FORM SELECTION	LEGEND: (Elements in bold are required) *Element used in Achievement +Element used in Quality ^ Element used in Target: HF #Element used in Target: Type 2 Diabetes

HF Limited **Patient ID:**

DEMOGRAPHIC DATA *Demographics Tab*

Sex	○ Male ○ Female ○ Unknown
Patient Gender Identify	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other. _____ ○ Did not disclose.
Patient-Identified Sexual Orientation	○ Straight or heterosexual ○ Lesbian or gay ○ Queer, pansexual, and/or questioning ○ Something else; please specify. _____. ○ Don't know ○ Declined to answer

***+^# Date of Birth**	___/___/_____ (MM/DD/YYYY)	**Patient Postal Code**	_____ - _____
Payment Source	❑ Medicare Title 18 ❑ Medicaid Title 19 ❑ Medicare – Private/HMO/PPO/Other ❑ Medicaid– Private/HMO/PPO/Other		❑ Private/HMO/PPO/Other ❑ VA/CHAMPVA/Tricare ❑ Self-pay/No Insurance ❑ Other/Not Documented/UTD
External Tracking ID	_____		

RACE AND ETHNICITY *Demographics Tab*

+ Race	❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Asian	❑ Native Hawaiian or Pacific Islander ❑ UTD
Hispanic Ethnicity	○ Yes	○ No/UTD

ARRIVAL AND ADMISSION INFORMATION *Admission Tab*

Internal Tracking ID:	_____	**Physician/Provider NPI:**	_____
+ Arrival Date/Time:	___/___/_____ ___: ____	❑ Unknown Date/UTD	
Admission Date:	___/___/_____		
Point of Origin for Admission or Visit:	❑ Non-Healthcare Facility Point of Origin ❑ Clinic ❑ Transfer From a Hospital (Different Facility) ❑ Transfer From a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) ❑ Transfer From Another Health Care Facility ❑ Emergency Room ❑ Information Not Available ❑ Transfer From a Hospice and is Under a Hospice Plan of Care or is Enrolled in a Hospice Program		
Discharge Date/Time	___/___/_____ ___: ____		

MEDICAL HISTORY *Admission Tab*

Medical History (Select all that apply):

Medical History (Select all that apply):	
❑ Anemia	❑ Heart failure

❑ Atrial Fib (chronic or recurrent) ❑ Atrial Flutter (chronic or recurrent) ❑ ATTR-CM ❍ Hereditary ❍ Wild-type ❑ CAD ❑ CardioMEMs (implantable hemodynamic monitor) ❑ COPD or Asthma ❑ CRT-D (cardiac resynchronization therapy with ICD) ❑ CRT-P (cardiac resynchronization therapy-pacing only) ❑ CVA/TIA ❑ Depression ❑ Diabetes ❑ Dialysis (chronic) ❑ Emerging Infectious Disease ❍ **MERS** ❍ **SARS-COV-1** ❍ **SARS-COV-2 (COVID-19)** ❍ **Other infectious respiratory pathogen** ❑ Familial hypercholesterolemia	❑ Heart Transplant ❑ Hyperlipidemia ❑ Hypertension ❑ ICD only ❑ Pacemaker ❑ Peripheral Vascular Disease ❑ Prior CABG ❑ Prior MI ❑ Prior PCI ❑ Renal insufficiency - chronic (SCr>2.0) ❑ Sleep-Disordered Breathing ❑ TAVR ❑ TMVR ❑ Tricuspid Valve procedure ❑ Valvular Heart Disease ❑ Ventricular assist device

❑ No Medical History

History of cigarette smoking? (In the past 12 months)	❍ Yes	❍ No
History of vaping or e-cigarette use in the past 12 months?	❍ Yes	❍ No/ND

Heart Failure History

Known history of HF prior to this admission?	❍ Yes	❍ No

DIAGNOSIS ***Admission Tab***

Heart Failure Diagnosis	❑ Heart Failure with CAD	❑ Heart Failure, no CAD	❑ Heart Failure, Secondary Diagnosis

Atrial Fibrillation (At presentation or during hospitalization)	❍ Yes	❍ No
Atrial Flutter (At presentation or during hospitalization)	❍ Yes	❍ No

New Diagnosis of Diabetes	❍ Yes	❍ No	❍ Not Documented

Active bacterial or viral infection at admission or during hospitalization	❑ None ❑ Bacterial infection ❑ Emerging Infectious Disease ❑ MERS ❑ SARS-COV-1 ❑ SARS-COV-2 (COVID-19) ❑ Influenza ❑ Seasonal Cold ❑ Other viral infection

