Disease Specific Care
Advanced Certification in Heart Failure

Program Management

Revised Standard DSPR.1

1. The program defines its leadership roles.

Revised Elements of Performance for DSPR.1

2. The program leaders are qualified to meet the program’s mission, goals, and objectives.

   Requirements Specific to Heart Failure Care Certification
   a. The program identifies a leader(s).
   b. The program leader(s) has experience in the care of patients with heart failure.
   c. The program establishes an interdisciplinary team to collaborate in the care of heart failure patients.

3. The program defines the accountability of its leaders.

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

4. The leaders participate in designing, implementing, and evaluating care, treatment, and services.

5. The leaders provide for the uniform performance of patient care, treatment, and services.

6. The leaders confirm that practitioners practice within the scope of their licensure, training, and current competency.

7. The leaders develop a performance improvement plan for leadership quality.

8. The leaders set expectations for development of plans to manage and improve quality at the program level.
Revised Standard DSPR.2
15 The program is designed, implemented, and evaluated collaboratively.

Revised Elements of Performance for DSPR.2
16 1. All relevant individuals and/or disciplines participate in designing the program.
17 2. All relevant individuals and/or disciplines participate in implementing the program.

Requirements Specific to Heart Failure Care Certification
18 a. The program identifies the role and responsibilities of each interdisciplinary team member involved in the care of heart failure patients.

Revised Standard DSPR.3
21 The program meets the needs of the target population and/or health care service area.

Revised Elements of Performance for DSPR.3
22 1. The leaders approve the program's mission and scope of service.
23 2. The program's mission and scope of service are defined in writing.

Requirements Specific to Heart Failure Care Certification
24 a. The scope of the program includes both inpatient and outpatient services, including transitions.
25 b. The program provides care coordination services across inpatient and outpatient settings.

26 3. The program identifies its target population.
27 4. The program's available services are relevant to the target population.

Requirements Specific to Heart Failure Care Certification
28 a. The program conducts at least one heart failure public education activity per year.
**Revised Standard DSPR.4**

29 The program follows a code of ethics.

**Revised Elements of Performance for DSPR.4**

30 1. The program protects the integrity of clinical decision making.

31 2. The program respects the participant’s right to decline participation in the program.

32 3. The program has a process for receiving and resolving complaints and grievances in a timely manner.

**Revised Standard DSPR.5**

33 The program complies with applicable laws and regulations.

**Revised Elements of Performance for DSPR.5**

34 1. The program complies with applicable laws and regulations.

**Revised Standard DSPR.6**

35 The program has current reference and resource materials readily available.

**Revised Elements of Performance for DSPR.6**

36 1. Reference materials (hard copy or electronic) are easily accessible to practitioners.

**Requirements Specific to Heart Failure Care Certification**

37 a. Either hard copy or electronic versions of the clinical practice guidelines or evidence-based practices for the care of individuals with heart failure are available in all areas where patient care is provided.

38 2. Reference materials and resources are authoritative and current.
Revised Standard DSPR.7

40  The program's facilities are safe and physically accessible.
41  Note: This standard applies only to programs with a physical area in which they regularly host participants for program-related activities (for example, visits, classes).

Revised Elements of Performance for DSPR.7

43  1. The program evaluates its security.
44  2. The program implements strategies to minimize security risks.
45  3. The program develops an emergency plan.
46  4. The program implements strategies to minimize the risk of disruption of care due to an environmental emergency.
47  5. The program evaluates its fire risk.
48  6. The program implements strategies to minimize the risk of fire and fire safety-related issues.
49  7. The program develops a medical equipment management plan.
50  8. The program implements its medical equipment management plan.
51  9. The program evaluates risks to its power, gas, and communication services.
52  10. The program implements strategies to minimize risks to its power, gas, and communication services.
53  11. Staff has learned environment of care risk-reduction strategies.
54  12. The program tracks incidents related to the environment of care and makes changes accordingly.
Revised Standard DSPR.8

55 The program communicates to participants the scope and level of care, treatment, and services it provides.

Revised Elements of Performance for DSPR.8

56 1. The program provides care, treatment, and services to the participants in a planned and timely manner.

Requirements Specific to Heart Failure Care Certification

57  a. The participant is re-evaluated by a program team member within 72 hours after inpatient discharge.
   
   Note: The re-evaluation may be conducted via phone call, home visit, or scheduled office appointment.
   
