Advanced Certification Heart Failure

PERFORMANCE MEASUREMENT
IMPLEMENTATION GUIDE

December 2014
## Advanced Certification Heart Failure (ACHF)

### Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACHF-01</td>
<td>Beta-Blocker Therapy (i.e., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge)</td>
</tr>
<tr>
<td>ACHF-02</td>
<td>Post-Discharge Appointment for Heart Failure Patients</td>
</tr>
<tr>
<td>ACHF-03</td>
<td>Care Transition Record Transmitted</td>
</tr>
<tr>
<td>ACHF-04</td>
<td>Discussion of Advance Directives/Advance Care Planning</td>
</tr>
<tr>
<td>ACHF-05</td>
<td>Advance Directive Executed</td>
</tr>
<tr>
<td>ACHF-06</td>
<td>Post-Discharge Evaluation for Heart Failure Patients</td>
</tr>
</tbody>
</table>

### General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>All Records,</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records,</td>
</tr>
<tr>
<td>ICD-9-CM Other Procedure Codes</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>ICD-9-CM Principal Diagnosis Code</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>ICD-9-CM Principal Procedure Code</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>ICD-9-CM Principal Procedure Date</td>
<td>All Records, Optional for All HBIPS and PBM Records</td>
</tr>
<tr>
<td>Race</td>
<td>All Records,</td>
</tr>
<tr>
<td>Sex</td>
<td>All Records,</td>
</tr>
</tbody>
</table>

### Measure Set Specific Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive Executed</td>
<td>ACHF-05, ACHFOP-07,</td>
</tr>
<tr>
<td>Element Name</td>
<td>Collected For</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge</td>
<td>ACHF-01,</td>
</tr>
<tr>
<td>Care Transition Record Transmitted</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Care Transition Record-Discharge Medications</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Care Transition Record-Follow-Up Treatment(s) and Service(s) Needed</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Care Transition Record-Procedures Performed During Hospitalization</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Care Transition Record-Reason for Hospitalization</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Care Transition Record-Treatment(s)/Service(s) Provided</td>
<td>ACHF-03,</td>
</tr>
<tr>
<td>Clinical Trial</td>
<td>ACHF-01, ACHF-02, ACHF-03, ACHF-06, ACHFOP-01, ACHFOP-02, ACHFOP-03, ACHFOP-04, ACHFOP-05,</td>
</tr>
<tr>
<td>Comfort Measures Only</td>
<td>ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06,</td>
</tr>
<tr>
<td>Discharge Disposition</td>
<td>ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06,</td>
</tr>
<tr>
<td>Discussion of Advance Directives/Advance Care Planning</td>
<td>ACHF-04, ACHFOP-06,</td>
</tr>
<tr>
<td>LVSD &lt; 40%</td>
<td>ACHF-01, ACHFOP-01, ACHFOP-02, ACHFOP-03,</td>
</tr>
<tr>
<td>Post-Discharge Appointment Scheduled Within 7 Days</td>
<td>ACHF-02,</td>
</tr>
<tr>
<td>Post-Discharge Evaluation Conducted Within 72 Hours</td>
<td>ACHF-06,</td>
</tr>
<tr>
<td>Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge</td>
<td>ACHF-01,</td>
</tr>
<tr>
<td>Reason for No Post-Discharge Appointment Within 7 Days</td>
<td>ACHF-02,</td>
</tr>
</tbody>
</table>

Initial Patient Population
Advanced Certification Heart Failure Population Algorithm

Start ACHF Measure Set
Population Logic

Process all cases that have successfully reached the point in the Transmission Data Processing Flow: Clinical which calls this initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Transmission Data Processing Flow: Clinical.

ICD-9-CM
Principal Diagnosis Code

Not on Table 2.1

On Table 2.1

ICD-9-CM Principal or Other Procedure Codes

At least one on Table 2.2

All Missing or None on Table 2.2

Patient Age (in years) = Admission Date – Birthdate
Use the month and day portion of admission date and birthdate to yield the most accurate age.

Patient Age

>= 18 years

< 18 years

Length of Stay (in days) = Discharge Date minus Admission Date

Length of Stay

<= 120 days

> 120 days

Patient is in ACHF Initial Population

Patient is not in ACHF Initial Population

Patient is eligible to be sampled for ACHF Measure Set

Patient is not eligible to be sampled for ACHF Measure Set

Set Initial Patient Population Reject Case Flag = "No"

Set Initial Patient Population Reject Case Flag = "Yes"

Return to Transmission Data Processing Flow: Clinical (Data Transmission section)
HF Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter for the measure set cannot sample. Hospitals that have five or fewer HF discharges (both Medicare and non-Medicare combined) in a quarter are not required to submit HF patient level data to the QIO Clinical Warehouse¹ and Joint Commissions Data Warehouse.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Quarterly Sampling
Hospitals performing quarterly sampling for HF must ensure that its Initial Patient Population and sample size meet the following conditions:

<table>
<thead>
<tr>
<th>Hospital's Measure</th>
<th>Average Quarterly Initial Patient Population Size N</th>
<th>Minimum Required Sample Size $n$</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 1516</td>
<td>304</td>
<td></td>
</tr>
<tr>
<td>381 - 1515</td>
<td>20% of Initial Patient Population size</td>
<td></td>
</tr>
<tr>
<td>76 - 380</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>6 - 75</td>
<td>No sampling; 100% Initial Patient Population required</td>
<td></td>
</tr>
</tbody>
</table>
| 0 - 5              | Submission of patient level data is encouraged but not required:  
  - CMS: if submission occurs, 1-5 cases of Initial Patient Population may be submitted ¹  
  - The Joint Commission: if submission occurs, 100% Initial Patient Population required |

Monthly Sampling
Hospitals performing monthly sampling for HF must ensure that its Initial Patient Population and sample size meet the following conditions:

<table>
<thead>
<tr>
<th>Hospital's Measure</th>
<th>Average Monthly Initial Patient Population Size N</th>
<th>Minimum Required Sample Size $n$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>≥ 506</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>131 - 505</td>
<td>20% of Initial Patient Population size</td>
<td></td>
</tr>
<tr>
<td>26 - 130</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>&lt;26</td>
<td>No sampling; 100% Initial Patient Population required</td>
<td></td>
</tr>
</tbody>
</table>

**Sample Size Examples**

- **Quarterly sampling:**
  - The HF Initial Patient Population size for a hospital has been 500 patients per quarter during the past year. The required quarterly sample size would be 100 (twenty percent of 500) heart failure patients per quarter -- as this number is smaller than the maximum condition (i.e., 304 cases) and larger than the minimum condition (i.e., 76 cases).
  - A hospital's HF Initial Patient Population size is 1,482 patients during the third quarter. The required sample size is 20% of the patient population or 297 cases for the quarter (twenty percent of 1,482 equals 296.4 rounded to the next highest whole number equals 297).
  - A hospital's HF Initial Patient Population size is 5 patients during the first quarter. Submission of patient level data is not required. If the hospital chooses to submit patient level data:
    - CMS: the quarterly sample size would be 1 5 cases for the quarter.\(^1\)
    - The Joint Commission: the required quarterly sample size would be 100% of the patient population or 5 cases for the quarter.

- **Monthly sampling:**
  - A hospital's HF Initial Patient Population size is 25 patients during March. Since this is less than the minimum condition (i.e., 26 cases), no sampling is allowed or 100% of the patient population of 25 cases is required.
  - A hospital's HF Initial Patient Population size is 503 patients during July. The required sample size is 20% of the patient population or 101 cases for the month (twenty percent of 503 equals 100.6 rounded to the next highest whole number equals 101).

\(^1\) The Heart Failure (HF) core measure sampling methodology is applicable to the ACHF measures. Data collection for the ACHF measures is required by Joint Commission Disease-Specific Care Certification.
Measure Information Form

Measure Set: Advanced Certification Heart Failure (ACHF)

Set Measure ID: ACHF-01

Performance Measure Name: Beta-Blocker Therapy (i.e., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge)

Description: Beta-blocker therapy (i.e., bisoprolol, carvedilol, or sustained-release metoprolol succinate) is prescribed for heart failure patients with LVSD at 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 systolic (LVS) function consistent with moderate or severe systolic dysfunction.

Rationale: Beta-blocker therapy has been recommended for the treatment of patients with heart failure and reduced left ventricular ejection fraction (LVEF) since the 1970s (HFSA, 2010). Several large-scale clinical trials have provided unequivocal evidence of important reductions in both morbidity and mortality. The marked beneficial effects of beta blockade has been well demonstrated in large-scale clinical trials of symptomatic patients with New York Heart Association (NYHA) class II-IV heart failure and reduced LVEF using carvedilol, bisoprolol, and sustained-release metoprolol succinate (Hunt et al., 2009). These beta-blockers, in addition to ACE inhibitors and diuretics, are considered routine therapy for heart failure patients with reduced LVEF. Beta-blocker therapy is well tolerated by the majority of patients, even those with co-morbidities such as, diabetes mellitus, chronic obstructive lung disease, and peripheral vascular disease.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients who are prescribed bisoprolol, carvedilol, or sustained-release metoprolol succinate for LVSD at hospital discharge.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:
- Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge

Denominator Statement: Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) < 40%.

Included Populations:
- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1, and Documentation of LVSD < 40%

Excluded Populations:
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patients who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients enrolled in a Clinical Trial
- Patients discharged to another hospital
- Patients who left against medical advice
- Patients who expired
- Patients discharged to home for hospice care
- Patients discharged to a healthcare facility for hospice care
- Patients with a documented Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge

**Data Elements:**

- Admission Date
- Birthdate
- Clinical Trial
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- ICD-9-CM Principal Procedure Date
- LVSD < 40%
- Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records.

**Data Accuracy:** Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Measure Algorithm:**
ACHF-01: Beta-Blocker Therapy (i.e., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate) Prescribed for LVSD at Discharge

**Numerator:** Patients who are prescribed bisoprolol, carvedilol, or sustained-release metoprolol succinate for LVSD at discharge.

