~- Patients are evaluated for cardiac transplantation if heart failure persists despite GDMT, device, and surgical management.~~

Requirements Specific to Heart Failure Care Certification

a. Eligible patients are referred to cardiac rehabilitation prior to discharge from the inpatient setting.
b. A referral for palliative care and/or hospice/end-of-life services is provided, if appropriate based on the patient's needs and goals.
c. Eligible patients are referred for device therapy (such as implantable cardioverter defibrillator [ICD], cardiac resynchronization therapy [CRT]), long-term mechanical circulatory support and/or cardiac transplantation.
d. Patients are educated and offered the appropriate immunizations and vaccinations.

DSDF.04

The program develops a plan of care that is based on the patient's assessed needs.

Element(s) of Performance for DSDF.04

1. The plan of care is developed using an interdisciplinary approach and patient participation.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. A member of the heart failure team and the patient review the current outcomes of care and therapeutic options.~~
~~b. The interdisciplinary team implements interventions for its heart failure patients that support the following:~~
~~- Implementing guideline-directed medical therapy~~
~~- Addressing barriers to behavioral change~~
~~- Reducing the risk of initial or subsequent hospitalizations for heart failure~~

2. The program individualizes the plan of care for each patient.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The plan of care for patients addresses advance directives.~~
~~b. The following items are addressed prior to discharge and at each follow-up visit:~~
~~- Initiation of guideline-directed medical therapy if not previously established and not contraindicated~~
~~- Precipitant causes of heart failure~~
~~- Barriers to optimal care transitions~~
~~- Limitations in post-discharge support~~
~~- Renal function and electrolytes as appropriate~~
~~- Assessment and management of comorbidities~~
~~- Reinforcement of heart failure education, self-care, emergency plans, and need for adherence~~
~~- Need for additional interventions due to heart failure progression~~
~~- Assessment of volume status and supine/upright hypotension if appropriate~~
~~- Consideration of palliative care or hospice care if appropriate~~
~~c. Patients have a clear, detailed, and evidence-based plan of care that addresses the following:~~
~~- Achievement of guideline-directed medical therapy goals~~
~~- Comorbidity management~~
~~- Follow-up with health care team~~
~~- Appropriate dietary and physical activities~~
~~- Compliance with secondary prevention guidelines for cardiovascular disease~~
~~d. The patient's plan of care is based on the etiology of their heart failure (heart failure with preserved ejection fraction [HFpEF] or heart failure with reduced ejection fraction [HFrEF]).~~

Requirement Specific to Heart Failure Care Certification

a. The program develops an individualized plan of care utilizing standardized definitions and criteria for assessing, diagnosing, classifying, and staging heart failure through the continuum of care.

3. The individualized plan of care is based on the patient's goals and the time frames to meet those goals. ☐ ☐

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. A comprehensive plan of care for patients is developed that includes short- and long-term interventions and goals.~~
~~b. The plan of care for hospitalized patients spans the inpatient and outpatient settings.~~

Requirements Specific to Heart Failure Care Certification

a. The program develops a plan of care for patients that includes short- and long-term interventions and goals.
b. The program utilizes a standardized patient reported outcome (PRO) tool to assess the patient's health status and quality of life and to inform treatment decisions throughout the continuum of care.
Note: Examples of standardized PRO tools that addresses quality of life include the Kansas City Cardiomyopathy Questionnaire (KCCQ) or the Minnesota Living with Heart Failure Questionnaire.

8. The program continually evaluates, revises, and implements revisions to the plan of care to meet the patient's ongoing needs.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. The patient's plan of care is updated regularly and made available to all members of the patient's health care team.~~

DSDF.05

The program manages comorbidities and concurrently occurring conditions and/or communicates the necessary information to manage these conditions to other practitioners.

