

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC CONTROL QIC BEGDTE REVDTE	Facility ID Control Number Abstractor ID Abstraction Begin Date Abstraction End Date	Auto-fill Auto-fill Auto-fill Auto-fill Auto-fill	
		Patient Identifiers		
	SSN PTNAMEF PTNAMEL BIRTHDT SEX MARISTAT RACE	Patient SSN First Name Last Name Birth Date Sex Marital Status Race	Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: can change Auto-fill: no change Auto-fill: no change	
		Administrative Data		
1	arrvdate	Enter the <u>earliest</u> documented date the patient arrived at acute care at this VAMC.	mm/dd/yyyy Abstractor may enter 99/99/9999 if arrival date is unable to be determined <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <= 6 mos prior to or = entradm and <= dtofdc </div> <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Warning if > 3 days prior to entradm </div>	<p>Arrival date is the earliest recorded date on which the patient arrived in the hospital's acute care setting where care for heart failure could be most appropriately provided. Arrival date may differ from admission date.</p> <p>ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>floor/observation/cath lab for a direct admit.</p> <ul style="list-style-type: none"> • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility. • Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted. EXAMPLE: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error. • For Observation Status: <ul style="list-style-type: none"> ◦ If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED. ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care. • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. • For Direct Admits: <ul style="list-style-type: none"> ◦ If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date. ◦ For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date. <p>If unable to determine the date of arrival, enter default 99/99/9999. If the arrival date documented in the record is obviously in error (e.g. 02/42/20XX) and</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				no other documentation is found that provides this information, enter 99/99/9999.
2	arrvtime	Enter the <u>earliest</u> documented time the patient arrived at acute care at this VAMC.	<p style="text-align: center;">_____ UMT</p> <p>If unable to find the time of arrival, the abstractor can enter 99:99</p> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> <p><= 6 mos prior to or = entradm/hfadmtm and < dtofdc/whatime</p> </div> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> <p>Warning if > 72 hours prior to entradm/hfadmtm</p> </div>	<p>Arrival time is the earliest recorded time the patient arrived in the hospital's acute care setting where care for heart failure could be most appropriately provided. Arrival time may differ from admission time.</p> <p>ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> • Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit. • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility. • Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted. EXAMPLE: ED face sheet list arrival time 1320, ED registration 1325, ED triage 1330, ED consent to treat form has 1:17 with AM circled. ED record documentation suggest the 1:17 AM is an obvious error. Enter 1320 for Arrival Time. • For Observation Status: <ul style="list-style-type: none"> ◦ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<ul style="list-style-type: none"> ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care. • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT. • For Direct Admits: <ul style="list-style-type: none"> ◦ If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time. ◦ For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time. <p>If unable to determine the time of arrival, enter default time 99:99. If the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
3	entradm	Admission date:	mm/dd/yyyy Computer will auto-fill ≤ dtofdc	<p>Auto-filled; can be modified if abstractor determines that the date is incorrect.</p> <ul style="list-style-type: none"> Admission date is the date the patient was actually admitted to acute inpatient care. 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. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. 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. <p>Exclusion: Admit to observation; Arrival date ONLY ALLOWABLE SOURCES: Physician orders (<u>priority</u> data source), Face Sheet</p>
4	hfadmtn	Admission time:	____ UMT Computer will auto-fill < dtofdc/whetime	<p>Auto-filled; can be modified Abstractor to verify admission time is correct. Admission time = time when the patient was formally admitted to inpatient status.</p> <p>Exclusion: Admit to observation time, Arrival time If correction is necessary, enter time in Universal Military Time.</p>
5	dtofdc	Discharge date:	mm/dd/yyyy Auto-filled: cannot be modified > = entradm	<p>Auto-filled. Cannot be modified The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
6	whatime	Discharge time:	<div> <div>____</div> <div>UMT</div> <div>> entradm/hfadmtm</div> </div>	<p>Does not auto-fill. Discharge time must be entered.</p> <p>Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.</p> <p>If the patient expired, use the time of death as the discharge time.</p> <p>Suggested sources for patient who expire: Death record, resuscitation record, physician progress notes, physician orders, nurses notes</p> <p>For other patients: If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the "Reports Tab."</p> <p>Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.</p> <p>Converting time to military time: If time is in the a.m., no conversion is required. If time is the p.m., add 12 to the clock hour time.</p>
7	prncode	Enter the ICD-9-CM principal diagnosis code.	<div> <div>____.____</div> <div>(3 digits/decimal point/two digits)</div> <div> Cannot enter 000.00, 123.45, or 999.99 </div> <div> If code entered is not in JC Table 2.1, Appendix A, the record is excluded. </div> </div>	<p>Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code <u>unless</u> the principal diagnosis code documented in the record is not the code displayed in the software.</p> <p>Principal diagnosis code must be one of the codes listed in Joint Commission Table 2.1 (Appendix A).</p> <p>Heart failure codes include both acute and chronic failure.</p> <p>If the heart failure diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as heart failure and is an acceptable diagnosis of heart failure (code the HF as if it existed or was established).</p> <p><u>Exclusion Statement:</u> Heart Failure is not the principal diagnosis, as required for inclusion in the Joint Commission Heart Failure Quality Measures.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
8	dxchf	Is the diagnosis of heart failure confirmed by physician documentation?	1, 2	<p>If the physician records a diagnosis of heart failure in the discharge summary or elsewhere in the medical record and heart failure is coded as the principal diagnosis, the case is to be reviewed. Either left-sided or right-sided failure is applicable.</p> <p>Answer "yes" if the diagnosis is chronic heart failure. Answer "no" if the diagnosis is history of heart failure.</p> <p>Any order in which heart failure is noted in the listing of discharge diagnoses is acceptable.</p> <p>If the heart failure diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as heart failure and is an acceptable diagnosis of heart failure.</p>
9	entrcoef1 entrcoef10 entrcoef11 entrcoef12 entrcoef2 entrcoef9 entrcoef4 entrcoef5 entrcoef6 entrcoef7 entrcoef8 entrcoef3	Enter the ICD-9-CM other diagnosis codes:	<p>__ __ __. __ __ (3 digits/decimal point/two digits) Can enter 12 codes</p> <p>Abstractor can enter xxx.xx in code field if no other dx found</p>	<p>Can enter 12 ICD-9-CM other diagnosis codes. Will auto-fill from the PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.</p> <p>If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab.</p> <p>Enter xxx.xx in code field if no other diagnoses codes exist for this record.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES		
10	prinpxdt prinpx	<p>Enter the ICD-9-CM principal procedure code and date the procedure was performed.</p> <p>Code Date</p> <table><tr><td>__ __. __ __</td><td>__/__/__</td></tr></table>	__ __. __ __	__/__/__	<p>__ __. __ __</p> <p>Abstractor can enter xx.xx in code field and 99/99/9999 in date field if there is no principal procedure</p> <div>Cannot enter 00.00</div> <p>mm/dd/yyyy</p> <p>Abstractor can enter 99/99/9999</p> <p>If no principal procedure, auto-fill othrpdx and othrpdxdt with xx.xx and 99/99/9999</p> <p>If code is listed in Appendix A, Table 2.2, the case is excluded.</p> <div>>= entradm and <= dtofdc</div>	<p>Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.</p> <ul style="list-style-type: none">VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain. <p>If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.</p> <p>Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.</p> <p>If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</p> <p>Exclusion: Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during the hospitalization are excluded (see Joint Commission Appendix A, Table 2.2 for LVAD and heart transplant ICD-9-CM procedure codes).</p> <p><u>Exclusion Statement</u></p> <p>Procedure code appearing in Joint Commission Table 2.2 excludes the case from the Heart Failure Hospital Quality Measures</p>
__ __. __ __	__/__/__					