58  b. Prior to inpatient discharge, a program team member and the participant collaborate to arrange a follow-up appointment
   
   with a health care provider to occur within seven days after discharge.

61 2. The program informs participants about how to access care, treatment, and services, including after hours (if applicable).

62 3. Adequate numbers and types of practitioners are available to deliver or facilitate the delivery of care, treatment, and services.

Requirements Specific to Heart Failure Care Certification

63  a. The program identifies an individual(s) to coordinate the care of participants.
   
64  b. The care coordinator(s) has education, experience, and knowledge in the care of individuals with heart failure.
   
   Note: See DSDF.4 EP 1

66 4. The program evaluates services provided through contractual arrangement to ensure that the scope and level of care, treatment, and services are consistently provided.

68 5. The program defines in writing the care, treatment, and services it provides.

Revised Standard DSPR.9

69 The scope and level of care, treatment, and services provided are comparable for individuals with the same acuity and type of disease being managed.

Revised Elements of Performance for DSPR.9

71 1. Individuals have access to an adequate level of resources required to meet the health care needs for the disease(s) being managed.

Requirements Specific to Heart Failure Care Certification

72  a. The organization provides participants with access to a practitioner 24 hours a day, 7 days a week.
   
   Note: Means of access may include use of the telephone and the internet, and referral to urgent care settings.
Eligible patients have access to the program.

Revised Elements of Performance for DSPR.10

1. The program defines enrollment and/or participation requirements.
2. The program uses a methodology based on perceived needs to identify potential participants that are not direct referrals.
3. The program gives multiple opportunities for individuals to participate in the program.
Delivering or Facilitating Clinical Care

Revised Standard DSDF.1
Practitioners are qualified and competent.

Revised Elements of Performance for DSDF.1

1. Practitioners have education, experience, training, and/or certification consistent with the program’s mission, goals, and objectives.

   Requirements Specific to Heart Failure Care Certification
   a. Practitioners providing care within their scope of practice to program participants are able to recognize and assess symptoms of heart failure and implement interventions based on the clinical practice guidelines and evidence-based care practices followed by the program.

2. Practitioners hired in the program meet minimum requirements for licensure, education, training, experience, and current competence.

3. The program evaluates practitioners for current licensure and current competence.

4. The program uses primary source verification to authenticate current licensure of all practitioners.

5. Orientation provides information and necessary training appropriate to program responsibilities.

6. The program assesses practitioner competence within program-defined time frames.

7. Ongoing in-service and other education and training activities are relevant to the program’s needs.

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

8. The program identifies and responds to their program-specific learning needs.
Revised Standard DSDF.2

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

Revised Elements of Performance for DSDF.2

1. The clinical practice guidelines used are based on evidence that has been evaluated as current by the clinical leaders.

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

2. The clinical practice guidelines used have been evaluated as appropriate for the target population.

3. When a program implements clinical practice guidelines selected by a sponsoring organization (for example, a disease management service provider uses a CPG chosen by the health plan with which it contracts), the program establishes that they are appropriate for their intended use.

4. The program’s assessment activities are consistent with clinical practice guidelines.

   Requirements Specific to Heart Failure Care Certification
   a. Assessments of participants are completed in accordance with the clinical practice guidelines or evidence-based care practices in a timeframe that meets the participant’s needs.

5. The program’s intervention activities are consistent with clinical practice guidelines.

   Requirements Specific to Heart Failure Care Certification
   a. Order sets, pathways, or medical record documentation reflect use of clinical practice guidelines and/or evidence-based care practices.

6. The program reviews clinical practice guidelines for appropriateness on an ongoing basis.

7. The program implements modifications to clinical practice guidelines.

8. Clinical leaders and practitioners review and approve clinical practice guidelines for implementation.

9. Practitioners are educated about clinical practice guidelines and their use.

   Requirements Specific to Heart Failure Care Certification
   a. Practitioners providing heart failure care can demonstrate knowledge of the clinical practice guidelines and evidence-based care practices followed by the program.
### Revised Standard DSDF.3

The program is designed to meet the participant's needs.