**Denominator:** Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) < 40%.
Measure Information Form

Measure Set: Advanced Certification Heart Failure (ACHF)
Set Measure ID: ACHF-02
Performance Measure Name: Post-Discharge Appointment for Heart Failure Patients

Description: Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.

Rationale: Care coordination is important for all patients, but especially for vulnerable populations, such as patients with heart failure and other chronic diseases. Today, the average Medicare patient sees two primary care and five specialists per year (NQF, 2010). For patients with multiple chronic conditions, the number of healthcare providers involved in the care of the patient is even higher.

The exchange of information from one healthcare provider to another should smooth the transition of care from the inpatient to outpatient setting. According to Bell and colleagues (2008), the separation of hospital and ambulatory care may result in significant care discontinuities after discharge. Therefore, it is paramount that discussions between providers summarize the patients history and communicate the plan for follow-up care after discharge in order to be effective. When done well, this exchange of information can avoid conflicting plans of care; overuse, underuse, and misuse of medications, tests and therapies; reduce costs and potentially adverse events.

The Joint Commissions 2014 Disease-Specific Care Advanced Certification Heart Failure standards require: The program [to provide] care coordination services across inpatient and outpatient settings. Scheduling of the initial follow-up appointment with the primary care provider is a first-step to ensuring continuity of care. In addition, standards require that care, treatment, and services are provided in a planned and timely manner, which includes the arrangement of a follow-up appointment with a health care provider to occur within seven days after discharge.

Type of Measure: Process
Improvement Noted As: Increase in the rate

Numerator Statement: Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.

Included Populations: Not applicable
Excluded Populations: None
Data Elements:
- Post-Discharge Appointment Scheduled Within 7 Days

Denominator Statement: All heart failure patients discharged from a hospital inpatient setting to home or home care.

Included Populations:
- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1, and
- A discharge to home, home care, or court/law enforcement

Excluded Populations:
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patient who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients enrolled in a Clinical Trial
- Patients discharged to locations other than home, home care, or law enforcement
- Patients with a documented Reason for No Post-Discharge Appointment Within 7 Days
- Patients who left against medical advice (AMA)

**Data Elements:**

- Admission Date
- Birthdate
- Clinical Trial
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- ICD-9-CM Principal Procedure Date
- Reason for No Post-Discharge Appointment Within 7 Days

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records.

**Data Accuracy:** Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Measure Algorithm:**
**ACHF-02: Post-Discharge Appointment for Heart Failure Patients**

**Numerator:** Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.

**Denominator:** All heart failure patients discharged from a hospital inpatient setting to home or home care.
Measure Information Form

**Measure Set:** Advanced Certification Heart Failure (ACHF)

**Set Measure ID:** ACHF-03

**Performance Measure Name:** Care Transition Record Transmitted

**Description:** 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
- Follow-up treatment and services needed (e.g., post-discharge therapy, oxygen therapy, durable medical equipment)

**Rationale:** The hand-over of care from one healthcare provider to another should smooth the transition of care from the inpatient to outpatient setting (van Walraven et al., 2002). Communication and information exchange should be completed to allow sufficient time for the receiving provider to treat the patient. The timeliness of communication should be consistent with the urgency of follow-up required (Kripalani et al., 2007). Communication and information exchange between providers may be in the form of a phone call, fax, or other secure vehicle, such as, mutual access to an electronic health record (EHR).

The Joint Commission's 2014 Disease-Specific Care Advanced Certification Heart Failure standards require: The program [to provide] care coordination services across inpatient and outpatient settings. Requirements specific to heart failure care certification include:

- The program identifies an individual to coordinate the care of participants.
- The program provides participants with access to a practitioner 24 hours a day, 7 days a week (access may include use of the telephone and the internet, and referral to urgent care settings).
- The program communicates important information regarding co-occurring conditions and co-morbidities to appropriate practitioner(s) to treat or manage conditions.
  - The program care coordinator(s) is responsible for the communication of relevant information among practitioners and across settings.
  - The program care coordinator(s) is responsible for sharing information among practitioners in a timeframe that meets the participant's needs.
  - The program care coordinator(s) is responsible for confirming practitioner receipt of information and actions taken.

**Type of Measure:**

**Improvement Noted As:**

**Numerator Statement:** Care transition record 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
- Follow-up treatment(s) and service(s) needed

**Included Populations:** Not applicable
**Excluded Populations:** None

**Data Elements:**

- Care Transition Record Transmitted
- Care Transition Record-Discharge Medications
- Care Transition Record-Follow-Up Treatment(s) and Service(s) Needed
- Care Transition Record-Procedures Performed During Hospitalization
- Care Transition Record-Reason for Hospitalization
- Care Transition Record-Treatment(s)/Service(s) Provided

**Denominator Statement:** All heart failure patients discharged from a hospital inpatient setting to home or home care

**Included Populations:**

- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1, and
- A discharge to home, home care, or court/law enforcement

**Excluded Populations:**

- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patient who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients enrolled in a Clinical Trial
- Patients discharged to locations other than home, home care, or law enforcement
- Patients who left against medical advice (AMA)

**Data Elements:**

- Admission Date
- Birthdate
- Clinical Trial
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- ICD-9-CM Principal Procedure Date

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records.

**Data Accuracy:** Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None
**Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion. Aggregate rate generated from count data reported as a proportion

**Selected References:**


**Measure Algorithm:**
ACHF-03: Care Transition Record Transmitted

**Numerator:** Care transition record 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
- Follow-up treatment(s) and service(s) needed

**Denominator:** All heart failure patients discharged from a hospital inpatient setting to home or home care.

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**Variable Key:**
- Discharge Counter
- Missing Flag
Initialize Discharge Counter = 0 (pres)
Set Missing Flag = No

Care Transition Record Discharge Medications

- Missing
  - Set Missing Flag = Yes
  - Add 1 to Discharge Counter

Care Transition Record Follow-Up Treatment(s) and Service(s) Needed

- Missing
  - Set Missing Flag = Yes
  - Add 1 to Discharge Counter

Care Transition Record Procedures Performed During Hospitalization

- Missing
  - Set Missing Flag = Yes
  - Add 1 to Discharge Counter

Care Transition Record Reason for Hospitalization

- Missing
  - Set Missing Flag = Yes
  - Add 1 to Discharge Counter

Note: Discharge counter and missing flags must be stored to identify the specific discharge instructions that are missing.
Measure Information Form

**Measure Set:** Advanced Certification Heart Failure (ACHF)

**Set Measure ID:** ACHF-04

**Performance Measure Name:** Discussion of Advance Directives/Advance Care Planning

**Description:** Patients who have documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider.

**Rationale:** Heart failure is a progressive, debilitating disease which carries with it a poor prognosis over time and high mortality rate. Physicians should acknowledge the life-threatening nature of the disease and discuss with patients and/or their caregivers prognosis, quality of life, pharmacologic and device therapies, self-management, and supportive care options (HFSA, 2010).

According to Heffner and Barbieri, most patients at fourteen cardiac rehabilitation programs across the United States, presumed the need for life-support at some point in the future and wanted to make their own decisions about end-of-life care. Most of the patients were aware of advance directives, desired more information, and preferred to get more information from their lawyers, families, physicians, or cardiac rehabilitation programs (Perkins, 2000). Despite this receptiveness, only 15% of patients had discussed advance directives with their physicians, and 10% had confidence that their physicians understood their wishes (Heffner and Barbieri, 2000).

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Patients who have documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider

**Included Populations:** Not applicable

**Excluded Populations:** None

**Data Elements:**

- Discussion of Advance Directives/Advance Care Planning

**Denominator Statement:** All heart failure patients

**Included Populations:**

- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1
- Patients who left against medical advice (AMA)
- Patients enrolled in a Clinical Trial

**Excluded Populations:**

- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patient who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients discharged to another hospital
- Patients discharged to home for hospice care
- Patients discharged to a health care facility for hospice care
- Patients who expire

**Data Elements:**

- Admission Date
- Birthdate
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- ICD-9-CM Principal Procedure Date

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records.

**Data Accuracy:** Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** Yes. please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion. Aggregate rate generated from count data reported as a proportion

**Selected References:**


**Measure Algorithm:**
ACHF-04: Discussion of Advance Directives/Advance Care Planning

**Numerator:** Patients who have documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider.

**Denominator:** All heart failure patients.

---

**START**

Run cases that are included in the ACHF Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

**Discharge Disposition**

- 2, 3, 4, 6

**Comfort Measures Only**

- 1, 2, 3

**Discussion of Advance Directives/Advance Care Planning**

- Y

**In Numerator Population**

**Case will be rejected**

**STOP**
Measure Information Form

Measure Set: Advanced Certification Heart Failure (ACHF)

Set Measure ID: ACHF-05

Performance Measure Name: Advance Directive Executed

Description: Patients who have documentation in the medical record that an advance directive was executed.

Rationale: Heart failure is a progressive, debilitating disease which carries with it a poor prognosis over time and high mortality rate. Physicians should acknowledge the life-threatening nature of the disease and discuss with patients and/or their caregivers prognosis, quality of life, pharmacologic and device therapies, self-management, and supportive care options (HFSA, 2010).

According to Heffner and Barbieri, most patients at fourteen cardiac rehabilitation programs across the United States, presumed the need for life-support at some point in the future and wanted to make their own decisions about end-of-life care. Most of the patients were aware of advance directives, desired more information, and preferred to get more information from their lawyers, families, physicians, or cardiac rehabilitation programs (Perkins, 2000). Despite this receptiveness, only 15% of patients had discussed advance directives with their physicians, and 10% had confidence that their physicians understood their wishes (Heffner and Barbieri, 2000).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients who have documentation in the medical record that an advance directive was executed.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:
- Advance Directive Executed

Denominator Statement: All heart failure patients.

