Pioneers in Quality

Performance Measurement Update to Advanced Certification in Heart Failure (ACHF)

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December 2024 release

The Joint Commission

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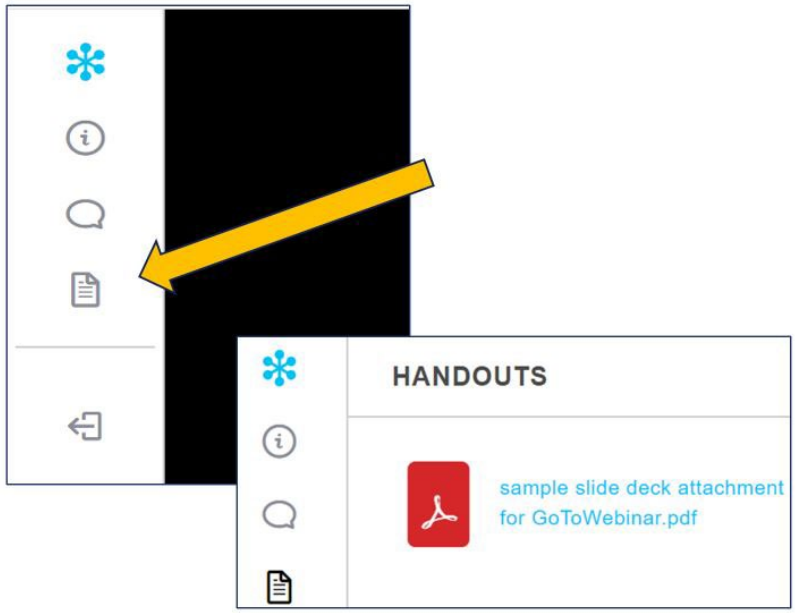

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- A follow-up email from the survey platform also provides the link to the CE certificate.

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Participant Learning Objectives

- Describe the intent and logic underlying the updated ACHF measure set.
- Utilize the information provided to understand clinical significance of new required GWTG-HF measures and answer questions to inform measure use/implementation.
- Facilitate your organization's implementation of the ACHF measure specifications.

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Disclosure Statement

These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

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Welcome & Introduction

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ACHF Performance Measurement

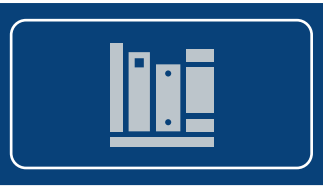
Overview of ACHF measurement update effective January 1, 2025

December 2024

The Joint Commission

Setting the Stage – Measure Development

Identify opportunities to update current requirements



Literature review for updated clinical practice guidelines and best practices

Collect feedback on proposed measures via public comment

Technical advisory panel input and consensus

Finalize collaboration with GWTG-HF

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New Performance Measures

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Measure Name	Rationale for Inclusion
AHAHF106 Defect-free Care for Quadruple Therapy Medication for Patients with HFrEF	• 2022 Clinical Practice Guidelines support with high level of evidence and Class 1 recommendation • Defect-free is more inclusive
AHA94 SGLT-2 inhibitor Prescribed at Discharge for Patients with HFpEF/HFmrEF	• 2022 Clinical Practice Guidelines support with moderate level of evidence and Class 2a recommendation • New patient population

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American Heart Association®
Get With The Guidelines®
Heart Failure

American Heart Association®

Get With The Guidelines – Heart Failure

Translating guidelines into practice

GWTG: Closing the Gaps Between Evidence, Guidelines, Implementation, and Equity

Get With The Guidelines (GWTG) is a proven in-hospital approach for improving patient outcomes in cardiovascular and stroke areas. GWTG promotes consistent adherence to the latest research-driven guidelines and provides data and information to professionals for continual improvement in patient care.