MEDICATIONS AT ADMISSION ***Admission Tab***

Medications Used Prior to Admission: ***[Select all that apply]***

❑ Patient on no meds prior to admission ❑ Anti-hyperglycemic medications ❑ DPP-4 Inhibitors ❑ GLP-1 receptor agonist ❑ Insulin ❑ Metformin ❑ Sulfonylurea ❑ Thiazolidinedione ❑ Other Oral Agents ❑ Other injectable/subcutaneous agents	☐ Mavacamten ☐ Mineralocorticoid Receptor Antagonist (MRA) ☐ SGLT2 ☐ Vericiguat

EXAMS/LABS AT ADMISSION						*Admission Tab*
Height						
Weight						
Labs (Closest to Admission)	**+Serum Creatinine (Admission)**	_____	❍ mg/dL	❍ µmol/L	❑ Not Available	
	+Potassium (K+) (Admission)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL	❑ Not Available
	+ EKG QRS Duration (ms)	_____	❑ Not Available			
	+ EKG QRS Morphology	❍ Normal ❍ LBBB	❍ RBBB ❍ NS-IVCD	❍ Paced ❍ Not available		

	Clinical Codes
ICD-10-CM Principal Diagnosis Code	

IN-HOSPITAL CARE *In-Hospital Tab*

Procedures

❑ No Procedures ❑ Cardiac Cath/Coronary Angiography ❑ CardioMEMs (implantable hemodynamic monitor) ❑ Coronary Artery Bypass Graft ❑ CRT-P (cardiac resynchronization therapy-pacing only) ❑ Dialysis or Ultrafiltration unspecified ❑ ICD only ❑ Mechanical Ventilation ❑ PCI ❑ Right Cardiac Catheterization ❑ TMVR ❑ Tricuspid Valve Procedure	❑ Atrial Fibrillation Ablation or Surgery ❑ Cardiac Valve Surgery ❑ Cardioversion ❑ CRT-D (cardiac resynchronization therapy with ICD ❑ Dialysis ❑ ECMO ❑ Intra-aortic Balloon Pump ❑ Left Ventricular Assist Device ❑ Pacemaker ❑ PCI with stent ❑ Stress Testing ❑ TAVR ❑ Transplant (Heart) ❑ Ultrafiltration

***+^ EF – Quantitative**	_____ %	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
***+^ EF – Qualitative**	❍ Not Applicable ❍ Normal or mild dysfunction ❍ Qualitative moderate/severe dysfunction ❍ Performed/results not available ❍ Planned after discharge ❍ Not performed	Obtained:	❍ This Admission ❍ Within the last year ❍ > 1 year ago
Documented LVSD?	❍ Yes		❍ No
* LVF Assessment?	❍ Yes	❍ No	❍ Not done, Reason Documented
+ Was the patient ambulating at the end of hospital day 2?		❍ Yes	❍ No ❍ Not Documented
+ Was DVT prophylaxis initiated by the end of hospital day 2?		❍ Yes	❍ No ❍ Contraindicated
+ Influenza Vaccination	❍ Influenza vaccine was given during this hospitalization during the current flu season ❍ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ❍ Documentation of patient's refusal of influenza vaccine ❍ Allergy/Sensitivity to influenza or if medically contraindicated ❍ Vaccine not available ❍ None of the above/Not Documented/UTD		
COVID-19 Vaccination	❍ COVID-19 vaccine was given during this hospitalization ❍ COVID-19 vaccine was received prior to admission, not during this hospitalization ❍ Documentation of patient's refusal of COVID-19 vaccine ❍ Allergy/Sensitivity to COVID-19 or if medically contraindicated ❍ Vaccine not available ❍ None of the above/Not Documented/UTD		
COVID-19 Vaccination Date	_____/_____/_____		

	❑ Unknown
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No/ND
+ Pneumococcal Vaccination	○ Pneumococcal vaccine was given during this hospitalization ○ Pneumococcal vaccine was received in the past, not during this hospitalization ○ Documentation of patient's refusal of pneumococcal vaccine ○ Allergy/sensitivity or if medically contraindicated to pneumococcal vaccine ○ None of the above/Not Documented/UTD

DISCHARGE INFORMATION					***Discharge Tab***
***+^ What was the patient's discharge disposition on the day of discharge?**	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)	
If other Health Care Facility:	○ Skilled Nursing Facility (SNF) ○ Inpatient Rehabilitation Facility (IRF) ○ Long Term Care Hospital (LTCH)			○ Intermediate Care Facility (ICF) ○ Other	
Skilled Nursing Facility	_____				
***+^ When is the earliest physician/APN/PA documentation of comfort measures only?**		○ Day 0 or 1 ○ Day 2 or after		○ Timing unclear ○ Not Documented	
Labs (Closest to Discharge)	**+Serum Creatinine (Discharge)**	_____	❍ mg/dL	❍ µmol/L	
	+Potassium (K+) (Discharge)	_____	❍ mEq/L	❍ mmol/L	❍ mg/dL