Included Populations:
- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1, and
- Patients who left against medical advice (AMA)
- Patients enrolled in a Clinical Trial

Excluded Populations:
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patients who have a Length of Stay Greater than 120 days
- Patients with Comfort Measures Only documented
- Patients discharged to another hospital
- Patients discharged to home for hospice care
- Patients discharged to a health care facility for hospice care
Patients who expire

Data Elements:

- Admission Date
- Birthdate
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code
- ICD-9-CM Principal Procedure Date

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

Measure Algorithm:
**ACHF-05: Advance Directive Executed**

**Numerator:** Patients who have documentation in the medical record that an advance directive was executed.

**Denominator:** All heart failure patients.

---

[Diagram of the process flow for ACHF-05: Advance Directive Executed]
Measure Information Form

Measure Set: Advanced Certification Heart Failure (ACHF)

Set Measure ID: ACHF-06

Performance Measure Name: Post-Discharge Evaluation for Heart Failure Patients

Description: Patients who receive a re-evaluation for symptoms worsening and treatment compliance by a program team member within 72 hours after inpatient discharge.

Rationale: Today, hospitals and providers in the United States are challenged to provide high-quality, cost-effective healthcare. Preventing readmissions to the hospital is one opportunity to control costs and deliver quality care. According to Hospital Compare (2010), the national 30-day readmission rate for heart failure is 24.7%. Jha and colleagues (2009) have concluded that data collection for discharge planning and instruction measures has not reduced unnecessary readmissions. Alternative interventions are needed to meet heart failure treatment goals post-discharge. Ongoing evaluation of patient symptoms and their functional consequences may help prevent hospital readmissions.

The Joint Commissions 2014 Disease-Specific Care Advanced Certification Heart Failure standards require that care, treatment, and services are provided in a planned and timely manner. Compliance with this standard is demonstrated through a re-evaluation of the patient by a program team member within 72 hours after inpatient discharge. The re-evaluation may be conducted via phone call, home visit, or scheduled office appointment.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients who have a documented re-evaluation conducted via phone call or home visit within 72 hours after discharge.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Post-Discharge Evaluation Conducted Within 72 Hours

Denominator Statement: All heart failure patients discharged from a hospital inpatient setting to home or home care AND patients leaving against medical advice (AMA).

Included Populations:

- Discharges with ICD-9-CM Principal Diagnosis Code for HF as defined in Appendix A, Table 2.1, and
- A discharge to home, home care, or court/law enforcement
- Patients who left against medical advice (AMA)

Excluded Populations:

- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-9-CM procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2)
- Patients less than 18 years of age
- Patient who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
• Patients enrolled in a Clinical Trial
• Patients discharged to locations other than home, home care or law enforcement

Data Elements:

• Admission Date
• Birthdate
• Clinical Trial
• Comfort Measures Only
• Discharge Date
• Discharge Disposition
• ICD-9-CM Other Procedure Codes
• ICD-9-CM Principal Diagnosis Code
• ICD-9-CM Principal Procedure Code
• ICD-9-CM Principal Procedure Date

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes. please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

Data Reported As: Aggregate rate generated from count data reported as a proportion. Aggregate rate generated from count data reported as a proportion

Selected References:


Measure Algorithm:
ACHF-06: Post-Discharge Evaluation for Heart Failure Patients

**Numerator:** Patients who have a documented re-evaluation conducted via phone call or home visit within 72 hours after discharge.

**Denominator:** All heart failure patients discharged from a hospital inpatient setting to home or home care AND patients leaving against medical advice (AMA).
Data Elements
Data Element Name: Admission Date
Collected For: All Records
Definition: The month, day, and year of admission to acute inpatient care.
Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?
Format: Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1
Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
Notes for Abstraction:
- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.
- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.
Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted 05-01-20xx.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
- For newborns that are born within this hospital, the Admission Date is the date the baby was born.
Suggested Data Sources:
- ONLY ALLOWABLE SOURCES
  - Physician orders

Advanced Certification Heart Failure
Performance Measurement Implementation Guide
- Face sheet
- UB-04

**Note**: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

**Excluded Data Sources**
- UB-04, "From" and "Through" dates

**Additional Notes:**

**Guidelines for Abstraction:**

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<tr>
<th>Inclusion</th>
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<tbody>
<tr>
<td>None</td>
<td>• Admit to observation</td>
</tr>
<tr>
<td></td>
<td>• Arrival date</td>
</tr>
</tbody>
</table>
**Data Element Name:** Advance Directive Executed

**Collected For:** ACHF-05, ACHFOP-07,

**Definition:** Documentation in the medical record that the patient has an advance directive. An advance directive is instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity, and therefore appoints a person to make such decisions on their behalf.

**Suggested Data Collection Question:** Was documentation present in the medical record that the patient has an advance directive?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes)** There was documentation present in the medical record of an advance directive.
- **N (No)** There was no documentation present in the medical record of an advance directive, or unable to determine from medical record documentation.

**Notes for Abstraction:**
- If there is documentation of an advance directive present in the medical record, select Yes.
- If the only documentation in the medical record is that the patient was asked if they have an advance directive and the patient response is no, select No.
- If there is documentation that the patient has an advance directive but a copy is not present in the medical record, select Yes.
- See inclusion list for acceptable documentation of advance directive.

**Suggested Data Sources:**
- History and physical
- Progress notes
- Discharge summary
- Care Transition Record
- Consultation form
- Discharge planning form
- MOLST/POLST Forms
- Hospice referral
- Outpatient medical record

**Additional Notes:**
- Collected for both inpatient and outpatient

**Guidelines for Abstraction:**

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<thead>
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<td>• Advance care plan</td>
<td>• DNR orders</td>
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<tr>
<td>• Advance decision</td>
<td>• Do Not Resuscitate Orders</td>
</tr>
<tr>
<td>• Advance directive</td>
<td></td>
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<tr>
<td>• Advance healthcare directive</td>
<td></td>
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<tr>
<td>• Health care proxy</td>
<td></td>
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<tr>
<td>• Living will</td>
<td></td>
</tr>
<tr>
<td>• MOLST (Medical Orders for Life-Sustaining Treatment)</td>
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<tr>
<td>• Personal directive</td>
<td></td>
</tr>
<tr>
<td>• POLST (Physician Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>• Power of attorney for healthcare</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Birthdate

Collected For: All Records

Definition: The month, day, and year the patient was born.

Note:
- Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.
- For HBIPS discharge measures, i.e., HBIPS-1, 4, 5, 6, 7, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Suggested Data Collection Question:
What is the patient's date of birth?

Format:
Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-Current Year)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
- Emergency department record
- Face sheet
- Registration form
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
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<th>Exclusion</th>
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<tbody>
<tr>
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</table>
Data Element Name: Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge

Collected For: ACHF-01

Definition: Documentation that bisoprolol, carvedilol, or sustained-release metoprolol succinate was prescribed at discharge. Beta-blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta-blockers improve the hearts pumping ability. The marked beneficial effects of beta blockade has been well demonstrated in large-scale clinical trials of symptomatic patients with New York Heart Association (NYHA) class II-IV heart failure and reduced LVEF using bisoprolol, carvedilol, and sustained-release metoprolol succinate.

Suggested Data Collection Question: Was bisoprolol, carvedilol, or sustained-release metoprolol succinate prescribed for LVSD at discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) Bisoprolol, carvedilol, or sustained-release metoprolol succinate was prescribed for LVSD at discharge.
N (No) Bisoprolol, carvedilol, or sustained-release metoprolol succinate was not prescribed for LVSD at discharge or unable to determine from medical record documentation.

Notes for Abstraction:
- Only select "Yes" for those beta-blockers identified in the list of inclusions. No other beta-blockers will be accepted for this data element
- In determining whether bisoprolol, carvedilol, or sustained-release metoprolol succinate was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list one of these beta-blockers that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is bisoprolol, carvedilol, or sustained-release metoprolol succinate in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - Consider it a discharge medication in the absence of contradictory documentation.
  - If documentation is contradictory (e.g., physician noted d/c carvedilol in the discharge orders, but carvedilol is listed in the discharge summary as discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed unable to determine” (select "No").
  - Consider documentation of a hold on bisoprolol, carvedilol, or sustained-release metoprolol succinate after discharge in one location and a listing of that beta-blocker as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not defined (e.g., Hold bisoprolol). Examples of a hold with a defined timeframe include Hold Toprol-XL x 2 days and Hold Coreg until after stress test.
  - If documentation is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of the beta-blocker after discharge (e.g., Hold Toprol-XL x 2 days, Start Zebeta as outpatient, Hold Coreg), select No.
  - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the
dictated date/time over transcribed date/time, file date/time, etc.

Examples:
- Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.
- Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.
- Disregard bisoprolol, carvedilol, or sustained-release metoprolol succinate documented only as a recommended medication for discharge (e.g., Recommend sending patient home on Coreg). Documentation must be more clear that the beta-blocker was actually prescribed at discharge.
- Disregard documentation of bisoprolol, carvedilol, or sustained-release metoprolol succinate prescribed at discharge when noted only by medication class (e.g., Beta-Blocker Prescribed at Discharge: Yes on a core measures form). The beta-blocker prescribed must be listed by name.

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician orders
- Physicians notes
- Discharge summary
- Medication administration record (MAR)
- Transfer sheet
- Discharge instruction sheet
- Medication reconciliation form

Additional Notes:

Guidelines for Abstraction:

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<tr>
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<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>Bisoprol</td>
<td>All other beta-blocker medications other than those listed as inclusions.</td>
</tr>
<tr>
<td>Bisoprolol/fumarate</td>
<td></td>
</tr>
<tr>
<td>Bisoprolol/hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Carvedilol</td>
<td></td>
</tr>
<tr>
<td>Carvedilol phosphate</td>
<td></td>
</tr>
<tr>
<td>Coreg</td>
<td></td>
</tr>
<tr>
<td>Coreg CR</td>
<td></td>
</tr>
<tr>
<td>Metoprolol succinate</td>
<td></td>
</tr>
<tr>
<td>Toprol-XL</td>
<td></td>
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<tr>
<td>Zebeta</td>
<td></td>
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<tr>
<td>Ziac</td>
<td></td>
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</tbody>
</table>
Data Element Name: Care Transition Record Transmitted

Collected For: ACHF-03,

Definition: A care transition record is a document or set of documents containing standardized components specific to the patients diagnosis, treatment, and care. A care transition record is transmitted to the next level of care provider no later than the seventh post-discharge day.