American Heart Association®
Get With The Guidelines®
Heart Failure

American Heart Association®
Get With The Guidelines®
Coronary Artery Disease

American Heart Association®
Get With The Guidelines®
Resuscitation

American Heart Association®
Get With The Guidelines®
Stroke

American Heart Association®
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AFib

American Heart Association®
Get With The Guidelines®
Heart Failure

by the #s

617 hospitals participating in 2024

118 measures covered and available in the registry

2.9 million patient records collected

173 total publications

10 publications in 2024

Over 1,000 GWTG – HF awards given in 2024

GWTG-HF

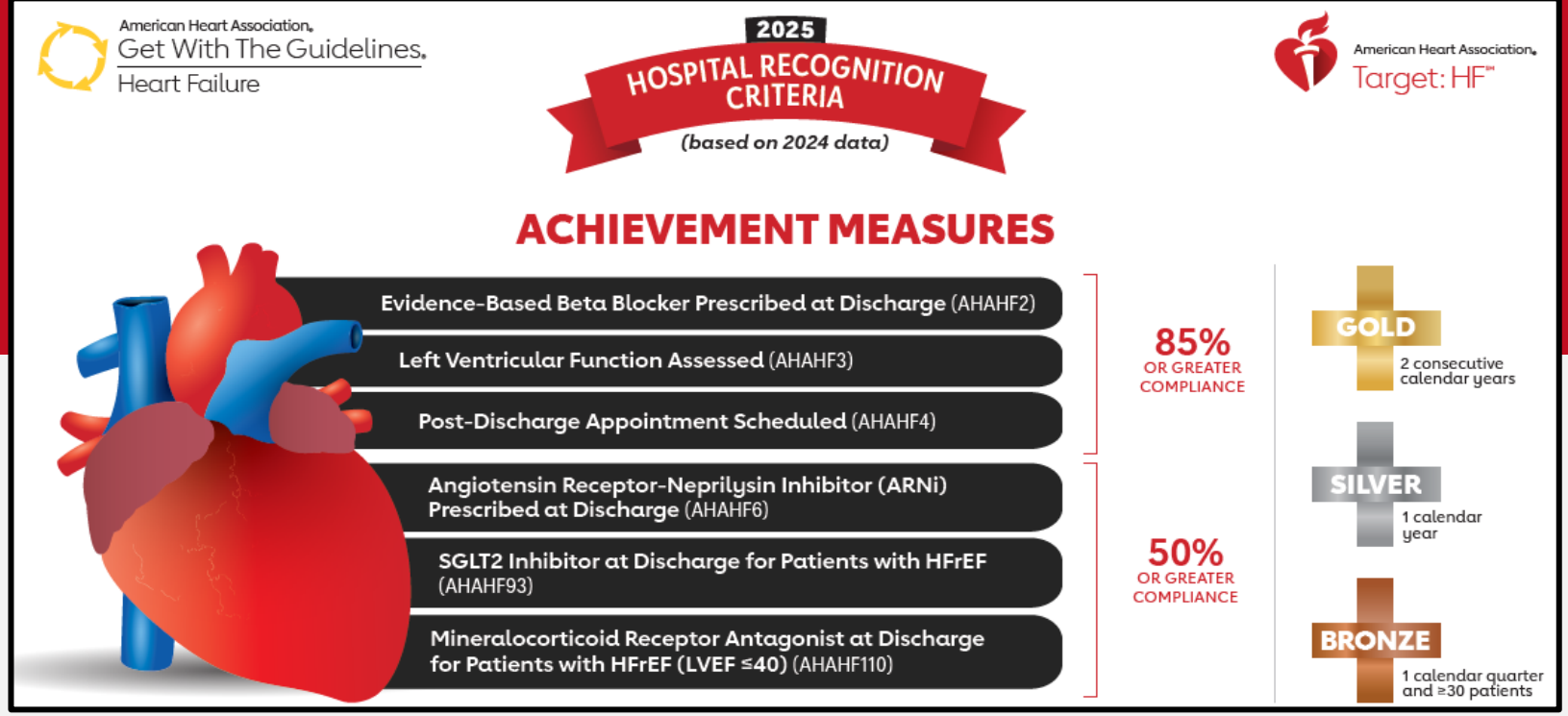
American Heart Association®
Get With The Guidelines®
Heart Failure