### Revised Elements of Performance for DSDF.3

<table>
<thead>
<tr>
<th>Page</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>116</td>
<td>1. The program defines the elements of assessment for the targeted population.</td>
</tr>
<tr>
<td></td>
<td><strong>Requirements Specific to Heart Failure Care Certification</strong></td>
</tr>
<tr>
<td>117</td>
<td>a. Functional capacity of the participant is assessed in accordance with the clinical practice guidelines or evidence-based care practices.</td>
</tr>
<tr>
<td>118</td>
<td>2. The assessment(s) are completed within the time frame determined by the program.</td>
</tr>
<tr>
<td>119</td>
<td>3. The plan of care is developed based on the participant's assessed needs.</td>
</tr>
<tr>
<td></td>
<td><strong>Requirements Specific to Heart Failure Care Certification</strong></td>
</tr>
<tr>
<td>121</td>
<td>a. A comprehensive plan of care for participants is developed which includes short and long term interventions and goals.</td>
</tr>
<tr>
<td>122</td>
<td>b. The plan of care for hospitalized participants spans the inpatient and outpatient settings.</td>
</tr>
<tr>
<td>123</td>
<td>c. The plan of care for participants addresses advance directives.</td>
</tr>
<tr>
<td>124</td>
<td>4. The program uses a specified method for prioritizing the needs of participants.</td>
</tr>
<tr>
<td>125</td>
<td>5. The program implements interventions based on priority and risk.</td>
</tr>
<tr>
<td></td>
<td><strong>Requirements Specific to Heart Failure Care Certification</strong></td>
</tr>
<tr>
<td>126</td>
<td>a. Based on priority and risk, the heart failure care team implements interventions across inpatient and outpatient settings that go beyond participant education and address the following:</td>
</tr>
<tr>
<td>127</td>
<td>1. Assistance with self-management activities</td>
</tr>
<tr>
<td>128</td>
<td>2. Fluid management</td>
</tr>
<tr>
<td>129</td>
<td>3. Symptom management</td>
</tr>
<tr>
<td>130</td>
<td>4. Nutrition/diet</td>
</tr>
<tr>
<td>131</td>
<td>5. Medications</td>
</tr>
<tr>
<td>132</td>
<td>6. Exercise</td>
</tr>
<tr>
<td>133</td>
<td>7. Stress reduction</td>
</tr>
<tr>
<td>134</td>
<td>8. Support in coping with progressive, chronic illness</td>
</tr>
<tr>
<td>135</td>
<td>9. Immunizations and vaccinations</td>
</tr>
<tr>
<td>136</td>
<td>10. Risk reduction</td>
</tr>
<tr>
<td>137</td>
<td>11. Palliative care</td>
</tr>
<tr>
<td>139</td>
<td>6. The program individualizes delivery of care.</td>
</tr>
<tr>
<td>140</td>
<td>7. The program continually evaluates, revises, and implements the plan of care to meet the participant’s ongoing needs.</td>
</tr>
</tbody>
</table>
Revised Standard DSDF.4

The program manages co-morbidities and concurrently occurring conditions and/or communicates the necessary information to manage these conditions to appropriate practitioners.

Revised Elements of Performance for DSDF.4

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

Requirements Specific to Heart Failure Care Certification

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

2. The program communicates important information regarding co-occurring conditions and co-morbidities to appropriate practitioner(s) to treat or manage the conditions.

Requirements Specific to Heart Failure Care Certification

- a. The program care coordinator(s) is responsible for the communication of relevant information among practitioners and across settings.
- b. The program care coordinator(s) is responsible for sharing participant information among practitioners in a timeframe that meets the participant’s needs.
- c. The program care coordinator(s) is responsible for confirming practitioner receipt of information and actions taken.

3. Co-morbidities and co-occurring conditions needing medical intervention are treated by the program practitioners or referred to appropriate practitioners for care.

4. The program has a process to provide emergency/urgent care.
Revised Standard DSSE.1
The program involves participants in making decisions about managing their disease or condition.

Revised Elements of Performance for DSSE.1

1. The program involves participants in decisions about their clinical care.

   Requirements Specific to Heart Failure Care Certification
   a. A designated member of the heart failure team discusses the course of care, treatment, and services with the participant.
   b. A designated member of the heart failure team and the participant review the current outcomes of care and therapeutic options.

2. Participants and practitioners mutually agree upon goals.

   Requirements Specific to Heart Failure Care Certification
   a. The mutually agreed upon goals address the participant’s disease and symptom management.
   b. The mutually agreed upon goals address the participant’s advance directives.

3. The program informs participants of their responsibility to provide information to facilitate treatment and cooperate with practitioners.