Suggested Data Collection Question: Was a care transition record transmitted to the next level of care provider no later than the seventh post-discharge day?

Format: 
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 The medical record contains a care transition record that was transmitted to the next level of care provider no later than the seventh post-discharge day.
2 The medical record contains a care transition record but was not transmitted to the next level of care provider by the seventh post-discharge day.
3 The medical record does not contain a care transition record, or unable to determine from medical record documentation.

Notes for Abstraction:
- There must be documentation in the medical record to indicate that the care transition record was transmitted to the next level of care provider.
- A care transition record may consist of one document or several documents which could be considered a care transition packet. The hospital must be able to identify which document(s) make up the care transition record and the hospital must identify what specific documents are transmitted to the next level of care provider.
- The care transition record could be in the form of a continuing care plan, discharge instruction form, or another patient-specific document(s) contained in the medical record.
- The first post-discharge day is defined as the day after discharge.
- The next level of care provider is the clinician, hospital or clinic responsible for managing the patients heart failure after hospital discharge.
  - The next level of care provider may be a primary care physician, cardiologist, advanced practice nurse (APN), or physician assistant (PA).
  - If the patient has referrals to more than one provider for follow-up after discharge, transmission of the care transition record must include the next level of care provider.
- Methods for transmitting the care transition record include, but are not limited to: U.S. mail, email, fax, EMR access, doctor's mailbox, medical transport personnel. Giving a copy of the care transition record to the patient DOES NOT comprise transmission.
- If the hospital has an electronic medical record (EMR), abstraction is a two-step process:
  1. Make a list of those next level of care providers who have complete access to the hospital EMR.
  2. Check the list of those providers who have EMR access against the providers named on the care transition record. If the next level of provider noted on the care transition record matches the list of providers who have EMR access, select allowable value ‘1’.

Suggested Data Sources:
- Aftercare discharge plan
- Care transition record
- Continuing care plan
- Discharge plan
- Discharge summary
- Medication reconciliation form
- Physician orders
Additional Notes:

Guidelines for Abstraction:

<table>
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<tr>
<th>Inclusion</th>
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</tbody>
</table>
Data Element Name: Care Transition Record-Discharge Medications

Collected For: ACHF-03,

Definition: Documentation in the care transition record includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge.

Suggested Data Collection Question: Is there documentation in the medical record of a care transition record which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There is documentation that the care transition record included discharge medications, dosage, and indication for use.
N (No) There is no documentation that the care transition record included discharge medications, dosage, and indication for use, OR unable to determine from medical record documentation.

Notes for Abstraction:
- Medications are defined as any prescription medications, sample medications, herbal remedies, vitamins, nutriceuticals, over-the-counter drugs and any product designated by the Food and Drug Administration (FDA) as a drug (taken from the 2014 Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)).
- Discharge medications are all medications prescribed for the patient at discharge, including PRN medications, and are NOT limited to only those medications prescribed for heart failure.
- All medications must have the names, dosage and indication for use listed in the care transition record in order to select Yes. The indication for use can be as short as one to two words, but must be present for all medications, not just heart failure medications.
- If documentation reflects that no medications were prescribed for the patient at the time of discharge, select Yes.

Suggested Data Sources:
- Aftercare discharge plan
- Care transition record
- Continuing care plan
- Discharge plan
- Discharge summary
- Medication reconciliation form
- Physician orders
- Progress notes
- Referral form

Additional Notes:

Guidelines for Abstraction:

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</thead>
<tbody>
<tr>
<td>• Routinely scheduled medications</td>
<td>None</td>
</tr>
<tr>
<td>• PRN medications</td>
<td>None</td>
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</tbody>
</table>
Data Element Name: Care Transition Record-Follow-Up Treatment(s) and Service(s) Needed

Collected For: ACHF-03,

Definition: Documentation in the care transition record includes follow-up treatment(s) and service(s) needed. Follow-up treatments and services include treatments and services to be initiated or continued to manage the patient's heart failure after discharge from the hospital.

Suggested Data Collection Question: Is there documentation in the medical record of the care transition record which includes follow-up treatment and services needed?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation that the care transition record included follow-up treatment and services.
N (No) There is no documentation that the care transition record included follow-up treatment or services, OR unable to determine from medical record documentation.

Notes for Abstraction: • Follow-up treatments and services needed after hospital discharge should be documented in the care transition record. The list of treatments and services includes, but is not limited to: laboratory tests and results; imaging services (e.g., MRI, PET/CT, ultrasound, x-rays and other radiology services); rehabilitation services (e.g., PT, OT, SLT); respiratory treatments (e.g., oxygen therapy, CPAP BiPAP, nebulizer treatments); nutrition services; hospice or home care services; mental health, or other counseling services. Durable medical equipment needs and transportation needs (e.g., Medi-car) should be included.
• Documentation of one or more follow-up treatments and/or services in the care transition record, select YES.
• If medical record documentation indicates that no follow-up treatment or services were ordered, select YES.
• Unchecked checkbox or blank space for documentation of follow-up treatment or services, select NO.

Suggested Data Sources: • Aftercare discharge plan
• Care transition record
• Continuing care plan
• Discharge plan
• Discharge summary
• Medication reconciliation form
• Physician orders
• Progress notes
• Referral form

Additional Notes:

Guidelines for Abstraction:

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</table>
Data Element Name: Care Transition Record-Procedures Performed During Hospitalization

Collected For: ACHF-03,

Definition: Documentation in the care transition record includes procedures performed during hospitalization. Procedures may be diagnostic (e.g., echocardiogram), therapeutic (e.g., thoracentesis), or surgical (e.g., pacemaker insertion).

Suggested Data Collection Question: Is there documentation in the medical record of a care transition record which includes procedures performed during hospitalization?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation that the care transition record included procedures performed during the hospitalization.

N (No) There is no documentation that the care transition record included procedures performed during the hospitalization, OR unable to determine from medical record documentation.

Notes for Abstraction:
• The procedures performed during hospitalization should be a list of any diagnostic procedure(s), therapeutic procedure(s), or surgery(s) performed during the hospital stay. Procedures described by name, ICD-9-CM Principal Procedure Code, or ICD-9-CM Other Procedure Codes are acceptable.
• If no procedures were performed during the hospitalization, select YES.
• Unchecked checkbox or blank space for documentation of procedures performed during hospitalization, select NO.

Suggested Data Sources:
• Aftercare discharge plan
• Care transition record
• Continuing care plan
• Discharge plan
• Discharge summary
• Medication reconciliation form
• Physician orders
• Progress notes
• Referral form

Additional Notes:

Guidelines for Abstraction:

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</thead>
<tbody>
<tr>
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<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Care Transition Record-Reason for Hospitalization

Collected For: ACHF-03,

Definition: Documentation in the care transition record includes the reason for hospitalization. The reason for hospitalization should be a short synopsis describing the events the patient experienced prior to this hospitalization. The reason for hospitalization may be listed as the triggering or precipitating event prior to the patients admission to the hospital.

Suggested Data Collection Question: Is there documentation in the medical record of a care transition record which includes the reason for hospitalization?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the care transition record included the reason for hospitalization.
N (No) There is no documentation that the care transition record included the reason for hospitalization, OR unable to determine from medical record documentation.

Notes for Abstraction:

- If the patients primary diagnosis and/or other or secondary diagnoses are listed on the care transition record, select YES.
- Documentation of the patients chief complaint on the care transition, select YES.
- Unchecked checkbox or blank space for documentation of reason for hospitalization, select NO.

Suggested Data Sources:

- Aftercare discharge plan
- Care transition record
- Continuing care plan
- Discharge plan
- Discharge summary
- Medication reconciliation form
- Physician orders
- Progress notes
- Referral form

Additional Notes:

Guidelines for Abstraction:

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<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Care Transition Record-Treatment(s)/Service(s) Provided

Collected For: ACHF-03,

Definition: Documentation in the care transition record includes treatment(s) and service(s) provided during hospitalization. Treatments and services include anything offered to or done for the patient during the hospital stay to manage his/her heart failure.

Suggested Data Collection Question: Is there documentation in the medical record of a care transition record which includes treatments and services provided during hospitalization?

Format: Length: 1
       Type: Alphanumeric
       Occurs: 1

Allowable Values: Y (Yes) There is documentation that the care transition record included treatment(s) and service(s) provided during hospitalization.
                N (No) There is no documentation that the care transition record included treatment(s) and service(s) provided during hospitalization, OR unable to determine from medical record documentation.

Notes for Abstraction: • Treatments and services provided during the hospital stay should be documented in the care transition record. The list of treatments and services includes, but is not limited to: laboratory tests and results; imaging services (e.g., MRI, PET/CT, ultrasound, x-rays and other radiology services); rehabilitation services (e.g., PT, OT, SLT); respiratory treatments (e.g., oxygen therapy, CPAP, BiPAP, nebulizer treatments); nutrition services; hospice services; mental health, or other counseling services.
               • If one or more treatments or services are documented in the care transition record, select Yes.
               • Documentation of tests with results pending that require follow-up, select YES.
               • Unchecked checkbox or blank space for documentation of treatment or services, select NO.

Suggested Data Sources:
• Aftercare discharge plan
• Care transition record
• Continuing care plan
• Discharge plan
• Discharge summary
• Medication reconciliation form
• Physician orders
• Progress notes
• Referral form

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Clinical Trial

Collected For: ACHF-01, ACHF-02, ACHF-03, ACHF-06, ACHFOP-01, ACHFOP-02, ACHFOP-03, ACHFOP-04, ACHFOP-05, CSTK-04, CSTK-06, PC,

Definition: Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PC, PN, SCIP, STK, VTE).

Suggested Data Collection Question: 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, PC, PN, SCIP, STK, VTE)?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PC, PN, SCIP, STK, VTE).
N (No) There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PC, PN, SCIP, STK, VTE), or unable to determine from medical record documentation.