Get With The Guidelines®- Heart Failure is the American Heart Association's collaborative quality improvement program demonstrated to **improve adherence to evidence-based care of patients hospitalized with heart failure**. The program provides hospitals with the web-based IQVIA Registry Platform (trademarked), decision support, robust registry, real-time benchmarking, and other performance improvement methodologies toward the goal of **enhancing patient outcomes and saving lives**.

Why GWTG - HF?

- **31% of HF patients** will be readmitted within 90 days
- **Fewer than 1 in 10 patients** are discharged on **quadruple therapy**
- **Poor transitions of care** and **suboptimal post-acute** care negatively impact patients
- **Social determinants of health (SDOH) data collection decreases disparities** at GWTG hospitals

GET WITH THE GUIDELINES



Quality Measures: Plus award: ≥75% on ≥ 4 measures

- AHAHF1: ACEI/ARBs or ARNI at Discharge
- AHAHF7: Anticoagulation for Atrial Fibrillation or Atrial Flutter
- AHAHF8: CRT-D or CRT-P Placed or Prescribed at Discharge
- AHAHF9: DVT Prophylaxis
- AHAHF10: Follow-up Visit Within 7 Days or Less
- AHAHF11: Hydralazine Nitrate at Discharge
- AHAHF12: ICD counseling or ICD placed or prescribed at discharge
- AHAHF13: Influenza Vaccination During Flu Season
- AHAHF91: Lab Monitoring Follow-Up
- AHAHF14: Pneumococcal Vaccination
- AHAHF106: Defect-Free Care for Quadruple Therapy for Patients With HFrEF
- AHAHF109: DOAC at Discharge for HF w/ Non-Valvular Afib or Aflutter
- AHAHF94: SGLT-2 Inhibitor at Discharge for Patients with HFpEF/HFmrEF

Target: HF

- AHAHF1: ACEI/ARBs or ARNI at Discharge
- AHAHF2: Evidence-Based Specific Beta Blockers
- AHAHF10: Follow-up Visit Within 7 Days or Less
- AHA15: Referral to HF Disease Management, 60 Minutes Pt Education, HF Interactive Workbook, or Referral to Outpatient Cardiac Rehab
- AHAHF110: MRA at Discharge for Patients with HFrEF

Target: HF Optimal; above, plus

- AHAHF106: Defect-Free Care for Quad Therapy for Patients w/ HFrEF

ACHF Measures Reports in GWTG

Operational Reports

Configurable Reports

Get With The Guidelines®-HF Measures Report

This report provides the ability to configure your own measures report. It also provides the ability to view your pre-defined reports.

- ACHF Measures
  - ACHF-01
  - ACHF-02
  - ACHF-03
  - ACHF-04
  - ACHF-05
  - ACHF-06

Updating 12/2024

Filters:

Standard Fields (non-Multiselect): Save Filters

Multiselect Fields (Standard and Custom):

Custom Fields (Single Select):

Provider/NPI:

Benchmarks:

- [x] My Hospital
- [ ] All Hospitals
- [ ] 300+ Discharges
- [ ] Academic Hospitals
- [ ] Certified AHA/TJC ACHF Hospitals
- [ ] Interventional Hospitals
- [ ] Middle Atlantic
- [ ] Middle Atlantic Hospitals
- [ ] New York
- [ ] Non-Transplant Hospitals
- [ ] Northeast
- [ ] Northeast Hospitals