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES					
11	othrpx1 othrpx2 othrpx3 othrpx4 othrpxdt5 othrpxdt1 othrpxdt2 othrpxdt3 othrpxdt4 othrpx5	<p>Enter the ICD-9-CM other procedure codes and dates the procedures were performed.</p> <p>Code Date</p> <table><tr><td>__ __. __ __</td><td>__/__/__</td></tr><tr><td>__ __. __ __</td><td>__/__/__</td></tr></table>	__ __. __ __	__/__/__	__ __. __ __	__/__/__	<p>__ __. __ __</p> <p>Abstractor can enter xx.xx in code field and 99/99/9999 in date field if no other procedure was performed</p> <p>mm/dd/yyyy</p> <p>Abstractor can enter 99/99/9999</p> <p>If code is listed in Appendix A, Table 2.2, the case is excluded.</p> <table><tr><td>>= entradm and <= dtofdc</td></tr></table> <p>Can enter 5 codes and dates</p>	>= entradm and <= dtofdc	<p>Can enter 5 procedure codes, other than the principal procedure code.</p> <p>Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.</p> <p>If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field.</p> <p>If no other procedures were performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.</p> <p>If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</p> <p>Exclusion: Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during the hospitalization are excluded (see Joint Commission Appendix A, Table 2.2 for LVAD and heart transplant ICD-9-CM procedure codes).</p> <p><u>Exclusion Statement</u></p> <p>Procedure code appearing in Joint Commission Table 2.2 excludes the case from the Heart Failure Hospital Quality Measures</p>
__ __. __ __	__/__/__								
__ __. __ __	__/__/__								
>= entradm and <= dtofdc									
12	dcdispo	<p>What was the patient's discharge disposition on the day of discharge?</p> <p>1. Home</p>	1, 2, 3, 4, 5, 6, 7, 99	<p>Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.</p> <ul style="list-style-type: none">• Only use documentation written on the day prior to discharge or the					

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<ul style="list-style-type: none"> Assisted Living Facilities (ALFs) - includes assisted living care at nursing home facility Court/Law Enforcement - includes detention facilities, jails, and prison Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters Home with Home Health Services Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization <p>2. Hospice - Home (or other home settings as listed in #1 above)</p> <p>3. Hospice - Health Care Facility</p> <ul style="list-style-type: none"> General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities <p>4. Acute Care Facility</p> <ul style="list-style-type: none"> Acute Short Term General and Critical Access Hospitals Cancer and Children's Hospitals Department of Defense and Veteran's Administration Hospitals <p>5. Other Health Care Facility</p>		<p>day of discharge when abstracting this data element. For example: Discharge planning notes on 04-01-20XX document the patient will be discharged back home. On 04-06-20XX, the nursing discharge notes on the day of discharge indicate the patient was being transferred back to skilled care. Enter "5".</p> <ul style="list-style-type: none"> Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date. 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. For example: Discharge planner note from day before discharge states "XYZ" Nursing Home. Nursing discharge note on day of discharge states "Discharged: Home." Select "1" 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. <ul style="list-style-type: none"> Acute Care Facility Hospice - Health Care Facility Hospice - Home Other Health Care Facility Home Values "2" and "3" hospice 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 "4". If the medical record identifies the facility the patient is being discharged to

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<ul style="list-style-type: none"> Extended or Immediate Care Facility (ECF/ICF) Long Term Acute Care Hospital (LTACH) Nursing Home or Facility including Veteran's 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) Veteran's Home <p>6. Expired 7. Left Against Medical Advice/AMA 99. Not documented or unable to determine</p>		<p>by name only (e.g., Park Meadows) and does not reflect the type of facility or level of care, select "5".</p> <ul style="list-style-type: none"> 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 "1". Selection of option "7" (left AMA) <ul style="list-style-type: none"> Explicit "left against medical advice" documentation is not required. (e.g., "Patient is refusing to stay for continued care"- select "7"). For the purposes of this data element, a signed AMA form is not required. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count. <p>Excluded Data Sources: Any documentation prior to the last two days of hospitalization coding documents.</p> <p>Suggested Data Sources: Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record</p>
		Acute Care		
13	comfort	<p>When is the earliest physician, APN, or PA documentation of comfort measures only?</p> <p>1. Day of arrival (day 0) or day after arrival (day 1) 2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but timing unclear 99. Comfort measures only was not documented by the physician/APN/PA or unable to determine</p>	<p>1, 2, 3, 99</p> <div>Warning if comfort = 2</div>	<p>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).</p> <p>ONLY accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES														
				<table><tr><td colspan="2">Inclusion (Only acceptable terms)</td></tr><tr><td>Brain death/dead</td><td>End of life care</td></tr><tr><td>Comfort care</td><td>Hospice</td></tr><tr><td>Comfort measures</td><td>Hospice Care</td></tr><tr><td>Comfort measures only (CMO)</td><td>Organ harvest</td></tr><tr><td>Comfort only</td><td>Terminal care</td></tr><tr><td colspan="2">DNR-CC</td></tr></table> <ul style="list-style-type: none">• Determine the <u>earliest</u> day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES. Do not factor in when comfort measures only was actually instituted. Example: "Discussed comfort care with family on arrival" noted in day 2 progress note - Select "2."• Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:<ul style="list-style-type: none">◦ Comfort measures only recommendation◦ Order for consultation/evaluation by hospice care◦ Patient/family request for comfort measures only◦ Plan for comfort measures only◦ Referral to hospice care service• If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option "1," "2," or "3" accordingly, unless otherwise specified.• 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).• Disregard documentation of an Inclusion term in the following situations:<ul style="list-style-type: none">◦ Inclusion term clearly described as negative (Examples: "No	Inclusion (Only acceptable terms)		Brain death/dead	End of life care	Comfort care	Hospice	Comfort measures	Hospice Care	Comfort measures only (CMO)	Organ harvest	Comfort only	Terminal care	DNR-CC	
Inclusion (Only acceptable terms)																		
Brain death/dead	End of life care																	
Comfort care	Hospice																	
Comfort measures	Hospice Care																	
Comfort measures only (CMO)	Organ harvest																	
Comfort only	Terminal care																	
DNR-CC																		

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>comfort care," "Not appropriate for hospice care," "Declines hospice care")Note: If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g., On Day 0, the physician documents, "The patient is not a hospice candidate." On Day 3, the physician orders a hospice consult. Select "2.")</p> <ul style="list-style-type: none"> Comfort measures made conditional upon whether or not the patient arrests. (Examples: "DNRCCA" (Do Not Resuscitate-Comfort Care Arrest; "Comfort Care Protocol will be implemented in the event of a cardiac or respiratory arrest"; "Family requests comfort measures only should the patient arrest.") Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, "Pt. on hospice at home" in MD/ED note). EXCEPTION: State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, 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) Pre-printed order forms signed by physician/APN/PA: Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from). Examples: <ul style="list-style-type: none"> Inclusion term used only in the title of the form (e.g., DNR-Comfort Care order form - option "Comfort Care" is not checked. Inclusion term used only in the pre-printed instruction for completing the form (e.g., "Copy of form to hospice", "Instructions" section of the form further defines the option

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>"Comfort care")</p> <p>ONLY ACCEPTABLE SOURCES: Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, Physician orders, Progress notes</p> <p>Excluded data source: Restraint order sheet</p> <p>Exclusion Statement: Clinician documentation of "comfort measures only" excludes the case from Joint Commission designated IHF Hospital Inpatient Quality measures. Abstraction of required data elements for VHA measures remains applicable.</p>
14	clntrial	During this hospital stay, was the patient enrolled in a clinical trial in which patients with heart failure were being studied?	<p>*1, 2</p> <p>*If 1, the record is excluded from the JC HF Hospital Quality Measures population. (Partial Abstraction Only)</p> <p>If 2, go to frstwt</p>	<p>In order to answer "Yes", BOTH of the following must be documented:</p> <p>1. There must be a signed consent form for the 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; AND</p> <p>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 heart failure were being studied. Patients may 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.</p> <p>In the following situations, select "No":</p> <p>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).</p> <p>2. It is not clear whether the study described in the signed patient consent form is experimental or observational.</p> <p>3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if the study population is not specified.</p> <p>ONLY ACCEPTABLE SOURCE: Signed consent form for clinical trial</p> <p>Exclusion Statement: Enrollment of the patient in a clinical trial during this hospital stay relevant to heart failure excludes the case from the Joint Commission HF Hospital Quality Measures.</p>
		Weight		