Notes for Abstraction:
• To select "Yes" to this data element, BOTH of the following must be true:

1. There must be a signed consent form for clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.

2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PC, PN, SCIP, STK, VTE). Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.
• In the following situations, select "No:"

1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.

2. It is not clear whether the study described in the signed patient consent form is experimental or observational.

3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.

AMI: Only capture patients enrolled in clinical trials studying patients with acute myocardial infarction (AMI), ST-elevation myocardial infarction (STEMI), Non ST-elevation MI (NSTEMI), heart attack, or acute coronary syndrome (ACS).

CAC: Only capture patients enrolled in clinical trials studying children with asthma.
HF: Only capture patients enrolled in clinical trials studying patients with heart failure (HF).

PC: Only capture patients enrolled in clinical trials studying pregnant patients or newborns. For Perinatal Care measures ONLY, it is appropriate for the ORYX® Vendor to default the data element to "No" unless a diagnosis code for clinical trial is present. If a code is present, or the organization knows via some other electronic method that the patient is participating in a clinical trial, default the data element to "Yes". Hospital abstractors may change defaulted value of "No" based on hospital participation in clinical trial.

PN: Only capture patients enrolled in clinical trials studying patients with pneumonia.

SCIP: The clinical trial should be relevant to one or more of the SCIP measures. Some examples may include but are not limited to:
- The clinical trial involved the use of antibiotics.
- The clinical trial involved testing a new beta-blocker.
- The clinical trial involved the use of VTE prophylaxis.

STK: Only capture patients enrolled in clinical trials studying patients with stroke.

VTE: Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).

**Suggested Data Sources:**

**ONLY ACCEPTABLE SOURCES:**
Signed consent form for clinical trial

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Comfort Measures Only

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format: Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  
1 Day 0 or 1: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).

2 Day 2 or after: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).

3 Timing unclear: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.

4 Not Documented/UTD: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:  
- Only accept terms identified in the list of inclusions. No other terminology will be accepted.  
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:  
  - Comfort measures only recommendation  
  - Order for consultation or evaluation by a hospice care service  
  - Patient or family request for comfort measures only  
  - Plan for comfort measures only  
  - Referral to hospice care service  
  - Discussion of comfort measures  
- Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value "1," "2," or "3" accordingly.  
  - Examples:  
    "Discussed comfort care with family on arrival" noted in day 2 progress note - Select "2."  
- State Authorized Portable Orders (SAPOs).  
  - SAPOs are specialized forms or identifiers authorized by state law that translate a patient's preferences about specific end-of-life treatment decisions into portable medical orders  
  - Examples:  
    - DNR-Comfort Care form  
    - MOLST (Medical Orders for Life-Sustaining Treatment)  
    - POLST (Physician Orders for Life-Sustaining Treatment)  
    - Out-of-Hospital DNR (OOH DNR)  
  - If there is a SAPO in the record that is dated and signed prior to arrival with an option in
which an inclusion term is found that is checked, select value "1."

○ If a SAPO lists different options for CMO and any CMO option is checked, select value "1," "2," or "3" as applicable.

○ If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.

○ For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.

Example:
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record "Patient is refusing comfort measures, wants to receive full treatment and be a full code."

• Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select value "4."

○ Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.

Examples:
- Comfort measures only order in previous hospitalization record.
- "Pt. on hospice at home" in MD ED note.

○ Inclusion term clearly described as negative or conditional.

Examples:
- "No comfort care"
- "Not appropriate for hospice care"
- "Comfort care would also be reasonable - defer decision for now"
- "DNRCCA" (Do Not Resuscitate - Comfort Care Arrest)
- "Family requests comfort measures only should the patient arrest."

○ Documentation of "CMO" should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., "hx dilated CMO" - Cardiomyopathy context).

• If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value "1," "2," or "3" for this data element.

Examples:
- Physician documents in progress note on day 1 "The patient has refused Comfort Measures" AND then on day 2 the physician writes an order for a Hospice referral. Select value "2."
- ED physician documents in a note on day of arrival "Patient states they want to be enrolled in Hospice" AND then on day 2 there is a physician progress note with documentation of "Patient is not a Hospice candidate." Select value "1."
**Additional Notes:**  
**Excluded Data Sources:**  
- Restraint order sheet

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain dead</td>
<td>None</td>
</tr>
<tr>
<td>Brain death</td>
<td></td>
</tr>
<tr>
<td>Comfort care</td>
<td></td>
</tr>
<tr>
<td>Comfort measures</td>
<td></td>
</tr>
<tr>
<td>Comfort measures only (CMO)</td>
<td></td>
</tr>
<tr>
<td>Comfort only</td>
<td></td>
</tr>
<tr>
<td>DNR-CC</td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
</tr>
<tr>
<td>Organ harvest</td>
<td></td>
</tr>
<tr>
<td>Terminal care</td>
<td></td>
</tr>
<tr>
<td>Terminal extubation</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Discharge Date

Collected For: All Records, Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format: Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Discharge Disposition

Collected For: ACHF-01, ACHF-02, ACHF-03, ACHF-04, ACHF-05, ACHF-06, CSTK-02, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC-04, PC-05,

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
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 Advice/AMA
8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:
- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
  Example: Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value “5” (Other Health Care Facility).
- The medical record must be abstracted as documented (taken at “face value”). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  Examples:
  - Discharge summary dictated 2 days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value “2” (Hospice - Home).
  - Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states Discharge home. Contradictory documentation, use latest. Select value “1” (Home).
  - Physician order on discharge states Discharge to ALF. Discharge instruction sheet completed after the physician order states patient discharged to SNF. Contradictory documentation, use latest. Select value “5” (Other Health Care Facility).
- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  - Acute Care Facility
  - Hospice - Health Care Facility
  - Hospice - Home
  - Other Health Care Facility
- Home
- Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" (Acute Care Facility).
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows), and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value "1" (Home).
- When determining whether to select value "7" (Left Against Medical Advice/AMA):
  - Explicit "left against medical advice" documentation is not required. E.g., Patient is refusing to stay for continued care - Select value "7".
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states Discharged home with belongings - Select "7".

**Suggested Data Sources:**
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social service notes
- Transfer record

**Excluded Data Sources**
- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Home (Value 1):</strong></td>
<td>None</td>
</tr>
<tr>
<td>• Assisted Living Facilities (ALFs) - Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities</td>
<td></td>
</tr>
<tr>
<td>• Court/Law Enforcement - includes detention facilities, jails, and prison</td>
<td></td>
</tr>
<tr>
<td>• Home - includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters</td>
<td></td>
</tr>
<tr>
<td>• Home with Home Health Services</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization</td>
<td></td>
</tr>
</tbody>
</table>
**Hospice - Home (Value 2):**
- Hospice in the home (or other Home setting as above in Value 1)

**Hospice Health Care Facility (Value 3):**
- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

**Acute Care Facility (Value 4):**
- Acute Short Term General and Critical Access Hospitals
- Cancer and Childrens Hospitals
- Department of Defense and Veterans Administration Hospitals

**Other Health Care Facility (Value 5):**
- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veterans Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home
Data Element Name: Discussion of Advance Directives/Advance Care Planning

Collected For: ACHF-04, ACHFOP-06,

Definition: Documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider. Advance directives are instructions given to individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity, and therefore appoints a person to make such decisions on their behalf.

Suggested Data Collection Question: Was documentation present in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There was documentation present in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider.
N (No) There was no documentation present in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider, or unable to determine from medical record documentation.

Notes for Abstraction: • If documentation of a discussion of advance directives or advance care planning with the patient and/or caregiver is present in the medical record, select Yes.
• The caregiver is defined as the patients family or other person (e.g. home health, VNA provider, prison official or law enforcement personnel) who will be responsible for care of the patient after discharge.
• Advance directive discussion may be with a physician/APN/PA, social worker, pastoral care, or nurse.
• A one-time discussion documented anywhere in the medical record is sufficient to select Yes for this data element.
• If the only documentation in the medical record is that the patient was asked if they have an advance directive and the patient response is no, select No.
• If there is documentation that the patient has an advance directive but a copy is not present in the medical record, select Yes.
• Documentation that the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, select Yes.
• Documentation that the patients cultural beliefs may be in conflict with the discussion of advance directives, e.g., Navajo Indian, select Yes.
• Documentation of patient/family refusal of a discussion, select Yes.
• If an advance directive is present in the medical record, select Yes.

Suggested Data Sources: • History and physical
• Progress notes
• Discharge summary
• Care Transition Record
• Consultation form
• Discharge planning form
• MOLST/POLST Forms
• Hospice referral
• Outpatient medical record

Additional Notes:
### Guidelines for Abstraction:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>- Advance care plan</td>
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</tr>
<tr>
<td>- Advance decision</td>
<td></td>
</tr>
<tr>
<td>- Advance directive</td>
<td></td>
</tr>
<tr>
<td>- Advance healthcare directive</td>
<td></td>
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<tr>
<td>- DNR orders</td>
<td></td>
</tr>
<tr>
<td>- Do Not Resuscitate Orders</td>
<td></td>
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<tr>
<td>- Health care proxy</td>
<td></td>
</tr>
<tr>
<td>- Living will</td>
<td></td>
</tr>
<tr>
<td>- MOLST (Medical Orders for Life-Sustaining Treatment)</td>
<td></td>
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<tr>
<td>- Personal directive</td>
<td></td>
</tr>
<tr>
<td>- POLST (Physician Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>- Power of attorney for healthcare</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Hispanic Ethnicity

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
Y (Yes) Patient is of Hispanic ethnicity or Latino.
N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, Race, is required in addition to this data element.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term Spanish origin can be used in addition to Hispanic or Latino. Examples: Black-Hispanic Chicano H Hispanic Latin American Latino/Latina Mexican-American Spanish White-Hispanic</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: ICD-9-CM Other Procedure Codes

Collected For: All Records, Optional for All HBIPS Records

Definition: The other or secondary ICD-9-CM codes identifying all significant procedures other than the principal procedure.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Other Procedure Date exists, etc.) will apply.