Library

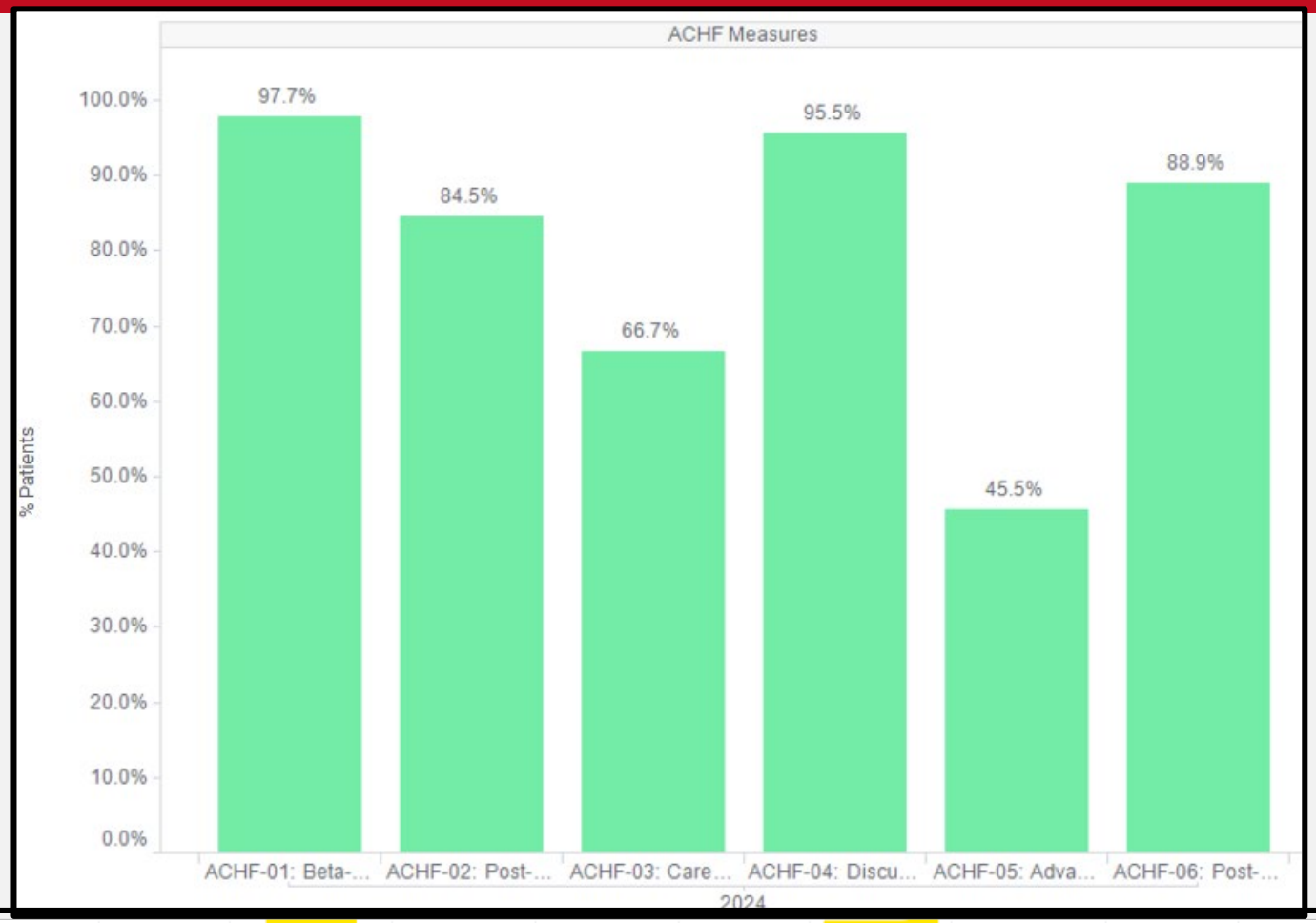
Reports & Measures

- GWTG-HF Achievement Measures
- GWTG-HF Quality Measures
- GWTG-HF Reporting Measures
- GWTG-HF Risk-Adjusted Mortality Ratio Measure
- GWTG-HF Descriptive Measures
- GWTG-HF Diabetes Measures
- GWTG-HF Data Quality Measures
- GWTG-HF Target: Heart Failure Honor Roll Measures
- GWTG-HF Composite Measures
- GWTG-HF KDBH CKD HF Inpatient Measures
- GWTG-HF 30 Day Post Acute Care Measures
- GWTG-HF BPCI Measures
- Specifications Manual for Joint Commission National Quality Measures
- GWTG-HF On-Demand Trend Report Measure Bundle Key
- GWTG-HF Implement-HF Measures (includes Descriptive and Reporting Measures)
- GWTG-HF Defect Free and Target HF Measure Descriptions

Case Report Forms (eCRF)

- GWTG-HF Full CRF
- ~~GWTG-HF Limited CRF~~
- GWTG-HF Full + ACHF CRF
- ~~GWTG-HF Limited + ACHF CRF~~
- 30 Day Follow-up CRF
- Implement-HF 30 Day Follow-up CRF
- GWTG-HF Middle East CRF
- GWTG-HF Cardio-Oncology Full CRF
- GWTG-HF Cardio-Oncology Limited CRF

Report Details & CMIP Data



Measure	Time Period	Patients Included	Patients Excluded	Exclusion (R)	Exclusion (P)	Numerator (E)	Denominator (D)	Exclusion (B)	Exclusion (X)	% Patients