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
15	frstwt	Enter the patient's first weight measured after acute care arrival.	<p style="text-align: center;">_____</p> <p>Abstractor can enter default zzz if no weight measured during this episode of care.</p> <p>If z-filled, auto-fill wtunit3 as 95, frstwtdt as 99/99/9999, weightdc as zzz, wtunitdc as 95, and dcwtdt as 99/99/9999 and go to assesslvf</p>	<p>Inpatient Sources: Nursing admission assessment. H&P, admission note, progress notes, nursing notes. Assessment form and notes by Dietary Service are a good source of weight and height data.</p> <p>If no weight was measured during this episode of care, enter default zzz.</p>
16	wtunit3	Unit of measure 1. Pounds 2. Kilograms 95. Not applicable	<p>1, 2, 95</p> <p>If frstwt is z-filled, will be auto-filled as 95</p> <div style="border: 1px solid black; padding: 5px;"> <p>Warning window when wtunit3 = 1 and weight <= 98 or >= 278</p> <p>When wtunit3 = 2, and weight <= 44 or >= 126</p> </div>	
17	frstwtdt	Enter the date the first weight was measured.	<p>mm/dd/yyyy</p> <p>Will be auto-filled as 99/99/9999 if frstwt is z-filled</p> <div style="border: 1px solid black; padding: 5px;"> <p>>= arrvdate and <= dtotdc</p> </div>	<p>Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.</p> <p>If the inpatient weight is z-filled, FRSTWTDT will auto-fill as 99/99/9999. The abstractor cannot enter 99/99/9999 default date if a valid weight was entered.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
18	weightdc	Enter the patient's weight measured on or prior to discharge.	<p>_____</p> <p>Abstractor can enter default zzz if only one weight measured during this episode of care.</p> <p>If z-filled, auto-fill wtunitdc as 95 and dcwtdt as 99/99/9999, and go to asesslvf</p>	<p>Inpatient Sources: Nursing admission assessment. H&P, admission note, progress notes, nursing notes. Assessment form and notes by Dietary Service are a good source of weight and height data.</p> <p>If only one weight was measured during this episode of care, enter default zzz.</p>
19	wtunitdc	Unit of measure 1. Pounds 2. Kilograms 95. Not applicable	<p>1, 2, 95</p> <p>If weightdc is z-filled, will be auto-filled as 95</p> <div>Warning window when wtunitdc = 1 and weight <= 98 or >= 278</div> <div>When wtunitdc = 2, and weight <= 44 or >= 126</div>	
20	dcwtdt	Enter the date the weight was measured on or prior to discharge.	<p>mm/dd/yyyy</p> <p>Will be auto-filled as 99/99/9999 if weightdc is z-filled</p> <div>> frstwtdt and <= dtofdc</div>	<p>Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.</p> <p>If the discharge weight is z-filled, DCWTDt will auto-fill as 99/99/9999. The abstractor cannot enter 99/99/9999 default date if a valid weight was entered.</p>
		Inpatient Admission Diagnostic Tests		
21	asesslvf	Is there documentation in the medical record of at least one of	1, 2, R	Left Ventricular Systolic Function (LVSF) assessment: diagnostic measure of

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>the following:</p> <ul style="list-style-type: none"> Left ventricular systolic function (LVSF) assessment at any time prior to arrival or during this hospitalization A plan for LVSF assessment after discharge A reason documented by a physician, nurse practitioner, or physician assistant for not assessing LVSF <p>1. Yes 2. No assessment at any time, no plan to assess after discharge, no reason documented, or unable to determine R. Reason documented by a physician, APN, or PA for not assessing LVSF prior to arrival, during hospital stay, or planned after discharge.</p>	<p>If 2 or R, auto-fill the following: lvfless as 95, inhowlvf as 95, efnumip as zz, narlvf as 95 and eftstdt as 99/99/9999</p>	<p>left ventricular contractile performance/wall motion. Ejection fraction (EF) is an index of LVSF. EF may be recorded in quantitative (EF=30%) or qualitative (moderate left ventricular systolic dysfunction) terms.</p> <p>LVSF assessments done any time prior to hospital arrival are acceptable (see Inclusion list).</p> <ul style="list-style-type: none"> Infer a test was done if the patient's LVSF is documented (e.g., "Pt. admitted with severe LV dysfunction"). In determining whether there is a plan to assess LVSF after discharge, the plan must be documented as definitive (e.g., "Will measure EF next week"). Documentation which only indicates that an LVSF assessment might be considered after discharge, such as "May do Echo in 1 month" is <u>NOT</u> sufficient. If there is documentation of both a reason for not assessing LVSF AND documentation that LVSF was assessed or that assessment is planned for after discharge, select "1." <p>Reasons for not performing LVSF assessment:</p> <ul style="list-style-type: none"> Reasons must be explicitly documented by a physician/APN/PA (e.g. "ESRD. Will not measure EF"; Echo report has "Technically difficult study, LVSF could not be measured.") Physician/APN/PA deferral of LVSF assessment to another physician/APN/PA does NOT count as a reason for not assessing LVSF unless the reason/problem underlying the deferral is also noted (e.g., "Consulting cardiologist to evaluate pt. for echo" - select "No."). <p><u>Exclude:</u> akinesis, dyskinesis, or hypokinesis not described as left ventricular; cardiomyopathy not described as endstage; contractility/hypocontractility; left ventricular compliance, dilatation/dilation, hypertrophy; BNP blood test</p> <p>Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay).</p> <p>Left Ventricular Systolic Function (LVSF) Assessment Inclusion list:</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>Echocardiogram (echo)</p> <ul style="list-style-type: none"> • Cardiac ultrasound • Transesophageal echo (TEE) • Transthoracic echo (TTE) <p>Cardiac Catheterization (cath) with Left Ventriculogram (LV gram)</p> <ul style="list-style-type: none"> • Cardiac cath with mention of LVSF • Cardiac/coronary angiogram/arteriogram with LV gram or mention of LVSF • Left heart cath with mention of LVSF • Left ventriculogram (LV gram) <p>Other LVSF Assessment Tests</p> <ul style="list-style-type: none"> • Cardiac MRI scan with mention of LVSF • CT scan of chest with mention of LVSF • Multiple gated acquisition scan (MUGA) or other cardiac imaging/testing described as gated or blood pool • Other nuclear test (e.g., SPECT, PET) with mention of LVSF <p>Left Ventricular Systolic Function (LVSF)</p> <ul style="list-style-type: none"> • Akinesis, dyskinesis, or hypokinesis described as left ventricular • Diastolic dysfunction, failure, function, or impairment • Dysfunction described as biventricular, left ventricular (LVD, LVSD), systolic, or ventricular • Ejection fraction (EF, LVEF) • Endstage cardiomyopathy • Failure described as biventricular, left ventricular, systolic, or ventricular • Function described as biventricular, left ventricular (LVF), systolic, or ventricular
22	lvfless	Is the most recent left ventricular systolic function documented as an ejection fraction (EF) less than 40% or a narrative	1, 2, 95 If assesslvf = 2 or R, will	LVSD: impairment of LV performance. EF is an index of LVSF. Use the most recent description of EF/LVSF/LVSD found (test done closest to