Element(s) of Performance for DSDF.05

1. The program coordinates care for patients with multiple health needs.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The program identifies a staff member(s) who is responsible for the coordination of care among the patient's practitioners across inpatient and outpatient care settings.~~
~~b. Coordination of care includes, at a minimum, the following:~~
~~- Patient identification and intake~~
~~- Patient education~~
~~- Patient engagement in care, including self-management~~
~~- Arrangement of services, as needed, including transportation, diagnostic testing, other disciplines (such as specialists or therapy), access to community resources, and obtaining medication~~
~~- Collaboration with the primary care provider and all other practitioners, including obtaining information regarding additional assessments and treatments~~
~~- Monitoring and acting on critical lab values~~
~~- Medication reconciliation~~
~~- Monitoring resource utilization~~
~~Note: Monitoring of resource utilization prevents duplicative diagnostics.~~
~~c. The coordination of care is evidenced in the medical record.~~

2. Patients with comorbidities and co-occurring conditions needing clinical and/or psychosocial care, treatment, and services are managed by the program's practitioners or referred to other practitioners for care.

~~***Requirement specific to Heart Failure Care Certification***~~

~~a. Other conditions leading or contributing to heart failure should be addressed by the program's practitioners.~~
~~Note: These conditions include, but are not limited to, obesity, diabetes, tobacco use, use of known cardiotoxic agents, hypertension, metabolic syndrome, and atherosclerotic disease.~~

Requirement Specific to Heart Failure Care Certification

a. The patient is referred to appropriate services if the patient reported outcome (PRO) tool or other assessment indicates a need (such as behavioral health and/or social services).

3. The program's practitioners communicate to other practitioners important information regarding co-occurring conditions and comorbidities needed to manage the patient's conditions.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The staff member(s) identified to coordinate care is responsible for the communication of relevant information among practitioners and across settings.~~
~~b. The staff member(s) identified to coordinate care is responsible for sharing patient information among practitioners in a time frame that meets the patient's needs.~~
~~c. The staff member(s) identified to coordinate care is responsible for confirming practitioner receipt of information and actions taken.~~

DSDF.06

The program initiates discharge planning and facilitates arrangements for subsequent care, treatment, and services to achieve mutually agreed upon patient goals.

Element(s) of Performance for DSDF.06

1. In preparation for discharge, the program discusses and plans with the patient and family the care, treatment, and services that are needed in order to achieve the mutually agreed upon self-management plan and goals.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. Prior to inpatient discharge, a program team member and the patient collaborate to arrange a follow-up appointment with a health care provider to occur within seven days after discharge.~~
~~b. The patient's understanding of the following is evaluated prior to inpatient discharge and thereafter at a frequency based on the assessed needs of the patient:~~
~~- Prescribed medications (name, dose, purpose, and how to take), and which over-the-counter drugs and supplements are allowed~~
~~- Diet and fluid intake based on patient's needs~~
~~- Activity level~~
~~- When and how to schedule and carry out follow-up appointments~~
~~- Weight monitoring~~
~~- How to recognize symptoms of worsening heart failure or dehydration, and when to call practitioner~~
~~- How adherence to the plan of care impacts activities of daily living~~
~~c. Patients are referred for cardiac rehabilitation when appropriate.~~

Requirements Specific to Heart Failure Care Certification

a. The program follows up with the patient within 72 hours after inpatient discharge to provide education and support, to manage symptoms, to recognize complications early after hospital discharge, and to answer patients' questions.
Note: The 72 hour follow-up care may be conducted via telehealth, phone call, home visit, or scheduled office appointment.
b. Prior to inpatient discharge, a program team member and the patient and/or family collaborate to arrange a follow-up appointment with a health care provider to occur within seven days after discharge.
Note 1: The patient's discharge instructions include documentation of the follow-up appointment with a healthcare provider to occur within seven days after discharge.
Note 2: The 7-day follow-up care may be conducted via telehealth, home visit, or scheduled office appointment.

Supporting Self-Management (DSSE) Chapter

DSSE.01

The program involves patients in making decisions about managing their disease or condition.