ACHF-01: Beta-Blocker Therapy (i.e. Bisoprolol, Carvedilol, or Sustained-Release ...	2024 Q1	1440	51424	47161	83	1382	58	3172	1091	96.0%
	2024 Q2	1503	47743	43705	95	1449	54	3228	810	96.4%
	2024 Q3	1378	40749	37050	185	1316	62	2918	781	95.5%
	2024 Q4	432	14232	12774	50	417	15	1001	457	96.5%

heart.org/quality

JOHNS HOPKINS
MEDICINE

Optimizing Heart Failure Care with Guideline-Directed Therapies

with the American Heart Association and The Joint Commission

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Advanced Heart Failure & Transplant Cardiology
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Disclosures: None

Agenda

1. Review clinical practice updates issued by the 2022 AHA/ACC/HFSA Heart Failure Guidelines and recent clinical trial and Expert Consensus Pathway updates for HFrEF, HFmrEF, and HFpEF.
   a. Evolution of Quad-based therapy for heart failure with reduced EF
   b. GDMT for HFpEF, HFmrEF
2. Review value-based assertions of heart failure GDMT
3. Consider the role of the HF System of Care.

Heidenreich P. AHA/ACC/HFSA Guideline for the Management of Heart Failure. *Circulation* 2022
Maddox T. ACC Expert Consensus Pathway. *JACC* 2024

6.7 million U.S. adults have heart failure

- 2030 projection: 8.5 million
- **379,800** death certificates

$30.7 billion a year (2012)