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>description consistent with moderate or severe systolic dysfunction (LVSD)?</p> <p>1. Yes</p> <p>2. No</p> <p>95. Not applicable</p>	<p>be auto-filled as 95</p> <p>Abstractor may enter 95 if there was only a plan for LVSF assessment after discharge</p>	<p>discharge if in-hospital test done). EF < 40% select "1"; EF >= 40% select "2".</p> <p><u>Guidelines for prioritizing EF/LVSF/LVSD documentation:</u></p> <p>1) LVSF assessment test report findings take precedence over findings documented in other sources (e.g. progress notes)</p> <p>2) Final report findings take priority over preliminary findings. Assume findings are final unless labeled as preliminary.</p> <p>3) Conclusion (impression, interpretation, or final diagnosis) section of the report takes priority over other sections.</p> <p>**If test for EF/LVSF was not performed during hospital stay, look for documentation of pre-arrival EF/LVSF test results documented in the record. Apply guidelines 1 - 3 above.</p> <p><u>Priority order for conflicting documentation when there are 2 or more different descriptions of EF/LVSF:</u></p> <p>1) Use the lowest calculated EF (e.g. 30%)</p> <p>2) Use lowest estimated EF. Estimated EFs often use descriptors such as "about," "approximate," or "appears." (e.g. EF appears to be 35%). Estimated EF may be documented as a range (use mid-point) or less than or greater than a given number.</p> <p>3) Use worst narrative description WITH severity specified (e.g., LVD/LVSD described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; EF described as low, poor, or very low)</p> <p>4) Use narrative description WITHOUT severity specified (e.g., biventricular dysfunction, LVD, LVSD, systolic dysfunction, left ventricular systolic failure, LVF/LVSF/EF) described as abnormal, compromised, decreased, reduced.</p> <p>5) 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.</p> <ul style="list-style-type: none"> • 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 <p>E.g., Impression section of echo report states only "diastolic dysfunction". Findings section states "EF 35%". Disregard "diastolic dysfunction" in the Impression</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
				<p>section and answer "Yes" due to EF 35%.</p> <p><u>Include:</u></p> <ul style="list-style-type: none">any terms (biventricular dysfunction; LVD/LVSD/systolic dysfunction; diffuse, generalized or global hypokinesis; LV akinesis/hypokinesis/dyskinesis; LV systolic failure) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; OR where severity is NOT specifiedbiventricular heart failure described as moderate or severeend stage cardiomyopathy <p><u>Exclude:</u></p> <p>1) any terms (see above) described as mild-moderate</p> <p>2) any terms (see above) described using one of the following negative Qualifiers or Modifiers:</p> <table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table> <p>If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, enter 95.</p>	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
23	inhowlvf1 inhowlvf4 inhowlvf95	During this inpatient admission, how was the <u>most recent</u> left ventricular systolic function documented in the record? Select all that apply: 1. Ejection fraction as a percentage 4. Narrative description 95. Not applicable	1, 4, 95 If assesslvf= 2, will be auto-filled as 95 If abstractor entered 1 for assesslvf and 95 for lvfless, auto-fill as 95 Auto-fill as follows for answers not selected: efnump as zz, narlvf as 95	EF may be taken from any knowledge of EF or LVSD (left ventricular systolic dysfunction) documented in the inpatient record for this admission. The question references the most recent EF or narrative description found in the record. EF is typically documented as a percentage (33%), percentage range (55-60%), or a narrative description (normal function). The question applies only to this inpatient admission. If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered "1," enter 95
24	eftstdt	Enter the date of the most recent test for left ventricular systolic function (EF).	mm/dd/yyyy If assesslvf = 2 or R, will be auto-filled as 99/99/9999 If assesslvf = 1, but no date available, abstractor may enter 99/99/9999 <div style="border: 1px solid black; padding: 2px; width: fit-content;"><= 5 years prior to or = arrvdate and <= dtofdc</div>	Enter the date the most recent EF was measured. EF may be measured by echocardiogram, during cardiac catheterization, or by various stress tests, including perfusion scans. Enter exact day and month if test was recent and dates are available.