Suggested Data Collection Question: What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

Format: Length: 5 (with or without decimal point)
Type: Alphanumeric
Occurs: 24


Notes for Abstraction: None

Suggested Data Sources:
- Face sheet
- Discharge summary
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
Data Element Name: ICD-9-CM Principal Diagnosis Code

Collected For: All Records, Optional for HBIPS-2 and HBIPS-3

Definition: The ICD-9-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format: Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1


Notes for Abstraction: None

Suggested Data Sources:
- Face sheet
- Discharge summary
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: **ICD-9-CM Principal Procedure Code**

Collect For: All Records, Optional for All HBIPS Records

Definition: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Principal Procedure Date exists, etc.) will apply.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the *principal* procedure for this record?

Format: Length: 5 (with or without decimal point)

Type: Alphanumeric

Occurs: 1


Notes for Abstraction: None

Suggested Data Sources:
- Face sheet
- Discharge summary
- UB-04

Additional Notes:

Guidelines for Abstraction:

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<thead>
<tr>
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<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
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</tbody>
</table>
**Data Element Name:** ICD-9-CM Principal Procedure Date

**Collected For:** All Records, Optional for All HBIPS and PBM Records

**Definition:** The month, day, and year when the principal procedure was performed.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Principal Procedure Code exists, etc.) will apply.

**Suggested Data Collection Question:** What was the date the principal procedure was performed?

**Format:**
- **Length:** 10 MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

**Notes for Abstraction:**
- If the principal procedure date is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

**Examples:**
- Documentation indicates the ICD-9-CM Principal Procedure Date was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-9-CM Principal Procedure Date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-20xx and documentation indicates the ICD-9-CM Principal Procedure Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the ICD-9-CM Principal Procedure Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for ICD-9-CM Principal Procedure Date allows the case to be accepted into the warehouse.

**Suggested Data Sources:**
- Consultation notes
- Face sheet
- Progress notes
- Discharge summary
- Diagnostic test reports
- Operative notes
- Procedure notes
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: LVSD < 40%

Collected For: ACHF-01, ACHFOP-01, ACHFOP-02, ACHFOP-03,

Definition: Left ventricular systolic dysfunction (LVSD) documented in medical record. LVSD is defined as a left ventricular ejection fraction less than 40% or a narrative description consistent with moderate or severe systolic dysfunction.

LVSD is an impairment of left ventricular performance. An ejection fraction (EF) is an index of left ventricular systolic function (LVSF) and reflects the proportion of blood ejected during each ventricular contraction compared with the total ventricular filling volume.

Suggested Data Collection Question: Is the left ventricular systolic function (LVSF) documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) LVSF is documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction.

N (No) LVSF is not documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction, or unable to determine from medical record documentation.

Notes for Abstraction: Results from in-hospital LVSF assessments filed into the chart after discharge should still be used.

A. Methodology:

- Final findings take priority over preliminary findings. Applies to test reports and findings noted outside of reports. If not labeled "preliminary," assume it is final.
- Conclusion section of report takes priority over other sections. Consider the "Impression," "Interpretation," and "Final Diagnosis" sections as equivalent with the "Conclusion" section.
- Apply Section B Conflicting Documentation priority order in ANY step in Methodology section when there are two or more different descriptions of Ejection Fraction/LVSF.
- Disregard the following terminology when reviewing the record for documentation of LVSF/LVSD. If documented, continue reviewing for LVSF/LVSD inclusions outlined in the Inclusion lists, as directed in the abstraction guidelines below.
  - Diastolic dysfunction, failure, function, or impairment
  - Ventricular dysfunction not described as left ventricular or systolic
  - Ventricular failure not described as left ventricular or systolic
  - Ventricular function not described as left ventricular or systolic
    E.g., Impression section of echo report states only "diastolic dysfunction." Findings section states "EF 35%." Disregard "diastolic dysfunction" in the Impression section and answer "Yes" due to EF 35%.

1. If one or more in-hospital tests performed:
   a. Use report from most recent test* (test done closest to discharge).
   b. If no report or no Ejection Fraction/LVSF findings noted in report, use other sources (e.g., progress notes) that clearly reference the most recent test*.
   c. If no Ejection Fraction/LVSF results from the most recent test are documented anywhere, use the report from the second most recent test*.
   d. If no Ejection Fraction/LVSF findings from second most recent test are documented anywhere, use other sources (e.g., progress notes) that clearly reference the second...
most recent test*. Continue working backwards (if greater than 2 tests) and use Ejection Fraction/LVSF from the most recent test* that has Ejection Fraction/LVSF findings, using the report over non-report sources as above.

e. If no Ejection Fraction/LVSF results from any in-hospital test are documented anywhere, skip to step 2a below.

*If you cannot determine between two in-hospital tests which was performed closest to the time of discharge, use BOTH tests:

1. Use reports. Reports take priority over non-report sources.
2. If no reports or no Ejection Fraction/LVSF findings on reports from any test, use other sources (e.g., progress notes) that clearly reference the tests.
3. If no Ejection Fraction/LVSF results from either in-hospital test documented anywhere, go to step 2a below.

2. If in-hospital test not done, no Ejection Fraction/LVSF results from any in-hospital test documented, OR documentation is not clear that one was done (e.g., echo ordered but no documentation that it was done):
   a. Assume notations of Ejection Fraction/LVSF with no timeframe ("floating" Ejection Fractions/LVSFs) are from assessments done prior to arrival.
   b. If timeframe known for ALL pre-arrival Ejection Fractions/LVSFs (no "floaters"):
      ■ Use results from the pre-arrival test known to be most recent (closest to hospital arrival).
      ■ Use report over other sources, and Conclusion (Impression, etc.) over other sections of report, as above.
   c. If one or more "floaters":
      ■ Compile all Ejection Fractions/LVSFs and eliminate those that you can determine are not the most recent, resulting in a list of Ejection Fraction/LVSF "Possibles."
      ■ If Ejection Fraction/LVSF from one test in the "Possibles" list is referenced both in a report and in another source, use the report, and use the Conclusion (Impression, etc.) over other sections of the report, as above, to determine which Ejection Fraction/LVSF from this test to add to the list of "Possibles."
      ■ Select final Ejection Fraction/LVSF from list of "Possibles" based on the Conflicting Documentation rules below.

B. Conflicting Documentation:

Apply the following priority order in cases of conflicting documentation within ANY ONE STEP in Methodology above, where there are two or more different descriptions of Ejection Fraction/LVSF:

1. Use lowest calculated ejection fraction. Presume calculated unless described as estimated (e.g., "Ejection fraction 30").
   ○ If calculated ejection fraction less than 40% select "Yes." If calculated ejection fraction greater than or equal to 40%, select "No."
2. Use lowest estimated ejection fraction. E.g., "Ejection fraction about 40%," "Ejection fraction approximately 30%," "Ejection fraction appears to be 35%," "Visually ejection fraction is 45%," "Ejection fraction 35-40% (use mid-point)," "Ejection fraction less than 40%.
   ○ If estimated ejection fraction less than 40%, select "Yes." If estimated ejection fraction greater than or equal to 40%, select "No."
3. Use worst narrative description with severity specified.
   ○ Select "Yes" if description is synonymous with term from Inclusion list A.
   ○ Select "No" if description with severity specified is NOT synonymous with term from Inclusion List A (e.g., normal, mild, preserved).
4. Use narrative description without severity specified. Select "Yes" if description is synonymous with term from Inclusion list B. Otherwise, select "No."

**Suggested Data Sources:**
- Consultation notes
- History and physical
## Additional Notes:

### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusion list A: Moderate/severe LVSD</strong></td>
<td><strong>Moderate or severe systolic dysfunction</strong></td>
</tr>
<tr>
<td>- Biventricular dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe</td>
<td>- Any term in Inclusion list A or B described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table</td>
</tr>
<tr>
<td>- Biventricular heart failure described as moderate or severe</td>
<td>- Any term in Inclusion list A or B described as mild-moderate</td>
</tr>
<tr>
<td>- Ejection fraction or left ventricular ejection fraction (LVEF) described as low, poor, or very low</td>
<td></td>
</tr>
<tr>
<td>- Endstage cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>- Hypokinesis described as diffuse, generalized, or global AND marked, moderate, moderate-severe, severe, significant, substantial, or very severe</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular (LV) akinesis described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular (LV) hypokinesis described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe in one or more segments of left ventricle</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular dysfunction (LVD), left ventricular systolic dysfunction (LVSD), or systolic dysfunction described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular function (LVF), left ventricular systolic function (LVSF), or systolic function described as low, poor, or very low</td>
<td></td>
</tr>
<tr>
<td>- Systolic failure described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe AND not described as right ventricular</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion list B: LVSD Severity not specified</strong></td>
<td></td>
</tr>
<tr>
<td>- Biventricular dysfunction where severity is not specified</td>
<td></td>
</tr>
<tr>
<td>- Ejection fraction or left ventricular ejection fraction (LVEF) described as abnormal, compromised, decreased, depressed, diminished, impaired, or reduced</td>
<td></td>
</tr>
<tr>
<td>- Hypokinesis described as diffuse, generalized, or global where severity is not specified</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular (LV) hypokinesis described as involving the entire left ventricle</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular dysfunction (LVD), left ventricular systolic dysfunction (LVSD), or systolic dysfunction where severity is not specified</td>
<td></td>
</tr>
<tr>
<td>- Left ventricular function (LVF), left ventricular systolic</td>
<td></td>
</tr>
</tbody>
</table>
function (LVSF), or systolic function described as abnormal, compromised, decreased, depressed, diminished, impaired, or reduced

- Systolic failure where severity is not specified AND not described as right ventricular
Data Element Name: Post-Discharge Appointment Scheduled Within 7 Days

Collected For: ACHF-02,

Definition: Documentation that a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.

Suggested Data Collection Question: Was a follow-up appointment for an office or home health visit for management of heart failure scheduled within 7 days post-discharge and documented including location, date, and time?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) A follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.
N (No) A follow-up appointment for an office or home health visit for management of heart failure was not scheduled within 7 days post-discharge and documented including location, date, and time, OR unable to determine from medical record documentation.