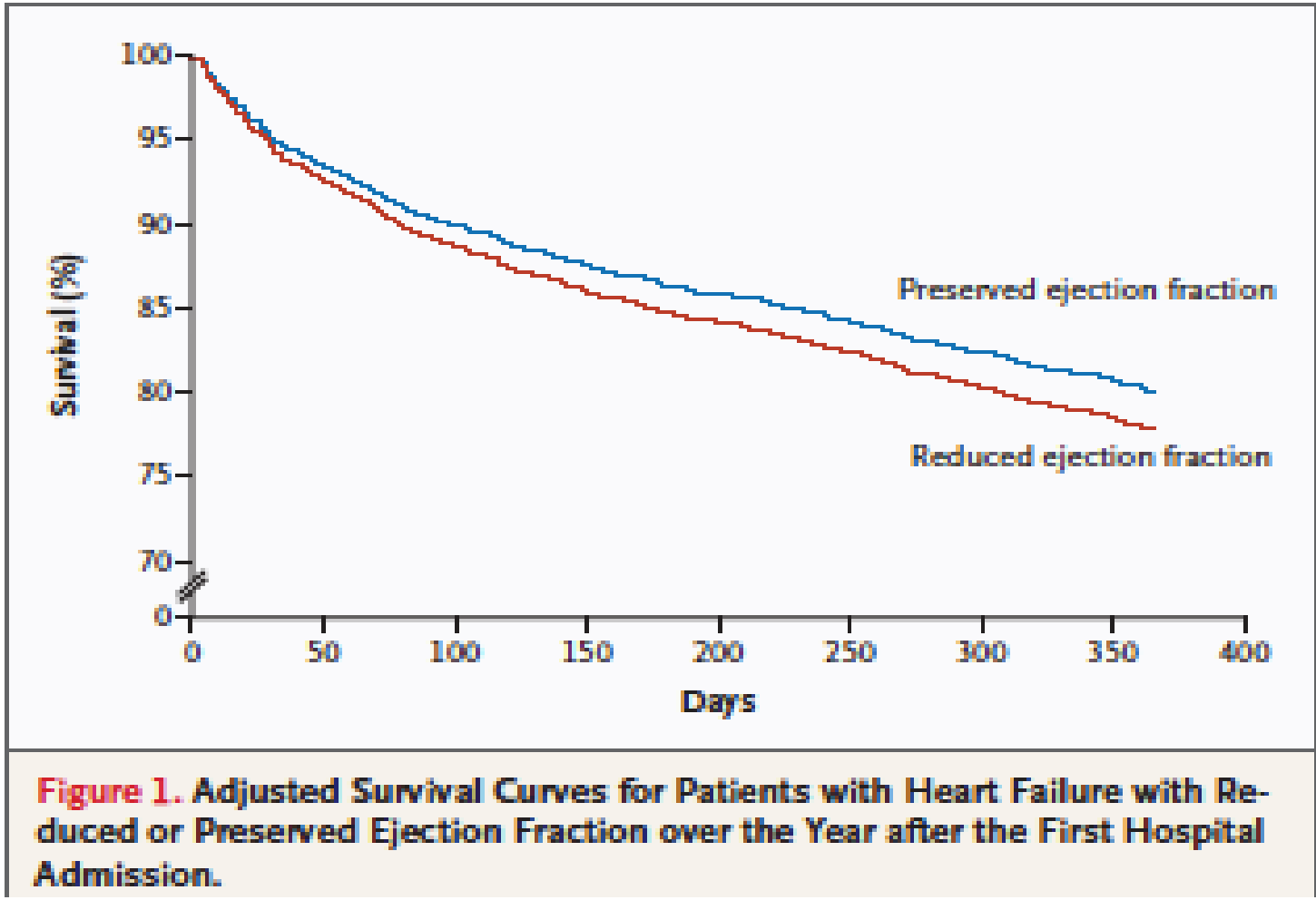