DISCHARGE MEDICATIONS			***Discharge Tab***
ACE Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ACE Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ACEI:	❑ Contraindicated ❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reason		
ARB Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARB Medication/ Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing ARB:	❑ Contraindicated ❑ Hypotensive patient who was at immediate risk of cardiogenic shock ❑ Hospitalized patient who experienced marked azotemia ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason		

	❑ Other Reasons		
ARNI Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
ARNI Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	○ Contraindicated ○ ACE inhibitor use within the prior 36 hours ❑ Allergy ❑ Hyperkalemia ❑ Hypotension ❑ Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reasons		
Reasons for not switching to ARNI at discharge:	❍ Yes ❍ No	❍ ARNI was prescribed at discharge	
If Yes,	❑ New Onset Heart Failure ❑ Not previously tolerating ACEI/ARB	❑ NYHA Class I ❑ NYHA Class IV	
Beta Blocker Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Beta Blocker Class	❍ Evidence-Based Beta Blocker ❍ Non-Evidence-Based Beta Blocker ❍ Unknown Class		
Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	❑ Contraindicated ❑ Asthma ❑ Fluid Overload ❑ Low Blood Pressure ○ Patient recently treated with an intravenous positive inotropic agent ○ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason		
Beta Blocker **Medication**/Dosage/Frequency	**Medication**:	Dosage:	Frequency:
SGLT2 Inhibitor Prescribed?	❍ Yes ❍ No ❍ NC		
	Medication:	Dosage:	Frequency:
Contraindications or Other Documented Reason(s) For Not Providing SGLT2 Inhibitor:	❑ Contraindicated ❑ Patient currently on dialysis ❑ Ketoacidosis ❑ Known hypersensitivity to the medication ❑ Type I diabetes (not approved for use in patients with Type I diabetes due to increased risk of ketoacidosis) ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reason		

Mineralocorticoid Receptor Antagonist (MRA) Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
MRA Medication/Dosage/Frequency	Medication:	Dosage:	Frequency:
Was there a dose increase since prior to admission?	❍ Yes ❍ No/ND		
Potassium ordered or planned after discharge?	❍ Yes ❍ No/ND		
Renal function test scheduled	❍ Yes ❍ No/ND		
Contraindications or Other Documented Reason(s) for Not Providing Mineralocorticoid Receptor Antagonist (MRA) at Discharge	❑ Contraindicated ❑ Allergy due to MRA ❑ Hyperkalemia ❑ Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women. ❑ Other contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reason		
Anticoagulation Therapy Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Anticoagulation Therapy Class	❑ Warfarin ❑ Direct Thrombin Inhibitor	❑ Factor Xa Inhibitor ❑ Other	
	Medication:	Dosage:	Frequency:
Anticoagulation Contraindication(s):	❑ Contraindicated ❑ Allergy to or complication r/t anticoagulation therapy (hx or current) ❑ Risk for bleeding or discontinued due to bleeding ❑ Serious side effect to medication ❑ Terminal illness/Comfort Measures Only ❑ Other Contraindications ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other		
Hydralazine Nitrate Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)		
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	❑ Contraindicated ❑ Not Eligible ❑ Not Tolerant ❑ Patient Enrolled in Clinical Trial ❑ Patient Reason ❑ System Reason ❑ Other Reasons		
Anti-hyperglycemic Prescribed?	❍ Yes ❍ No ❍ NC		
Antihyperglycemic Class/Medication	Class:	Medication:	
	Class:	Medication:	
	Class:	Medication:	