Notes for Abstraction:
- A follow-up appointment is an appointment with a physician/APN/PA in a physician office or ambulatory care clinic OR a home health visit with a RN/APN for professional nursing services that occurs within 7 days of discharge from the inpatient setting.
- Follow-up scheduled within 7 days via telemedicine/teleconference to assess the patient in the home setting should be treated as a home health visit, select Yes.
- Documentation of the scheduled office appointment must include location, date and time in order to select Yes. If all three pieces of information are not documented, select No.
- Documentation of a home health visit must include the date in order to select Yes. Documentation of the time is optional only for a home health visit, as the time of the visit may vary.
- If the follow-up appointment is scheduled beyond 7 days post-discharge, select No.

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Home health referral form

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Post-Discharge Evaluation Conducted Within 72 Hours

Collected For: ACHF-06,

Definition: Documentation that the post-discharge evaluation was conducted with the patient and/or caregiver(s) within 72 hours following hospital discharge.

Suggested Data Collection Question: Was there documentation that the post-discharge evaluation was conducted with the patient and/or caregiver(s) within 72 hours of hospital discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
- Y (Yes) There is documentation that the post-discharge evaluation was conducted with the patient and/or caregiver(s) within 72 hours of hospital discharge.
- N (No) There is no documentation that the post-discharge evaluation was conducted with the patient and/or caregiver(s) within 72 hours of hospital discharge OR unable to determine from medical record documentation.

Notes for Abstraction:
- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.
- The post-discharge evaluation must be conducted within 72 hours following the patient's discharge from the hospital in order to select Yes. To compute 72 hours, count the day after hospital discharge as day 1. Documentation of a post-discharge evaluation conducted any time up to 23:59 of day 3, select YES for this data element.
- If the post-discharge evaluation was conducted beyond the 72 hour timeframe, select No.
- A post-discharge evaluation conducted within 72 hours via telephone or electronically, i.e., e-mail is sufficient to select Yes for this data element. Documentation of a home health evaluation or office appointment scheduled within 72 hours is also acceptable to select Yes.
- If documentation reflects that after 3 attempts to contact the patient and/or caregiver, the post-discharge evaluation could not be conducted because attempts to contact the patient and/or caregiver were unsuccessful, select Yes.

EXAMPLES:
- Home phone number provided at discharge is a wrong number, AND no e-mail address or other contact information was provided by the patient and/or caregiver at discharge.
- Calls placed go to a voicemail system. Message left for patient and/or caregiver requesting a return phone call, but no return call received.
- E-mail address generates an undeliverable message and no phone number is available for the patient and/or caregiver.
- E-mail message delivered with no return response from the patient and/or caregiver.

Suggested Data Sources:
- Home Health Forms,
- Logs from follow-up phone calls or other logs that record follow-up information

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
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</tbody>
</table>
Data Element Name: Race

Collected For: All Records

Definition: Documentation of the patients race.

Suggested Data Collection Question: What is the patients race?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values: Select one:
1 White: Patients race is White or the patient has origins in Europe, the Middle East, or North Africa.
2 Black or African American: Patients race is Black or African American.
3 American Indian or Alaska Native: Patients race is American Indian/Alaska Native.
4 Asian: Patients race is Asian.
5 Native Hawaiian or Pacific Islander: Patients race is Native Hawaiian/Pacific Islander.
6 RETIRED VALUE (effective 07-01-05 discharges)
7 UTD: Unable to determine the patients race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:
- The data element Hispanic Ethnicity is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms Hispanic and Latino are actually descriptions of the patients ethnicity, it is not uncommon to find them referenced as race. If the patients race is documented only as Hispanic/Latino, select White. If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic select Black). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American</td>
<td>None</td>
</tr>
<tr>
<td>A person having origins in any of the black racial groups of Africa. Terms such as Haitian or Negro can be used in addition to Black or African American.</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
</tr>
<tr>
<td>A person having origins in any of the original peoples of North and South America (including Central America) and</td>
<td></td>
</tr>
</tbody>
</table>
who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American.)

**Asian**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White**
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

**Native Hawaiian or Pacific Islander**
A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
Data Element Name: Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge

Collected For: ACHF-01,

Definition: Reasons for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge:
- Beta-blocker allergy
- Second or third-degree heart block on ECG on arrival or during hospital stay and does not have a pacemaker
- Other reasons documented by physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Bisoprolol, carvedilol, and sustained-release metoprolol succinate are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta-blockers improve the hearts pumping ability.

Suggested Data Collection Question: Is there documentation of a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge?

Format: Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  
Y (Yes) There is documentation of a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge.

N (No) There is no documentation of a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge, OR unable to determine from medical record documentation.

Notes for Abstraction:
- If there is documentation in the medical record of LVSD greater than or equal to 40%, this data element is not required.
- A beta-blocker allergy or sensitivity documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., Allergies: Beta-blockers Impotence select Yes).
- Documentation of an allergy/sensitivity to one particular beta-blocker is acceptable to take as an allergy to the entire class of beta-blockers (e.g., Allergic to Toprol-XL).
- When conflicting information is documented in a medical record, select Yes.
- When determining whether there is second or third-degree heart block on ECG on arrival or during hospital stay AND does not have pacemaker:
  - Consider this true if (1) there are findings of second or third-degree heart block on the ECG AND this same ECG does NOT show pacemaker findings, OR (2) There is documentation of a finding of second or third-degree heart block (not specifically referenced as an ECG finding) without mention of the presence of pacemaker findings (e.g., Second-degree heart block per ER report).
  - Disregard pacemaker findings if documentation suggests the patient has a non-functioning pacemaker.
  - Second or third-degree heart block and pacemaker ECG findings can be taken from unsigned ECG reports. Physician/APN/PA documentation is not required.
  - Second or third-degree heart block findings and pacemaker findings from telemetry and rhythm strips are acceptable.
  - In cases where ECG findings of second- or third-degree heart block are referenced and documentation does not address the presence or absence of pacemaker findings, infer no pacemaker findings. E.g., ECG on arrival showed second-degree heart block per H&P.
• When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge:
  ○ Reasons must be explicitly documented (e.g., COPD - No BBs, HR running in 50s. Hold off on beta-blocker therapy) or clearly implied (e.g., Severe hypotension with beta-blockers in past, BBs contraindicated, Pt. refusing all medications, Supportive care only no medications, BBs not indicated, beta-blocker on pre-printed order form is crossed out, No beta-blockers [no reason given]). If reasons are not mentioned in the context of beta-blockers, do not make inferences (e.g., Do not assume that bisoprolol, carvedilol, or sustained-release metoprolol succinate is not being prescribed because of the patient's history of Peripheral Vascular Disease alone).
  ○ Physician/APN/PA or pharmacist documentation of a hold on bisoprolol, carvedilol, or sustained-release metoprolol succinate or discontinuation of one of these beta-blockers that occurs during the hospital stay constitutes a clearly implied reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge. A hold/discontinuation of all p.o. medications counts if bisoprolol, carvedilol, or sustained-release metoprolol succinate p.o. was on order at the time of the notation.

EXCEPTION:
  • Documentation of a conditional hold/discontinuation of bisoprolol, carvedilol, or sustained-release metoprolol succinate does not count as a reason for not prescribing one of these beta-blockers at discharge UNLESS (1) it exists as an order to hold/discontinue the beta-blocker if the blood pressure (BP) or heart rate (HR) falls outside certain parameters, AND (2) the beta-blocker was held due to a BP/HR outside the parameters. Nursing documentation is acceptable. E.g., Hold bisoprolol for SBP less than 100 ordered and the nurse documents that the bisoprolol was held for a BP of 90/50 select Yes.

• Discontinuation of bisoprolol, carvedilol, or sustained-release metoprolol succinate documented in combination with the start of a another one of these beta-blockers (i.e., switch from bisoprolol to carvedilol) does not count as a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge.

Examples:
  ○ Stop carvedilol and Start Coreg 12.5 mg po bid in same physician order
  ○ Change metoprolol succinate to Coreg in progress note
  ○ Do not continue after discharge checked for metoprolol succinate and Continue after discharge checked for Toprol-XL on a physician-signed discharge medication reconciliation form
  ○ Discontinuation of bisoprolol, carvedilol, or sustained-release metoprolol succinate at a particular dose documented in combination with the start of a different dose of that beta-blocker (i.e., change in dosage) does not count as a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge.

Examples:
  ○ Stop sustained-release metoprolol succinate 25 mg po and Start sustained-release metoprolol succinate 50 mg po in same physician order
  ○ Increase bisoprolol 5 mg to 10 mg in progress note
  ○ Do not continue after discharge checked for Coreg 3.125 mg bid and Continue after discharge checked for Coreg 6.25 mg bid on a physician-signed discharge medication reconciliation form

  • Reason documentation which refers to a more general medication class is not acceptable (e.g., Hold all BP meds).
  • Deferral from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing bisoprolol, carvedilol, or sustained-release metoprolol succinate at discharge unless the problem underlying the deferral is also noted.
Examples:
- Consulting cardiologist to evaluate pt. for beta-blocker treatment - select No.
- Pt. hypotensive. Start Coreg if OK with cardiology. - select "Yes.
- If there is documentation of a plan to initiate/restart bisoprolol, carvedilol, or sustained-release metoprolol succinate, and the reason/problem underlying the delay in starting/restarting the beta-blocker is also noted, this constitutes a clearly implied reason for not prescribing a beta-blocker discharge.
  - Acceptable examples (select Yes):
    - BP's running low. May start Zebeta as outpatient.
    - Add Toprol-XL if HR stabilizes
  - Unacceptable examples (select "No"):
    - Consider starting Coreg in a.m.
    - May add beta-blockers when pt. can tolerate
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating no bisoprolol due to hypotension - select Yes, even if documentation indicates that the hypotension had resolved by the time of discharge and the beta-blocker was restarted).
- Crossing out of bisoprolol, carvedilol, or sustained-release metoprolol succinate counts as a "clearly implied reason" for not prescribing one of these beta-blockers at discharge only if on a pre-printed form.
- When the current record includes documentation of a pre-arrival reason for no bisoprolol, carvedilol, or sustained-release metoprolol succinate, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  - Pre-arrival beta-blocker allergy
  - Pre-arrival hold/discontinuation or notation such as "No carvedilol" IF the underlying reason/problem is also noted (e.g., Coreg discontinued in transferring hospital secondary to hypotension).