Element(s) of Performance for DSSE.01

1. The program involves patients in decisions about their care, treatment, and services.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. A designated member of the heart failure team discusses the course of care, treatment, and services with the patient.~~
~~b. A member of the interdisciplinary team discusses with the patient their goals, progress, and next steps, and then documents the discussion in the medical record.~~

2. The program assesses the patient's readiness, willingness, and ability to engage in self-management activities.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The assessment of the patient's ability to engage in self-management includes psychosocial barriers.~~
~~Note: Psychosocial barriers may include psychological screening, health care literacy level, social assessment, and economic barriers.~~
~~b. Assessment information guides the development of the self-management plan.~~

Requirement Specific to Heart Failure Care Certification

a. The program reviews the patient's health-related social needs (HRSNs) as part of the assessment of the patient's ability to engage in self-management.
Note: Examples of HRSNs include access to transportation, difficulty paying for prescriptions or medical bills, education and literacy, food insecurity, or housing insecurity.

5. Patients and practitioners mutually agree upon goals.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The mutually agreed upon goals address the patient's disease and symptom management.~~
~~b. The mutually agreed upon goals address the patient's advance directives.~~

DSSE.02

The program addresses the patient's self-management plan.

Element(s) of Performance for DSSE.02

1. The program promotes lifestyle changes that support self-management activities.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. As relevant to the patient's needs, patient lifestyle changes that are promoted by the program include the following:~~
~~- Nutrition~~
~~- Fluid management~~
~~- Activity and exercise~~
~~- Weight management~~
~~- Reduction of symptom aggravating behaviors~~
~~(See also DSSE.3, EP 5a)~~

5. The program addresses the education needs of the patient regarding disease progression and health promotion.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. Health promotion education addresses risks related to the following:~~
~~- Alcohol consumption~~
~~- Tobacco use~~
~~- Illicit drug use~~
~~b. Health promotion education addresses the need for influenza and pneumonia vaccinations.~~

Requirement Specific to Heart Failure Care Certification

a. The program addresses the educational needs of the patient and family to further their understanding of living with heart failure throughout the continuum of care, including, but not limited to, the following:
- An explanation of what heart failure means, how it affects the patient's heart, and the underlying cause(s) of the patient's heart failure
- Signs and symptoms of worsening heart failure, when to notify the licensed practitioner(s), and how to contact the care team if signs and symptoms worsen
- Self-management (for example, medication adherence, adherence to a low-sodium diet, monitoring daily weights, physical activity, and stress reduction)

6. The program revises the self-management plan according to the patient's assessed needs.

Requirements Specific to Heart Failure Care Certification

a. The program reviews and revises the patient's self-management plan, as needed throughout the continuum of care, to manage the progression of heart failure disease.
b. The program reviews the health-related social needs when revising the self-management plan.

DSSE.03

The program addresses the patient's education needs.

Element(s) of Performance for DSSE.03

1. The program's education materials comply with recommended elements of care, treatment, and services, which are supported by literature and promoted through clinical practice guidelines and evidence-based practice. Ⓓ

~~Requirement Specific to Heart Failure Care Certification~~

~~a. Patient education includes, at a minimum, the following topics:~~
~~- Signs and symptoms of heart failure~~
~~- Risk factor reduction~~
~~- Recognition and management of symptoms~~
~~- Medications, including side effects~~
~~- Dietary guidance, including food label reading~~
~~- Fluid management~~
~~- Exercise~~
~~- Weight monitoring~~
~~- Importance of follow-up appointments~~
~~- When to call the practitioner~~

5. The program addresses the education needs of the patient regarding their disease or condition and care, treatment, and services.

~~Requirement Specific to Heart Failure Care Certification~~

~~a. The program provides specific education to facilitate heart failure self-care. (Refer to DSSE.02, EP 1)~~

Clinical Information Management (DSCT) Chapter

DSCT.04

The program shares information with relevant practitioners and/or health care organizations about the patient's disease or condition across the continuum of care.