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
25	efnumip	Enter the most recent EF percentage documented in the medical record.	<div>__ __%</div> <div>If inhowlvf > 1, auto-fill as zz</div> <div>If abstractor entered 1 for assesslvf and 95 for lvfless, auto-fill as default zz</div> <div>If lvfless = 1, cannot enter 40 or ></div> <div>If lvfless = 2, cannot enter < 40</div>	<div>If only a number is documented (and it is not a decimal), it may be assumed it is a percentage. If an EF range is provided, enter EF as a percentage and use the midpoint of the range. Example: EF documented as 50-55%. The midpoint would be 52.5%, so it would be rounded up to 53%.</div> <div>If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered "1," enter default zz.</div>				
26	narlvsf	Enter the <u>most recent</u> description of LVSF documented during this admission: 1. Moderately or moderately-to-severely reduced (or depressed, abnormal, or impaired) 2. Severely reduced (or depressed, abnormal, or impaired) 3. Other description 95. Not applicable	<div>1, 2, 3, 95</div> <div>If inhowlvf > 4, auto-fill as 95</div> <div>If abstractor entered 1 for assesslvf and 95 for lvfless, auto-fill as 95</div>	<div>The question applies only to this inpatient admission.</div> <div>Do not include systolic dysfunction described using one of the following negative Qualifiers or Modifiers:</div> <div><table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table></div> <div>If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered "1," enter 95.</div>	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
27	funcap	Specify the patient's most recent functional status or exercise tolerance documented during this admission. 1. Asymptomatic or no limitation of physical activity (NYHA Class I) 2. Slight limitation of physical activity (NYHA Class II) 3. Marked limitation of physical activity (NYHA Class III) 4. Unable to carry out any physical activity without discomfort or cardiac symptoms at rest (NYHA Class IV) 99. No documentation of functional status	1, 2, 3, 4, 99	1. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea (shortness of breath), or anginal pain. Limiting symptoms may occur with marked exertion. 2. Comfortable at rest, but ordinary physical activity (see above) results in fatigue, palpitation, dyspnea, or anginal pain. 3. Comfortable at rest, but less than ordinary physical activity (see above) causes fatigue, palpitation, dyspnea, or anginal pain. 4. Patient has symptoms at rest that increase with any physical activity. Inability to perform any physical activity without discomfort. Abstractor can accept any of the above descriptions or NYHA Classification. Only accept documentation of functional status/exercise tolerance from this inpatient admission.
28	inptcmb1 inptcmb2 inptcmb3 inptcmb4 inptcmb99	Were any of the following documented during this admission? Indicate all that apply: 1. Dementia 2. Metastatic or end stage malignancy 3. Do not resuscitate order (DNR) during current admission 4. Currently enrolled in hospice 99. No documentation of the above	1, 2, 3, 4, 99	Documentation may be taken from the inpatient record for this admission. Enter ALL conditions that apply. Any type of dementia is applicable, such as Alzheimer's, vascular, dementia due to HIV, head trauma, Parkinson's, Huntington's Disease, or Creutzfeldt-Jakob Disease.
		Inpatient Procedures		
29	icdpx	Is there documentation the patient had an implantable cardioverter-defibrillator (ICD) placed during this hospitalization?	1, 2 If 2 auto-fill, icdpxt as 99/99/9999 and go to crtpx	An implantable cardioverter-defibrillator (ICD) is a device designed to quickly detect a life-threatening, rapid heartbeat coming from the ventricles of the heart. The ICD attempts to convert an abnormal rhythm back to normal by delivering an electrical shock to the heart. This action is called defibrillation. The device may also be referred to as an automatic implantable cardioverter-defibrillator (AICD). ICD-9-CM procedure code: 37.94.
30	icdpxdt	Enter the date the ICD was implanted.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if icdpx = 2 <div style="border: 1px solid black; padding: 2px; display: inline-block;">>= entradm and <= dtofdc</div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
31	crtpx	Is there documentation the patient had implantation of a biventricular (BiV) pacemaker for cardiac resynchronization therapy (CRT) during this hospitalization?	1, 2 If 2 auto-fill, crtpxd as 99/99/9999	Cardiac resynchronization therapy (CRT) is achieved by implantation of a biventricular pacemaker. The biventricular pacemaker <u>simultaneously</u> paces both the left and right ventricles in order to synchronize the pumping action of the ventricles. The CRT device may have 3 leads - one in the right atrium and one in each of the ventricles. If the device also has a defibrillator it may be referred to as a CRT-D. ICD-9-CM procedure codes: 00.50, 00.51
32	crtpxd	Enter the date the CRT device was implanted.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if crtpx = 2 <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;"> >= entradm and <= dtofdc </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable
		Medications During Admission		
33	admace	During this admission, was the patient on an angiotensin converting enzyme inhibitor (ACEI)? Examples of ACEI include, but are not limited to: <ul style="list-style-type: none"> • enalapril • captopril • lisinopril • benazepril • ramipril • combinations of ACEI with hydrochlorothiazide 1. Yes 2. No	1, 2 If 1, auto-fill contace3 as 95, admarb as 95, contrarb1 as 95 If 2, go to contace3	During this admission: refers to the ACEI being administered during this episode of care. ACEI: Angiotensin converting enzyme inhibitors; ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. If there is a prescription for an ACEI to be started after discharge, but an ACEI was not administered prior to discharge, select "2." For a list of ACEI medications refer to TJC Appendix C, Table 1.2 or a drug handbook.
34	contace3	Does the record document any of the following reasons for not prescribing an ACEI during this admission? 1. ACEI allergy or intolerance 5. Moderate or severe aortic stenosis 95. Not applicable 97. Other reasons documented by a physician/APN/PA or	1, 5, 95, 97, 98, 99 Will be auto-filled as 95 if admace = 1	Documentation of a reason anytime during hospital stay is acceptable. 1. ACEI allergy/sensitivity: allergy/sensitivity documented anytime counts regardless of type of reaction noted (e.g. "Allergies: ACEI - cough"); allergy/sensitivity to one ACEI is acceptable as an allergy to all ACEIs. 5. Moderate or Severe Aortic Stenosis (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
		pharmacist 98. Patient refusal of ACE inhibitors documented by physician/APN/PA or pharmacist 99. No documented reason		<p>mention of repair, replacement, valvuloplasty, or commissurotomy. INCLUDE: AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified</p> <p>EXCLUDE:</p> <ul style="list-style-type: none">• Aortic insufficiency/regurgitation only• AS described as 1+ or 2+• Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers: <table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table> <p>97. Other reason(s) documented by a physician/APN/PA or pharmacist:</p> <ul style="list-style-type: none">• Must explicitly link the noted reason with non-prescription of an ACEI.• Should be considered implicit documentation for also not prescribing an ARB for the following five conditions ONLY:<ul style="list-style-type: none">◦ Angioedema◦ Hyperkalemia◦ Hypotension◦ Renal artery stenosis	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<ul style="list-style-type: none"> Worsening renal function/renal disease/dysfunction If the patient is on hydralazine and nitrates, <u>and</u> the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as "other reason." When conflicting documentation regarding a reason for not prescribing an ACEI is documented in the medical record, select "yes" for the applicable reason. <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.</p>
35	admarb	<p>During this admission, was the patient on an angiotensin II receptor antagonist (ARB or AIIRA)?</p> <p>Examples of ARB medications include, but are not limited to:</p> <ul style="list-style-type: none"> candesartan eprosartan irbesartan losartan valsartan combinations of ARB with hydrochlorothiazide <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95</p> <p>Will be auto-filled as 95 if admace = 1</p> <p>If 1, auto-fill contrarb1 as 95</p> <p>If 2, go to contrarb1</p>	<p>During this admission: refers to the ARB being taken or prescribed during this episode of care.</p> <p>ARB: Angiotensin receptor blockers or angiotensin II receptor antagonists (AIIRA); ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors</p> <p>If there is a prescription for an ARB to be started after discharge, but an ARB was not administered prior to discharge, select "2."</p> <p>For a list of ARB medications refer to TJC Appendix C, Table 1.7 or a drug handbook.</p>
36	contrarb1	<p>Does the record document any of the following reasons for not prescribing an ARB during this admission?</p> <p>1. ARB (AIIRA) allergy or sensitivity</p> <p>2. Moderate or severe aortic stenosis</p> <p>95. Not applicable</p> <p>97. Other reasons documented by a physician/APN/ PA or pharmacist for not prescribing an ARB</p>	<p>1, 2, 95, 97, 98, 99</p> <p>Will be auto-filled as 95 if admarb = 1 or admace = 1</p>	<p>Documentation of a reason anytime during hospital stay is acceptable.</p> <p>1. ARB allergy/sensitivity: any documented allergy/sensitivity counts, regardless of type of reaction noted (e.g. "Allergies: ARB-cough"); allergy/sensitivity to one ARB is acceptable as allergy to all ARBs.</p> <p>2. Moderate or Severe Aortic Stenosis (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. INCLUDE:</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
		98. Patient refusal of ARBs documented by physician/APN/PA or pharmacist 99. No documented reason		<p>AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified</p> <p>EXCLUDE:</p> <ul style="list-style-type: none">• Aortic insufficiency/regurgitation only• AS described as 1+ or 2+• Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers: <table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table> <p>97. Other reason(s) documented by a physician/APN/PA or pharmacist:</p> <ul style="list-style-type: none">• Must explicitly link the noted reason with non-prescription of an ARB.• Should be considered implicit documentation for also not prescribing an ACEI for the following five conditions ONLY:<ul style="list-style-type: none">◦ Angioedema◦ Hyperkalemia◦ Hypotension◦ Renal artery stenosis◦ Worsening renal function/renal disease/dysfunction	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<ul style="list-style-type: none"> • If the patient is on hydralazine and nitrates, <u>and</u> the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as "other reason." • When conflicting documentation regarding a reason for not prescribing an ARB is documented in the medical record, select "yes" for the applicable reason. <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.</p>
37	admbb	<p>Was the patient on a beta-blocker during this admission? Examples of beta-blockers include but are not limited to:</p> <ul style="list-style-type: none"> • metoprolol succinate or tartrate • carvedilol • atenolol • nadolol • propranolol • combination of beta-blockers with other drugs <p>1. Yes 2. No</p>	<p>1, 2 If 1, auto-fill contrabb as 95 If 2, go to contrabb</p>	<p>During this admission: refers to the beta-blocker being taken or prescribed during this episode of care.</p> <p>If there is a prescription for a beta-blocker to be started after discharge, but a beta-blocker was not administered prior to discharge, select "2."</p> <p>For a list of beta-blocker medications refer to TJC Appendix C, Table 1.3 or a drug handbook.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
38	contrabb	<p>Does the record document any of the following reasons for not prescribing a beta-blocker during this admission?</p> <p>1. Beta-blocker allergy</p> <p>2. Bradycardia (heart rate less than 60 bpm) while not on a beta-blocker</p> <p>3. Second or third degree heart block on ECG and does not have a pacemaker</p> <p>9. Post-heart transplant patient</p> <p>10. Documentation of severely decompensated heart failure</p> <p>95. Not applicable</p> <p>97. Other reasons documented by a physician/APN/ PA or pharmacist</p> <p>98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist</p> <p>99. No documented reason</p>	<p>1, 2, 3, 9, 10, 95, 97, 98, 99</p> <p>Will be auto-filled as 95 if admbb = 1</p>	<p>Documentation of reason anytime during hospital stay is acceptable.</p> <p>1. Beta-blocker (BB) allergy/sensitivity/intolerance: documented allergy/sensitivity/intolerance counts regardless of type of reaction noted; allergy/sensitivity/intolerance to one BB is acceptable as allergy to all BBs. EXCLUDE: Allergy to BB eye drops (e.g., Cosopt).</p> <p>2. Bradycardia: must be documented by a clinician as the reason for non-use of a beta-blocker; however if record states "patient's heart rate is consistently less than 60 bpm," this is acceptable.</p> <p>3. Second or third degree heart block: Do not attempt to use the ECG tracing to answer this question. The ECG interpretation of second or third degree heart block must be documented in the record by a clinician or by electronic interpretation. Documentation of the ECG interpretation does not have to be linked specifically to contraindication to beta-blocker.</p> <p>10. Severely decompensated heart failure: cardiac decompensation is marked by dyspnea, venous engorgement, and edema. Abstractor may not make this decision based on symptoms described in record. There must be specific diagnosis by a physician/APN/PA.</p> <p>97. Other reason(s) documented by a physician/APN/ PA or pharmacist:</p> <ul style="list-style-type: none"> • Must explicitly link the noted reason with non-prescription of a beta-blocker. Documentation of a reason anytime during the hospital stay is acceptable. • When conflicting documentation regarding a reason for not prescribing BB is documented in the medical record, select "yes" for the applicable reason. <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blocker medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
39	aldostrx	Was the patient on an aldosterone antagonist (Examples: spironolactone, eplerenone) during this admission? 1. Yes 2. No	1, 2 If 1, auto-fill aldostno as 95	During this admission = patient received an aldosterone antagonist during this episode of care. If there is a prescription for an aldosterone antagonist to be started after discharge, but an aldosterone antagonist was not administered prior to discharge, select "2." Brand name for spironolactone: Aldactone Brand name for eplerenone: Inspra For a list of aldosterone antagonist medications refer to a drug handbook.
40	aldostno	Does the record document any of the following reasons for not prescribing an aldosterone antagonist during this admission? 1. Allergy, intolerance, or sensitivity 2. Renal insufficiency 3. Hyperkalemia 95. Not applicable 97. Other reason documented by a physician/APN/ PA or pharmacist 98. Patient refusal of aldosterone antagonist documented by physician/APN/PA or pharmacist 99. No documented reason	1, 2, 3, 95, 97, 98, 99 Will be auto-filled as 95 if aldostrx = 1	Documentation of a reason any time during admission is acceptable. Allergy: Documentation of aldosterone antagonist allergy or sensitivity or patient's inability to tolerate one or more side effects is sufficient. Renal insufficiency: acute renal insufficiency/failure (ARI/ARF); arterionephrosclerosis; azotemia; chronic renal disorder; chronic renal failure (CRF); chronic renal insufficiency; diabetic kidney disease; hemodialysis or peritoneal dialysis. Hyperkalemia: serum potassium > 5.5 meq/L that cannot be reduced (not a transient event) Other reason: must be documented by a physician/APN/PA or pharmacist. <ul style="list-style-type: none"> Must explicitly link the noted reason with non-prescription of an aldosterone antagonist
		If dedispo = 2, 3, 4, 6, or 7 auto-fill all remaining questions as "95,"and go to end		
		Inpatient Discharge Medications		