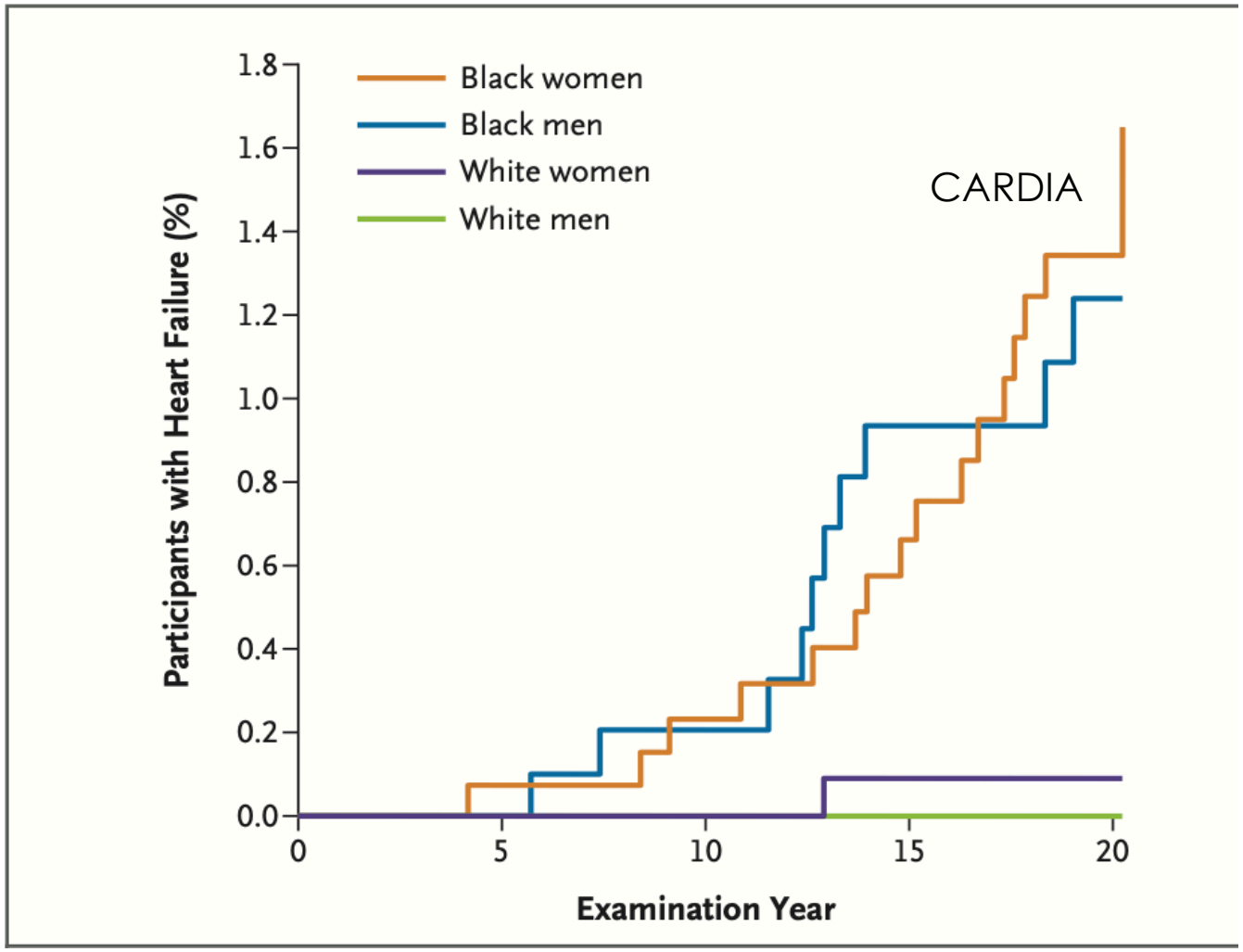