Suggested Data Sources:
- Emergency department record
- History and physical
- Nursing notes
- Physician orders
- Physicians notes
- Discharge summary
- Medication administration record (MAR)
- Transfer sheet
- Consultation notes
- ECG reports
- Vital signs graphic record

Additional Notes: Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Guidelines for Abstraction:
second-degree, or third-degree
- Atrioventricular (AV) dissociation
- Heart block (HB) described as 2 to 1, 3 to 1, complete (CHB), high degree, high grade, second-degree, or third-degree
- Mobitz Type 1 or 2
- Wenckebach

Pacemaker findings
- Paced rhythm
- Paced spikes
- Pacing described as atrial, AV, dual chamber, or ventricular

<table>
<thead>
<tr>
<th>Qualifiers and Modifiers Table</th>
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</thead>
<tbody>
<tr>
<td>2nd/3rd degree heart block (HB)</td>
</tr>
<tr>
<td>2nd/3rd degree heart block (HB), or any of the other 2nd/3rd degree heart block inclusion terms, described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table</td>
</tr>
<tr>
<td>Atrial flutter</td>
</tr>
<tr>
<td>Atrioventricular (AV) block or conduction block, type/degree not specified</td>
</tr>
<tr>
<td>First-degree atrioventricular (AV) block</td>
</tr>
<tr>
<td>First-degree heart block (HB)</td>
</tr>
<tr>
<td>Heart block, type/degree not specified</td>
</tr>
<tr>
<td>Intraventricular conduction delay (IVCD)</td>
</tr>
</tbody>
</table>
Data Element Name: Reason for No Post-Discharge Appointment Within 7 Days

Collected For: ACHF-02,

Definition: Documentation by a physician/APN/PA in the medical record of a reason for not scheduling a post-discharge appointment within 7 days.

Suggested Data Collection Question: Is there documentation by a physician/APN/PA in the medical record of a reason for not scheduling a post-discharge appointment within 7 days?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation of a reason for not scheduling a post-discharge appointment within 7 days.
N (No) There is no documentation of a reason for not scheduling a post-discharge appointment within 7 days, OR unable to determine from medical record documentation.

Notes for Abstraction: * Reasons for not scheduling a post-discharge appointment within 7 days must be documented by the physician/APN/PA.
  - If reasons are not mentioned in the context of 7 days after discharge, do not make inferences (e.g., do not assume that an appointment was scheduled for 14 days post-discharge because one was not available within 7 days unless documentation explicitly states so.)
    - Reasons must be explicitly documented (e.g., 4 week wait at county clinic. Follow-up scheduled with Dr. X at 10:30 on X/XX/XXXX.)
  - When conflicting information is documented in the medical record, select Yes. * If documentation indicates that the follow-up appointment was not scheduled because the patient is cognitively impaired, (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available to receive the details of the scheduled appointment, select Yes.
  - The caregiver is defined as the patients family or other person (e.g. home health, VNA provider, prison official or law enforcement personnel) who will be responsible for care of the patient after discharge.
  - The following do not require physician/APN/PA documentation:
    - Patient is a visitor from another country or a state or region outside of the providers scope of referral
    - Patient refusal of follow-up appointment
    - Patient is discharged to a court/law enforcement setting

Suggested Data Sources: • Nursing notes
• Progress notes
• Physician orders
• Discharge summary
• Discharge instruction sheet,
• Home health referral form

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Sex
Collected For: All Records
Definition: The patient's documented sex on arrival at the hospital.
Suggested Data Collection Question: What is the patient's sex on arrival?
Format: Length: 1
Type: Character
Occurs: 1
Allowable Values:
M = Male
F = Female
U = Unknown
Notes for Abstraction:
- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select Unknown if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.
Suggested Data Sources:
- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04
Additional Notes:
Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
Data Element Name: Unique Blinded Case Identifier

Collected For: All Records, All Records (Used in transmission of anonymous patient-level data to the Joint Commission)

Definition: An identifier that is assigned to each patient by the organization that uniquely identifies the patient for the episode of care. It is a fictitious identifier used to differentiate between individual patient records.

Suggested Data Collection Question: What number has been assigned to identify the patient?

Format: Length: 9
Type: Numeric
Occurs: 1

Allowable Values: Any valid positive number up to nine digits

• This identifier should not be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.

• Since a unique identifier is used for each medical record that is abstracted for the Joint Commission pilot, organizations need to link this tracking identifier to the original patient record. This link will be important in the event that data quality issues arise and it is requested that the episode of care data be reviewed or if the case is selected to be included in the data reliability study.

Notes for Abstraction:

Suggested Data Sources:

Additional Notes: Does not apply, determined by the organization.

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tbody>
</table>
Tables
Appendix A

Table 2.1 - Heart Failure (HF)

<table>
<thead>
<tr>
<th>Heart Failure (HF)</th>
<th>ICD9 Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2.1 402.01</td>
<td>Mal Hyper HT DIS W HF</td>
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</tr>
<tr>
<td>Table 2.1 402.11</td>
<td>Benign HYP HT DIS W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 402.91</td>
<td>Hyp HT DIS NOS W HT FAIL</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.01</td>
<td>Mal HYP HT/KD I-IV W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.03</td>
<td>Mal HYP HT/KD STG V W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.11</td>
<td>Ben HYP HT/KD I-IV W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.13</td>
<td>Ben HYP HT/KD STG V W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.91</td>
<td>HYP HT/KD NOS I-IV W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 404.93</td>
<td>HYP HT/KD NOS ST V W HF</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.0</td>
<td>CHF NOS</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.1</td>
<td>Left Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.20</td>
<td>Systolic HRT Failure NOS</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.21</td>
<td>AC Systolic HRT Failure</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.22</td>
<td>CHR Systolic HRT Failure</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.23</td>
<td>AC on CHR SyST HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.30</td>
<td>Diastolic HRT Failure NOS</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.31</td>
<td>AC Diastolic HRT Failure</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.32</td>
<td>CHR Diastolic HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.33</td>
<td>AC on CHR Diast HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.40</td>
<td>Syst/Diast HRT Fail NOS</td>
<td></td>
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<tr>
<td>Table 2.1 428.41</td>
<td>AC Syst/Diastol HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.42</td>
<td>CHR Syst/Diastl HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.43</td>
<td>AC/CHR Syst/Dia HRT Fail</td>
<td></td>
</tr>
<tr>
<td>Table 2.1 428.9</td>
<td>Heart Failure NOS</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.2 - LVAD and Heart Transplant

<table>
<thead>
<tr>
<th>LVAD and Heart Transplant</th>
<th>ICD9 Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2.2 33.6</td>
<td>Comb Heart/Lung Transpla</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.51</td>
<td>Heart Transplantation</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.52</td>
<td>Imp Tot Int Bi HT RP Sys</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.53</td>
<td>Repl/Rep THR UNT TOT HRT</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.54</td>
<td>Repl/Rep OTH TOT HRT Sys</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.60</td>
<td>Imp Bivn Ext HRT Ast Sys</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.62</td>
<td>Insrt Non-Impl Circ Dev</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.63</td>
<td>Repair Heart Assist Sys</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.65</td>
<td>Imp Ventr Ext HRT Ast Sys</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.66</td>
<td>Implantable HRT Assist</td>
<td></td>
</tr>
<tr>
<td>Table 2.2 37.68</td>
<td>Percutan HRT Assist Sydst</td>
<td></td>
</tr>
</tbody>
</table>
Appendix H

Table 2.6.1 Qualifiers

- Qualifiers are words used as adjectives to indicate some uncertainty about whether or not a condition really exists.
- The following qualifiers should be abstracted as **negative findings**, unless otherwise specified in a data element's guidelines - **Consider this list all-inclusive**:  

<table>
<thead>
<tr>
<th>Qualifier Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>And/or (+/-; e.g., “ST abnormalities consistent with ischemia and/or injury”), except when comparing only Inclusions (e.g., “ST segment elevation and/or STEMI”)</td>
</tr>
<tr>
<td>Cannot exclude</td>
</tr>
<tr>
<td>Cannot rule out</td>
</tr>
<tr>
<td>Could/may/might be</td>
</tr>
<tr>
<td>Could/may/might have</td>
</tr>
<tr>
<td>Could/may/might have been</td>
</tr>
<tr>
<td>Could/may/might have had</td>
</tr>
<tr>
<td>Could/may/might indicate</td>
</tr>
<tr>
<td>Or, except when comparing only Inclusions</td>
</tr>
<tr>
<td>Possible</td>
</tr>
<tr>
<td>Questionable (?)</td>
</tr>
<tr>
<td>Risk of</td>
</tr>
<tr>
<td>Ruled out (r’d/o, r/o’d)</td>
</tr>
<tr>
<td>Suggestive of</td>
</tr>
<tr>
<td>Suspect</td>
</tr>
<tr>
<td>Suspicious</td>
</tr>
<tr>
<td>Vs., except when comparing only Inclusions</td>
</tr>
</tbody>
</table>

Table 2.6.2 Modifiers

- Quantitative modifiers are adjectives that quantitatively describe a condition.
- The following quantitative modifiers should be abstracted as **negative findings**, unless otherwise specified in a data element's guidelines - **Consider this list all-inclusive**:  

<table>
<thead>
<tr>
<th>Modifier Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
</tr>
<tr>
<td>Insignificant/not significant/no significant</td>
</tr>
<tr>
<td>Minor</td>
</tr>
<tr>
<td>Scant</td>
</tr>
<tr>
<td>Slight</td>
</tr>
<tr>
<td>Sub-clinical</td>
</tr>
<tr>
<td>Subtle</td>
</tr>
<tr>
<td>Trace</td>
</tr>
<tr>
<td>Trivial</td>
</tr>
</tbody>
</table>