4. The program informs participants of all potential consequences for noncompliance with recommended treatment(s).

5. The program assesses the participant’s readiness, willingness, and ability to engage in self-management activities.

   Requirements Specific to Heart Failure Care Certification
   a. Information gathered in the assessment of the participant’s ability to engage in self-management includes psychosocial barriers.
   Note: Psychosocial barriers may include psychological screening, health care literacy level, social assessment, and economic barriers.
   b. Assessment information guides the development of the self-management plan.

6. The program assesses the family’s readiness, willingness, and ability to provide or support self-management activities when needed.
The program addresses lifestyle changes that support self-management regimens.

Revised Elements of Performance for DSSE.2

1. As necessary, the program promotes lifestyle changes that support self-management regimens.

   Requirements Specific to Heart Failure Care Certification

   a. As relevant to the participant's needs, participant lifestyle changes that are promoted by the program include:
      - Nutrition, particularly sodium restriction, fat reduction, and diabetic diet, if appropriate
      - Fluid management
      - Activity and exercise
      - Weight management
      - Reduction of symptom aggravating behaviors

2. As necessary, the program involves family and community support structures in the participant's care regimens.

3. As necessary, the program evaluates barriers to lifestyle changes.

4. The program assesses and documents the participant's response to recommended lifestyle changes.

5. The program assesses the effectiveness of efforts to help the participant in making lifestyle changes.
Revised Standard DSSE.3

The program addresses participants’ education needs.

Revised Elements of Performance for DSSE.3

1. The program's materials comply with recommended elements of intervention supported by the literature and promoted through the clinical practice guidelines.

2. The program presents content in a manner that is culturally sensitive.

3. The program presents content in an understandable manner relevant to the participant's level of literacy.

4. The program makes initial and ongoing assessments of the participant's comprehension of program-specific information.

5. The program addresses the participant's education needs related to lifestyle changes that support self-management regimens.

6. The program addresses the education needs of the participant regarding health promotion.

Requirements Specific to Heart Failure Care Certification

a. Health promotion education addresses risk related to the following:
   - Alcohol consumption
   - Tobacco use
   - Illicit drug use

b. Health promotion education addresses the need for influenza and pneumonia vaccinations.

7. The program addresses the education needs of the participant regarding disease prevention.

8. The program addresses the education needs of the participant regarding his or her illness(es) and treatment(s).

Requirements Specific to Heart Failure Care Certification

a. The participant's understanding of the following is evaluated prior to inpatient discharge and thereafter at a frequency based on the assessed needs of the participant:
   - Prescribed medications (name, dose, purpose, and how to take), and which over-the-counter drugs and supplements are allowed
   - Diet and fluid intake based on participant's needs
   - Activity level
   - When and how to schedule and carry out follow-up appointments
   - Weight monitoring
   - How to recognize symptoms of worsening heart failure or dehydration, and when to call practitioner
   - How adherence to the plan of care impacts activities of daily living

9. The program communicates to the participant the results of its family risk assessment.
Revised Standard DSCT.1
225 Participant information is confidential and secured.

Revised Elements of Performance for DSCT.1

226 1. The program preserves participant confidentiality.
227 2. Records and information are safeguarded against loss, destruction, tampering, and unauthorized access or use.
228 3. Participants are made aware of how data and information related to them will be used by the organization.
229 4. Practitioners are made aware of how data and information related to them will be used by the organization.
230 5. The program defines methods for adding comments in the form of statements or addenda into the formal records.
231 6. The program defines access limitations to information for individuals and/or positions.
232 7. The program defines access limitations to information connected to compliance measures for individuals and/or positions.
233 8. The program defines criteria requiring the release of information by consent.
234 9. The program defines a process that is followed when confidentiality and security are violated.

Revised Standard DSCT.2
235 Information management processes meet the program's internal and external information needs.

Revised Elements of Performance for DSCT.2

236 1. Data are easily retrieved in a timely manner without compromising security and confidentiality.
237 2. The program determines how long health records and other data and information are retained in accordance with applicable law and patient need.
238 3. The program uses aggregate data and information to support managerial decisions.
239 4. The program uses aggregate data and information to support operations.
240 5. The program uses aggregate data and information to support performance improvement activities.
241 6. The program uses aggregate data and information to support participant care.
Revised Standard DSCT.3
243 Participant information is gathered from a variety of sources.

Revised Elements of Performance for DSCT.3

244 1. Information is gathered directly from the participant and/or family.
245 2. Information is gathered from all relevant practitioners or health care organizations.