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
41	aceidc	<p>Was an angiotensin converting enzyme inhibitor (ACEI) prescribed at discharge?</p> <p>Examples of ACEI include, but are not limited to:</p> <ul style="list-style-type: none"> • enalapril • captopril • lisinopril • benazipril • ramipril • combinations of ACEI with hydrochlorothiazide <p>1. Yes 2. No</p>	<p>1, 2</p> <p>If 1, auto-fill noacewhy as 95, allerace as 95, arbatdc as 95, noarbdc as 95, allerarb as 95</p> <p>If 2, go to noacewhy</p>	<p>In determining whether an ACEI was prescribed at discharge, review all discharge medication documentation available in the chart.</p> <p>If there is conflicting documentation among different medical record sources, the following guidelines apply:</p> <ul style="list-style-type: none"> • In cases where there is an ACEI in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. Consider the ACEI a discharge medication in the <u>absence</u> of contradictory documentation (see below). • If documentation is contradictory (e.g., physician noted "dc lisinopril" in discharge orders, but lisinopril is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether an ACEI was prescribed at discharge, the case should be deemed unable to determine and answered as "2." • Consider documentation of a "hold" on an ACEI after discharge as contradictory ONLY if the timeframe on the hold is not defined (e.g., "Hold lisinopril" does not have a timeframe). • If an ACEI is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ACEI for a time period after discharge (e.g. "Start lisinopril as outpatient"), select "2." • Disregard an ACEI documented only as a recommended medication for discharge (e.g., "Recommend sending pt home on Vasotec"). Documentation must be clear that the ACEI was actually prescribed. • Disregard documentation of ACEI prescribed at discharge when noted only by medication class (e.g., "ACEI Prescribed at Discharge: Yes" on a core measures form). The ACEI must be listed by name. <p>For a list of ACEI medications refer to TJC Appendix C, Table 1.2 or a drug handbook.</p>
42	noacewhy	<p>Does the record document any of the following reasons for not prescribing an ACEI at discharge?</p> <p>1. ACEI allergy</p> <p>5. Moderate or severe aortic stenosis</p>	<p>1, 5, 95, 97, 98, 99</p> <p>Will be auto-filled as 95 if aceidc = 1</p>	<p>Documentation of a reason anytime during hospital stay is acceptable.</p> <p>1. ACEI allergy/sensitivity: documented allergy or sensitivity documented at anytime during the hospital stay counts regardless of type of reaction noted (e.g. "Allergies: ACEI - cough"); allergy/sensitivity to one ACEI is acceptable as an</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
		95. Not applicable 97. Other reasons documented by a physician/APN/ PA or pharmacist for not prescribing an ACEI at discharge 98. Patient refusal of ACE inhibitors documented by physician/APN/PA or pharmacist 99. No documented reason	If < 1, auto-fill all race as 95, and go to arbatdc	<p>allergy to all ACEIs.</p> <p>5. Moderate or Severe Aortic Stenosis (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. INCLUDE: AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified</p> <p>EXCLUDE:</p> <ul style="list-style-type: none">• Aortic insufficiency/regurgitation only• AS described as 1+ or 2+• Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers: <table border="1"><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table> <p>97. Other reason(s) documented by a physician/APN/PA or pharmacist:</p> <ul style="list-style-type: none">• Must explicitly link the noted reason with non-prescription of an ACEI.• Should be considered implicit documentation for also not prescribing an ARB for the following five conditions ONLY:<ul style="list-style-type: none">◦ Angioedema	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<ul style="list-style-type: none"> ◦ Hyperkalemia ◦ Hypotension ◦ Renal artery stenosis ◦ Worsening renal function/renal disease/dysfunction • Documentation of a hold/discontinuation of an ACEI during the hospital stay constitutes a "clearly implied" reason for not prescribing an ACEI at discharge (e.g., "Patient hypotensive. May start ACEI as outpatient"). • EXCEPTIONS: <ul style="list-style-type: none"> ◦ Documentation of a conditional hold/discontinuation of an ACEI does not count as a reason for not prescribing at discharge UNLESS (1) it exists as a physician/APN/PA or pharmacist order to hold/discontinue the ACEI if BP falls outside certain parameters, AND (2) the ACEI was held due to BP outside the parameters Nursing documentation is acceptable (e.g., Physician order: "Hold lisinopril for SBP < 90" and nurse documents: "lisinopril held for BP 80/50"). ◦ Discontinuation of a particular ACEI medication documented in combination with the start of a different ACEI medication (i.e., switch in type of ACEI medication) does not count as a reason for not prescribing an ACEI at discharge. Example: - "Stop benazepril" and "Start captopril 50 mg po bid" in same physician order. ◦ Discontinuation of an ACEI medication at a particular dose documented in combination with the start of a different dose of that ACEI (i.e., change in dosage) does not count as a reason for not prescribing an ACEI at discharge. Examples: - "Stop lisinopril 20 mg po q am" and "Start lisinopril 30 mg po q am" in same physician order - "Increase Altace 5 mg to 10 mg" in progress note • Documentation of both a plan to initiate/restart an ACEI and the reason/problem underlying the delay in starting/restarting ACEI constitutes a "clearly implied" reason for not prescribing ACEI at discharge (e.g., "Pt.

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>hemodynamically unstable. May start ACEI as outpatient.").</p> <ul style="list-style-type: none"> • If the patient is on hydralazine and nitrates, <u>and</u> the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as "other reason." • Documentation of a pre-arrival hold/discontinuation of an ACEI or pre-arrival "other reason" for not prescribing an ACEI counts as a reason for not prescribing at discharge ONLY if the underlying reason is noted. • When conflicting documentation regarding a reason for not prescribing an ACEI at discharge is documented in the medical record, select "yes" for the applicable reason. • Unacceptable Reasons: <ul style="list-style-type: none"> ◦ Documentation of a conditional hold/discontinuation of an ACEI (e.g. "Hold lisinopril if cough recurs.") without documentation the ACEI was held due to the specified reason. ◦ Documentation of a hold which refers to a more general medication class (e.g. "Hold all BP meds"). ◦ Deferral of an ACEI from one prescriber to another does NOT count as a reason unless underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for ACEI" is NOT acceptable). <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.</p> <p>Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay).</p>
43	allerace	<p>Is there documentation of the ACEI allergy/adverse reaction in the allergy box on the CPRS cover sheet?</p> <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95 Will be auto-filled as 95 if aceide = 1 or noacewhy < 1</p>	<p>The intent of the question is to determine if the allergy/adverse reaction to the ACE inhibitor was documented in the allergy package of CPRS.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
44	arbatdc	<p>Was an angiotensin II receptor antagonist (ARB or AIIRA) prescribed at discharge?</p> <p>Examples of ARB include, but are not limited to:</p> <ul style="list-style-type: none"> • candesartan • eprosartan • irbesartan • losartan • valsartan • combinations of ARB with hydrochlorothiazide <p>1. Yes 2. No 95. Not Applicable</p>	<p>1, 2, 95</p> <p>Will be auto-filled as 95 if aceide = 1</p> <p>If 1, auto-fill noarbdc as 95 and allerarb as 95</p> <p>If 2, go to noarbdc</p>	<p>In determining whether an ARB was prescribed at discharge, review all discharge medication documentation available in the chart.</p> <p>If there is conflicting documentation among different medical record sources, the following guidelines apply:</p> <ul style="list-style-type: none"> • In cases where there is an ARB in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. Consider the ARB a discharge medication in the <u>absence</u> of contradictory documentation (see below). • If documentation is contradictory (e.g., physician noted "dc losartan" in discharge orders, but losartan is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether an ARB was prescribed at discharge, the case should be deemed unable to determine and answered as "2." • Consider documentation of a "hold" on an ARB after discharge as contradictory ONLY if the timeframe on the hold is not defined (e.g., "Hold losartan" does not have a timeframe). • If an ARB is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ARB for a time period after discharge (e.g. "Start losartan as outpatient"), select "2." • Disregard an ARB documented only as a recommended medication for discharge (e.g., "Recommend sending pt home on candesartan"). Documentation must be clear that the ARB was actually prescribed. • Disregard documentation of ARB prescribed at discharge when noted only by medication class (e.g., "ARB Prescribed at Discharge: Yes" on a core measures form). The ARB must be listed by name. <p>For a complete list of ARB medications, refer to TJC Appendix C, Table 1.7 or a drug handbook.</p>
45	noarbdc	<p>Does the record document any of the following reasons for not prescribing an ARB at discharge?</p> <p>1. ARB (AIIRA) allergy or sensitivity 2. Moderate or severe aortic stenosis</p>	<p>1, 2, 95, 97, 98, 99</p> <p>Will be auto-filled as 95 if arbatdc = 1</p>	<p>Documentation of a reason anytime during hospital stay is acceptable.</p> <p>1. ARB allergy/sensitivity: documented allergy or sensitivity anytime during the hospital stay counts regardless of type of reaction noted (e.g. "Allergies: ARB-cough"); allergy/sensitivity to one ARB is acceptable as allergy to all ARBs.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
		95. Not applicable 97. Other reasons documented by a physician/ APN/PA or pharmacist for not prescribing an ARB 98. Patient refusal of ARBs documented by physician/APN/PA or pharmacist 99. No documented reason	If < 1, auto-fill allerarb as 95 and go to bbatdc	<p>2. Moderate or Severe Aortic Stenosis (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. INCLUDE: AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified</p> <p>EXCLUDE:</p> <ul style="list-style-type: none">• Aortic insufficiency/regurgitation only• AS described as 1+ or 2+• Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers: <table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table> <p>97. Other reason(s) documented by a physician/APN/PA or pharmacist:</p> <ul style="list-style-type: none">• Must explicitly link the noted reason with non-prescription of an ARB.• Should be considered implicit documentation for also not prescribing an ACEI for the following five conditions ONLY:<ul style="list-style-type: none">◦ Angioedema◦ Hyperkalemia	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial							