Element(s) of Performance for DSCT.04

2. The program shares information with relevant practitioners and/or health care organizations to facilitate continuation of patient care.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. The staff member(s) identified to coordinate care is responsible for communicating the patient's current medication information at all transitions of care, and as changes occur in the outpatient setting, to all relevant practitioners across inpatient and outpatient settings.~~
~~b. The staff member(s) identified to coordinate care is responsible for communicating information necessary to continue the patient's treatment to relevant practitioners within 72 hours after inpatient discharge. (Refer to DSDF.05, EP 3)~~
~~c. Care coordination, with special attention to care transitions, is designed to achieve guideline-directed medical therapy.~~

DSCT.05

The program initiates, maintains, and makes accessible a medical record for every patient.

Element(s) of Performance for DSCT.05

6. The medical record contains sufficient information to facilitate continuity of care.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. To support coordination of care, the patient's medical record contains all results of diagnostic tests and therapeutic interventions and procedures.~~

Performance Measurement (DSPM) Chapter

DSPM.01

The program has an organized, comprehensive approach to performance improvement.

Element(s) of Performance for DSPM.01

1. The program leader(s) identifies goals and sets priorities for improvement in a performance improvement plan. Ⓓ

Requirement Specific to Heart Failure Care Certification

a. In addition to the standardized performance measures, the program selects a minimum of two additional patient care data elements related to assessment, diagnosis, or treatment of heart failure to measure patient outcomes and inform performance improvement activities.
Note: Data already collected through registry participation may be used to meet this requirement.

2. The program leader(s) involves the interdisciplinary team and other practitioners across disciplines and/or settings in performance improvement planning and activities.

~~***Requirements Specific to Heart Failure Care Certification***~~

~~a. Heart failure performance measures are analyzed by the heart failure interdisciplinary team and the organization's quality department.~~
~~b. The heart failure program has a designated committee that meets a minimum of twice per year to evaluate protocols and practice patterns as indicated.~~

Requirements Specific to Heart Failure Care Certification

a. The program's interdisciplinary team and other licensed practitioners participate in the review of all major adverse cardiac events, including, but not limited to, the following:
- Unanticipated or cardiovascular-related death
- Acute myocardial infarction
- Stroke
b. The program's interdisciplinary team and other licensed practitioners identify opportunities for improving care, treatment, and management of patients across the continuum of care, which include, but are not limited to, the following:
- Failure to recognize the need for or provide timely interventions
- Rehospitalization for heart failure within 30 days of inpatient discharge
- Other complications as determined by the organization

DSPM.03

The program collects measurement data to evaluate processes and outcomes.
Note: Measurement data must be internally trended over time and may be compared to an external data source for comparative purposes.

Element(s) of Performance for DSPM.03

1. The program selects valid, reliable performance measures that are relevant to the target population and based on clinical practice guidelines or other evidence-based practice.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. Performance measures are based on professionally developed clinical practice guidelines with the goal of improving the quality of care for patients with heart failure.~~

DSPM.04

The program collects and analyzes data to determine variance from the clinical practice guidelines.

Element(s) of Performance for DSPM.04

1. The program tracks data variances at the patient level.

Key: (D) indicates that documentation is required; R indicates an identified risk area;

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. In addition to required standardized measures, the program collects the following heart failure performance measurement data:~~
~~- Whether the patient's functional capacity improved~~
~~- Whether the patient's symptoms stabilized~~
~~- Whether the patient was re-hospitalized for heart failure symptoms within 30 days of inpatient discharge~~

2. The program evaluates variances that affect program performance and outcomes.

~~***Requirement Specific to Heart Failure Care Certification***~~

~~a. The performance improvement program includes evaluation of care processes in inpatient and outpatient settings and transitions in care.~~

Requirements Specific to Heart Failure Care Certification

a. The performance improvement program includes evaluation of care processes in inpatient and outpatient settings and all transitions in care.
b. The program analyzes its heart failure data in the American Heart Association's Get with the Guidelines-Heart Failure registry and uses it for quality improvement purposes.

3. The program uses data analysis to modify performance improvement activities in support of clinical practice guidelines.

Requirements Specific to Heart Failure Care Certification

a. Program leaders and staff review measurement results to determine whether goals were achieved.
b. Program leaders and staff review and prioritize identified improvement opportunities.