ASA Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)			
ASA Medication/Dosage/Frequency	Medication:		Dosage:	Frequency:
Other Antiplatelets Prescribed?	❍ Yes ❍ No ❍ NC (None-Contraindicated)			
Other Antiplatelets Medication/Dosage/Frequency	Medication:		Dosage:	Frequency:
Clopidogrel Prescribed?	❍ Yes ❍ No ❍ NC			
Clopidogrel Dosage/Frequency	Dosage:		Frequency:	
Ivabradine Prescribed?	❍ Yes ❍ No ❍ NC			
Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:	❑ Contraindicated ❑ Allergy to Ivabradine ❑ Patient 100% atrial or ventricular paced ❑ Other Contraindications ❑ Not Eligible ❑ NYHA class I or IV ❑ Not in sinus rhythm ❑ New Onset of HF ❑ Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated ❑ Not Tolerant		❑ Patient Enrolled in Clinical Trial ❑ Patient Reasons ❑ System Reasons ❑ Other Medical Reasons	
Lipid Lowering Medication Prescribed?	❍ Yes ❍ No ❍ NC			
Lipid Lowering Class/Medication/Dosage/Frequency	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
Omega-3 Prescribed?	❍ Yes ❍ No ❍ NC			
Other Medications				
❑ Antiarrhythmic (Discharge) ❑ Amiodarone ❑ Dofetilide ❑ Sotalol ❑ Other antiarrhythmics	❑ Ca Channel Blocker (Discharge) ❑ Digoxin (Discharge) ❑ Diuretic (Discharge) ❑ Loop Diuretic ❑ Thiazide Diuretic		❑ Finerenone ❑ Mavacamten ❑ Nitrate (Discharge) ❑ Ranolazine ❑ Renin Inhibitor (Discharge) ❑ Vericiguat ❑ Other Anti-Hypertensive ❑ Other medications at discharge	

OTHER THERAPIES		***Discharge Tab***
CRT Therapy		
+CRT-D Placed or Prescribed?	❍ Yes	❍ No

+CRT-P Placed or Prescribed?	❍ Yes	❍ No
+Reason for not Placing or Prescribing?	❍ Yes	❍ No
+Documented Reason(s) for Not Placing or Prescribing CRT Therapy?	❑ Contraindications ❑ Not receiving optimal medical therapy ❑ Not NYHA functional Class III or ambulatory Class IV ❑ Patient Reason	❑ Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF ❑ System Reason

RISK INTERVENTIONS		***Discharge Tab***
Smoking Cessation Counseling Given	❍ Yes	❍ No
Smoking Cessation Therapies Prescribed (select all that apply)	❑ Treatment Not Specified ❑ Counseling Only ❑ Over the Counter Nicotine Replacement Therapy	❑ Prescription Medications ❑ Other

DISCHARGE INSTRUCTIONS					***Discharge Tab***
Activity Level	❍ Yes	❍ No	Diet (Salt restricted)	❍ Yes	❍ No
Follow-up	❍ Yes	❍ No	Medications	❍ Yes	❍ No
Symptoms Worsening	❍ Yes	❍ No	Weight Monitoring	❍ Yes	❍ No
Follow-up Visit Scheduled	❍ Yes	❍ No	***+^ Date/Time of first follow-up visit:**	___/___/_____ ___:____	
***** Location of first follow-up visit:**			❍ Office Visit ❍ Home Health Visit	❍ Telehealth ❍ Not Documented	
***+^ Medical or Patient Reason for no follow-up appointment being scheduled?**			❍ Yes	❍ No	
Follow-up Phone Call Scheduled	❍ Yes	❍ No	Date/Time of first follow-up phone call:	___/___/_____ ❍ Unknown	
Follow-up appointment scheduled for diabetes management?	❍ Yes	❍ No	Date of diabetes management follow-up visit:	___/___/_____ (MM/DD/YYYY) ❍ Unknown	

OTHER RISK INTERVENTIONS				***Discharge Tab***
TLC (Therapeutic Lifestyle Change) Diet	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referred to Outpatient Cardiac Rehab Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referral to Outpatient HF Management Program	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Referral My HF Guide/AHA Heart Failure Interactive Workbook	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
^ Provision of at least 60 minutes of Heart Failure Education by a qualified educator	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	❍ Yes	❍ No	❍ Not Documented	❍ Not Applicable
Advance Directive Executed	❍ Yes		❍ No	

POST DISCHARGE TRANSITION			***Discharge Tab***
Care Transition Record Transmitted	❍ By the seventh post-discharge day ❍ Exists, but not transmitted by the seventh post-discharge day ❍ No Care Transition Record/UTD		
Care Transition Record Includes	❑ All were included *(Check all yes)*		
	Discharge Medications	❍ Yes	❍ No
	Follow-up Treatment(s) and Service(s) Needed	❍ Yes	❍ No
	Procedures Performed During Hospitalization	❍ Yes	❍ No
	Reason for Hospitalization	❍ Yes	❍ No
	Treatment(s)/Service(s) Provided	❍ Yes	❍ No

Health Related Social Needs Assessment			
During this admission, was a standardized health related social needs form or assessment completed?	❍ Yes	❍ No/ND	
If yes, identify the areas of unmet social need. (select all that apply):	❑ None ❑ Education ❑ Employment ❑ Financial Strain ❑ Food ❑ Living Situation/Housing	❑ Mental Health ❑ Personal Safety ❑ Substance Abuse ❑ Transportation Barriers ❑ Utilities	