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<ul style="list-style-type: none"> ◦ Hypotension ◦ Renal artery stenosis ◦ Worsening renal function/renal disease/dysfunction • Documentation of a hold/discontinuation of an ARB during the hospital stay constitutes a "clearly implied" reason for not prescribing an ARB at discharge (e.g., "Patient hypotensive. May start ARB as outpatient"). • EXCEPTIONS: <ul style="list-style-type: none"> ◦ Documentation of a conditional hold/discontinuation of an ARB does not count as a reason for not prescribing at discharge UNLESS (1) it exists as a physician/APN/PA or pharmacist order to hold/discontinue the ARB if BP falls outside certain parameters, AND (2) the ARB was held due to BP outside the parameters Nursing documentation is acceptable (e.g., Physician order: "Hold losartan for SBP < 100"and/ nurse documents "losartan held for BP 80/50"). ◦ Discontinuation of a particular ARB medication documented in combination with the start of a different ARB medication (i.e., switch in type of ARB medication) does not count as a reason for not prescribing an ARB at discharge. Example: - "Change Diovan to Verdia" in progress note. ◦ Discontinuation of an ARB medication at a particular dose documented in combination with the start of a different dose of that ARB (i.e., change in dosage) does not count as a reason for not prescribing an ARB at discharge. Examples: - "Do not continue after discharge" checked for Cozaar 25 mg and "Continue after discharge" checked for Cozaar 50 mg on a physician-signed discharge medication reconciliation form • Documentation of both a plan to initiate/restart an ARB and the reason/problem underlying the delay in starting/restarting ARB constitutes a "clearly implied" reason for not prescribing ARB at discharge (e.g., "Pt. hemodynamically unstable. May start ARB as outpatient."). • If the patient is on hydralazine and nitrates, <u>and</u> the record documents this drug therapy is a better option than ACEI or ARB for

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>the patient, this documentation is acceptable as "other reason."</p> <ul style="list-style-type: none"> Documentation of a pre-arrival hold/discontinuation of an ARB or pre-arrival "other reason" for not prescribing an ARB counts as a reason for not prescribing at discharge ONLY if the underlying reason is noted. When conflicting documentation regarding a reason for not prescribing an ARB at discharge is documented in the medical record, select "yes" for the applicable reason. Unacceptable Reasons: <ul style="list-style-type: none"> Documentation of a conditional hold/discontinuation of an ARB (e.g. "Stop losartan if BP < 90 systolic.") without documentation the ARB was held due to the specified parameter. Documentation of a hold which refers to a more general medication class (e.g. "Hold all BP meds"). Deferral of an ARB from one prescriber to another does NOT count as a reason unless underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for ARB" is NOT acceptable). <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.</p> <p>Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay).</p>
46	allerarb	<p>Is there documentation of the ARB allergy/adverse reaction in the allergy box on the CPRS cover sheet?</p> <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95</p> <p>Will be auto-filled as 95 if arbatdc = 1 or noarbdc > 1, or aceidc = 1</p>	<p>The intent of the question is to determine if the allergy/adverse reaction to the ARB was documented in the allergy package of CPRS.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
47	bbatdc	<p>Was a beta-blocker prescribed at discharge? Examples of beta-blockers include but are not limited to:</p> <ul style="list-style-type: none"> • metoprolol succinate or tartrate • carvedilol • atenolol • nadolol • propranolol • combination of beta-blockers with other drugs <p>1. Yes 2. No</p>	<p>1, 2, 95</p> <p>If 1, auto-fill nobbatdc as 95 and allerbb as 95 If 2, go to nobbatdc</p>	<p>In determining whether a beta-blocker was prescribed at discharge, review all discharge medication documentation available in the chart.</p> <p>If there is conflicting documentation among different medical record sources, the following guidelines apply:</p> <ul style="list-style-type: none"> • In cases where there is a beta-blocker in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. Consider the beta-blocker a discharge medication in the <u>absence</u> of contradictory documentation (see below). • If documentation is contradictory (e.g., physician noted "dc metoprolol" in discharge orders, but metoprolol is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether a beta-blocker was prescribed at discharge, the case should be deemed unable to determine and answered as "2." • Consider documentation of a "hold" on a beta-blocker after discharge as contradictory ONLY if the timeframe on the hold is not defined (e.g., "Hold metoprolol" does not have a timeframe). • If a beta-blocker is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of a beta-blocker for a time period after discharge (e.g. "Start metoprolol as outpatient"), select "2." <p>For a list of beta-blocker medications refer to TJC Appendix C, Table 1.3 or a drug handbook. Acceptable Sources: discharge instructions, discharge orders, discharge summary</p>
48	nobbatdc	<p>Does the record document any of the following reasons for not prescribing a beta- blocker at discharge?</p> <p>1. Beta-blocker allergy 3. Second or third degree heart block on ECG on arrival or during hospitalization and does not have a pacemaker</p>	<p>1, 3, 9, 10, 95, 97, 98, 99</p> <p>Will be auto-filled as 95 if bbatdc = 1</p>	<p>Documentation of reason anytime during hospital stay is acceptable.</p> <p>1. Beta-blocker (BB) allergy/sensitivity: documented allergy/sensitivity counts regardless of type of reaction noted; allergy/sensitivity to one BB is acceptable as allergy to all BBs. EXCLUDE: Allergy to BB eye drops (e.g., Cosopt).</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES		
		9. Post-heart transplant patient 10. Severely decompensated heart failure documented by physician/APN/PA 95. Not applicable 97. Other reasons documented by a physician/APN/PA or pharmacist for not prescribing a beta blocker at discharge 98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist 99. No documented reason	If <> 1, auto-fill allerbb as 95	<div>3. Second or third-degree heart block (HB):<ul style="list-style-type: none">Findings on arrival ECG or ECG during hospitalization that does not show pacemaker findings OR findings without mention of pacemaker (e.g., "second-degree heart block" per ED report).Disregard pacemaker findings if documentation suggests non-functioning pacemaker.Any notation of 2nd/3rd degree HB and pacemaker findings on ECG report or other source is acceptable with/without physician/APN/PA signature. INCLUDE: Stand alone/modified by "variable" or "intermittent": Atrioventricular (AV) block described as 2:1, 3:1, 2nd degree, or 3rd degree; AV dissociation; HB described as 2:1, 3:1, complete (CHB), high degree, high grade, 2nd degree, 3rd degree; Mobitz Type 1 or 2; Wenckebach; Pacemaker findings of paced rhythm/spikes; pacing described as atrial, AV, dual chamber or ventricular. EXCLUDE:<ul style="list-style-type: none">atrial flutterAV blockAV conduction block1st degree AV block1st degree HBHB type/degree not specifiedIntraventricular conduction delay (IVCD)HB, or any other 2nd/3rd degree HB inclusion terms described using any of the following negative qualifiers or modifiers:</div> <div><div>JC Appendix H, Table 2.6 Qualifiers/Modifiers</div><table><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been,</td><td>Modifiers: borderline, insignificant, not significant, no</td></tr></table></div>	Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been,	Modifiers: borderline, insignificant, not significant, no
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been,	Modifiers: borderline, insignificant, not significant, no					