Revised Standard DSCT.4
246 The program shares information with any relevant practitioner or setting about the participant’s disease or condition across the continuum of care.

Revised Elements of Performance for DSCT.4

248 1. The program shares information directly with the participant and/or family.
249 2. The program shares information with other relevant practitioners or health care organizations as needed.

Requirements Specific to Heart Failure Care Certification

250 a. The care coordinator(s) is responsible for communicating the participant’s current medication information at all transitions of care, and as changes occur in the outpatient setting, to all relevant practitioners across inpatient and outpatient settings.
251 b. The care coordinator(s) is responsible for communicating information necessary to continue the participant’s treatment to relevant practitioners within 72 hours after inpatient discharge.

Note: See DSDF.4 EP 1.
Revised Standard DSCT.5

255 The program initiates, maintains, and makes accessible a health or medical record for every participant.

Revised Elements of Performance for DSCT.5

256 1. Practitioners have access to all participant information as needed.

257 2. The health or medical record contains sufficient information to identify the patient or the participant (if other than the patient).

258 3. The health or medical record contains sufficient information to support the diagnosis.

259 4. The health or medical record contains sufficient information to justify care, treatment, and services.

260 5. The health or medical record contains sufficient information to document the course and results of care, treatment, and services.

261 6. The health or medical record contains sufficient information to track the patient’s movement through the care system.

262 7. The health or medical record contains sufficient information to facilitate continuity of care both internally and externally to the program.

Requirements Specific to Heart Failure Care Certification

263 a. To support coordination of care, the participant’s medical record contains all results of diagnostic tests and therapeutic interventions and procedures.

265 8. Health or medical records are periodically reviewed for complete, accurate, and timely maintenance.
The program has an organized, comprehensive approach to performance improvement.

Revised Elements of Performance for DSPM.1

1. The performance improvement program: Is well designed and planned.

   Requirements Specific to Heart Failure Care Certification
   a. The performance improvement program includes evaluation of care processes in inpatient and outpatient settings and transitions in care.

2. The performance improvement program: Collects relevant data.


4. The performance improvement program: Improves and sustains performance.

5. The program plans performance improvement activities for practitioners across disciplines and/or settings.

6. The program utilizes patient satisfaction data for performance improvement activities.
Revised Standard DSPM.2

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

Revised Elements of Performance for DSPM.2

277  1. The program selects valid, reliable performance measures based on clinical practice guidelines or other evidence relevant to the management of the disease.
279  2. The program collects data related to processes and/or outcomes of care at the level of the individual participant.

Requirements Specific to Heart Failure Care Certification

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

285  3. The program aggregates data at the program level.
286  4. The program reports aggregated data results to The Joint Commission at defined intervals.
287  5. The program analyzes its measurement data.
288  6. The program uses measurement data to improve processes and outcomes.

Revised Standard DSPM.3

289  The program maintains data quality and integrity.

Revised Elements of Performance for DSPM.3

290  1. The program uses data sets, definitions, codes, classifications, and terminology throughout the organization.
291  2. Data collection is timely, accurate, complete, and relevant to the program.
292  3. The program minimizes data bias.
293  4. The program monitors data reliability and validity.
294  5. The program defines sampling methodology based on measurement principles.
295  6. The program uses data analysis tools.
296  7. The program evaluates variables that affect program outcomes.
Revised Standard DSPM.4

297 The process for identifying, reporting, managing, and tracking sentinel events is defined and implemented.

Revised Elements of Performance for DSPM.4

298 1. A process exists for identifying these events if and when they occur.

299 2. A process exists for internally tracking these events if and when they occur.

300 3. A process exists for analyzing these events if and when they occur.

301 4. The program implements changes based on its analysis of sentinel events.

Revised Standard DSPM.5

302 The program collects and analyzes data regarding variance from the clinical practice guidelines to improve the standardized process.

Revised Elements of Performance for DSPM.5

303 1. The program tracks data variances at the individual participant level.

304 2. The program uses outcomes analysis to determine modification to the clinical practice guidelines and their use.

Requirements Specific to Heart Failure Care Certification

305 a. The program routinely reviews and updates its order sets and pathways.

Revised Standard DSPM.6

306 The program evaluates participant perception of the quality of care.

Revised Elements of Performance for DSPM.6

307 1. The program evaluates patient/participant satisfaction and perception of quality of care.

308 2. The program uses patient/participant satisfaction results to analyze quality of care and make improvements.