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<div> <div> <p>could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</p> </div> <div> <p>significant, minor, scant, slight, sub- clinical, subtle, trace, trivial</p> </div> </div> <p>10. Severely decompensated heart failure: cardiac decompensation is marked by dyspnea, venous engorgement, and edema. Abstractor may not make this decision based on symptoms described in record. There must be specific diagnosis by a physician/APN/PA.</p> <p>97. Other reason(s) documented by a physician/APN/ PA or pharmacist:</p> <ul style="list-style-type: none"> • Must explicitly link noted reason with non-prescription of BB. • Documentation of hold/discontinuation of BB during admission constitutes a "clearly implied" reason for not prescribing at discharge (e.g., "BP still low. May start metoprolol as outpatient."). • EXCEPTION: Documentation of a conditional hold/discontinuation of BB does NOT count as reason for not prescribing BB at discharge UNLESS (1) it exists as an order to hold/discontinue if BP or HR falls outside certain parameters, AND (2) BB was held due to a BP/HR outside the parameters. Nursing documentation is acceptable (e. g., Physician order: "Hold atenolol for SBP < 100" and nurse documents "atenolol held for BP 90/50"). • Documentation of both a plan to initiate/restart BB and the reason/problem underlying delay in starting/restarting constitutes a "clearly implied" reason for not prescribing BB at discharge (e.g., "BPs low. May start atenolol as outpatient."). • Documentation of a pre-arrival hold/discontinuation or pre-arrival "other reason" for not prescribing BB counts as a reason for not prescribing BB at discharge ONLY if underlying reason is noted. • When conflicting documentation regarding a reason for not prescribing BB at discharge is documented in the medical record, select "yes" for the applicable reason. • Unacceptable Reasons: <ul style="list-style-type: none"> ◦ Documentation of a conditional hold/discontinuation of BB (e.g.,

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>"Stop metoprolol if SBP < 100.") without documentation BB was held due to the specified parameter (e.g. SBP < 100).</p> <ul style="list-style-type: none"> Documentation of a hold which refers to a more general medication class (e.g. "Hold all BP meds"). Deferral of BB from one prescriber to another does NOT count as a reason unless underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for BB" is NOT acceptable). Documentation referring to eye drops containing BBs <p>98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that patient refused BB medications or all medications is acceptable. Documentation that patient refused BP medications is NOT acceptable.</p> <p>Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay).</p>
49	allerbb	<p>Is there documentation of the beta-blocker allergy/adverse reaction in the allergy box on the CPRS cover sheet?</p> <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95</p> <p>Will be auto-filled as 95 if bbatdc = 1 or nobbatdc < 1</p>	<p>The intent of the question is to determine if the allergy/adverse reaction to the beta-blocker was documented in the allergy package of CPRS.</p>
50	aldantdc	<p>Was an aldosterone antagonist (Examples: spironolactone, eplerenone) prescribed at discharge?</p> <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95</p> <p>If 1, auto-fill noaldant as 95 and allerald as 95 If 2, go to noaldant</p>	<p>Prescribed at discharge: instructed to continue aldosterone antagonist taken at home prior to admission, or taken during the episode of care, or provided a new prescription at discharge.</p> <p>Brand name for spironolactone: Aldactone Brand name for eplerenone: Inspira</p> <p>For a list of aldosterone antagonist medications refer to a drug handbook.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES										
51	noaldant	Does the record document any of the following reasons for not prescribing an aldosterone antagonist at discharge? 1. Allergy, intolerance, or sensitivity 2. Renal insufficiency 3. Hyperkalemia 95. Not applicable 97. Other reason documented by a physician/APN/ PA or pharmacist 98. Patient refusal of aldosterone antagonist documented by physician/APN/PA or pharmacist 99. No documented reason	1, 2, 3, 95, 97, 98, 99 Will be auto-filled as 95 if aldantdc = 1 If <> 1, auto-fill allerald as 95	Notation of aldosterone antagonist allergy or sensitivity is sufficient. Side effects of spironolactone include breast pain and swelling in men, and menstrual irregularities in women. Patient's inability to tolerate one or more such side effects must be documented, if reason for not prescribing or discontinuing drug. Renal insufficiency: acute renal failure; arterionephrosclerosis; azotemia; chronic renal disorder; chronic renal failure (CRF); chronic renal insufficiency; diabetic kidney disease; hemodialysis or peritoneal dialysis Hyperkalemia: serum potassium > 5.5 meq/L that cannot be reduced (not a transient event)										
52	allerald	Is there documentation of the aldosterone antagonist allergy/adverse reaction in the allergy box on the CPRS cover sheet? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if aldantdc = 1 or noaldant <> 1	The intent of the question is to determine if the allergy/adverse reaction to the aldosterone antagonist was documented in the allergy package of CPRS.										
		Enable Medication Reconciliation Module as applicable and if age >= 65 enable Delirium Risk												
		<table><tr><td colspan="2">Joint Commission Appendix A.1: Table 2.1 Codes applicable to Heart Failure:</td></tr><tr><td>402.01</td><td>malignant hypertensive heart disease with heart failure</td></tr><tr><td>402.11</td><td>benign hypertensive heart disease with heart failure</td></tr><tr><td>402.91</td><td>unspecified hypertensive heart disease with heart failure</td></tr><tr><td>404.01</td><td>malignant hypertensive heart and kidney disease with heart</td></tr></table>	Joint Commission Appendix A.1: Table 2.1 Codes applicable to Heart Failure:		402.01	malignant hypertensive heart disease with heart failure	402.11	benign hypertensive heart disease with heart failure	402.91	unspecified hypertensive heart disease with heart failure	404.01	malignant hypertensive heart and kidney disease with heart		
Joint Commission Appendix A.1: Table 2.1 Codes applicable to Heart Failure:														
402.01	malignant hypertensive heart disease with heart failure													
402.11	benign hypertensive heart disease with heart failure													
402.91	unspecified hypertensive heart disease with heart failure													
404.01	malignant hypertensive heart and kidney disease with heart													

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		failure		
		404.03 malignant hypertensive heart and kidney disease with congestive heart failure and renal failure		
		404.11 benign hypertensive heart and kidney disease with heart failure		
		404.13 benign hypertensive heart and kidney disease with congestive heart failure and renal failure		
		404.91 hypertensive heart and kidney disease with congestive heart failure, unspecified		
		404.93 hypertensive heart and kidney disease with congestive heart failure and renal failure, unspecified		
		428.0 heart failure		
		428.1 left heart failure		
		428.20 unspecified systolic heart failure		
		428.21 acute systolic heart failure		
		428.22 chronic systolic heart failure		
		428.23 acute on chronic systolic heart failure		
		428.30 unspecified diastolic heart failure		
		428.31 acute diastolic heart failure		
		428.32 chronic diastolic heart failure		

VHA EXTERNAL PEER REVIEW PROGRAM
HEART FAILURE INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		428.33 acute on chronic diastolic heart failure		
		428.40 unspecified combined systolic and diastolic heart failure		
		428.41 acute combined systolic and diastolic heart failure		
		428.42 chronic combined systolic and diastolic heart failure		
		428.43 acute on chronic combined systolic and diastolic heart failure		
		428.9 heart failure, unspecified		