Figure 1. Adjusted Survival Curves for Patients with Heart Failure with Reduced or Preserved Ejection Fraction over the Year after the First Hospital Admission.

Bhatia N Engl J Med 2006, Heidenreich Circulation 2022
Gianluigi Savarese, Peter Moritz Becher, Lars H Lund, Petar Seferovic, Giuseppe M C Rosano, Andrew J S Coats, Global burden of heart failure: a comprehensive and updated review of epidemiology, *Cardiovascular Research*,, https://doi.org/10.1093/cvr/cvac013

Disparate early HF burden in BIPOC

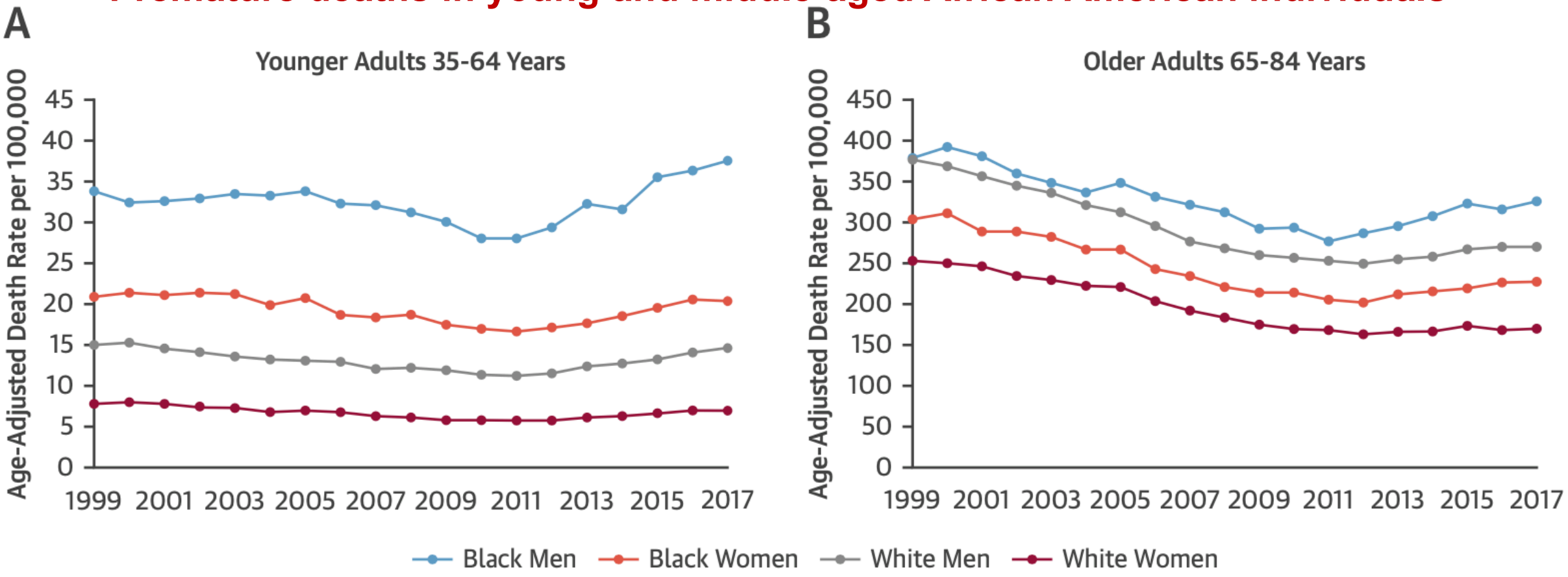


20x ↑ incident HF among Black men and women compared to White men and women before age 50.

Bibbins-Domingo K, et al. *N Engl J Med* 2009

FIGURE 1 Age-Adjusted HF-Related CVD Mortality Rates in the United States, 1999 to 2017

Premature deaths in young and middle-aged African American individuals



Death rates per 100,000 are shown for younger and older adults by sex and race. CVD = cardiovascular disease; HF = heart failure.

Glynn et al J Am Coll Cardiol 2019

2022 HF Guidelines Overview

- A Common Framework to Improve Care
  - Staging and Severity: New emphasis on primary prevention of HF
  - Universal Classification by LVEF and Common Diagnostics/ Diagnostic Aids (HFpEF*)
- The "-rEF to –pEF" spectrum of HF medical therapies
  - Quadruple-Based GDMT for HFrEF; New GDMT Arsenal for HFpEF and HFmrEF
- Minimize Interruptions in GDMT
- Address Social Determinants of Health & HF Disparities
- *Value-Based* Assertions regarding HF Therapeutics
- Addressing Goals of Care & Timely Referral for Advanced Therapies
- Considerations in Special Populations* & the Need of Multi-Disciplinary Care:
  - HF in Pregnancy; Recognition and Rx of Cardiac Amyloidosis
- Treat the whole patient: co-morbidity management

Heidenreich P. et al. *Circulation.* 2022

Common Language of Severity & Progression

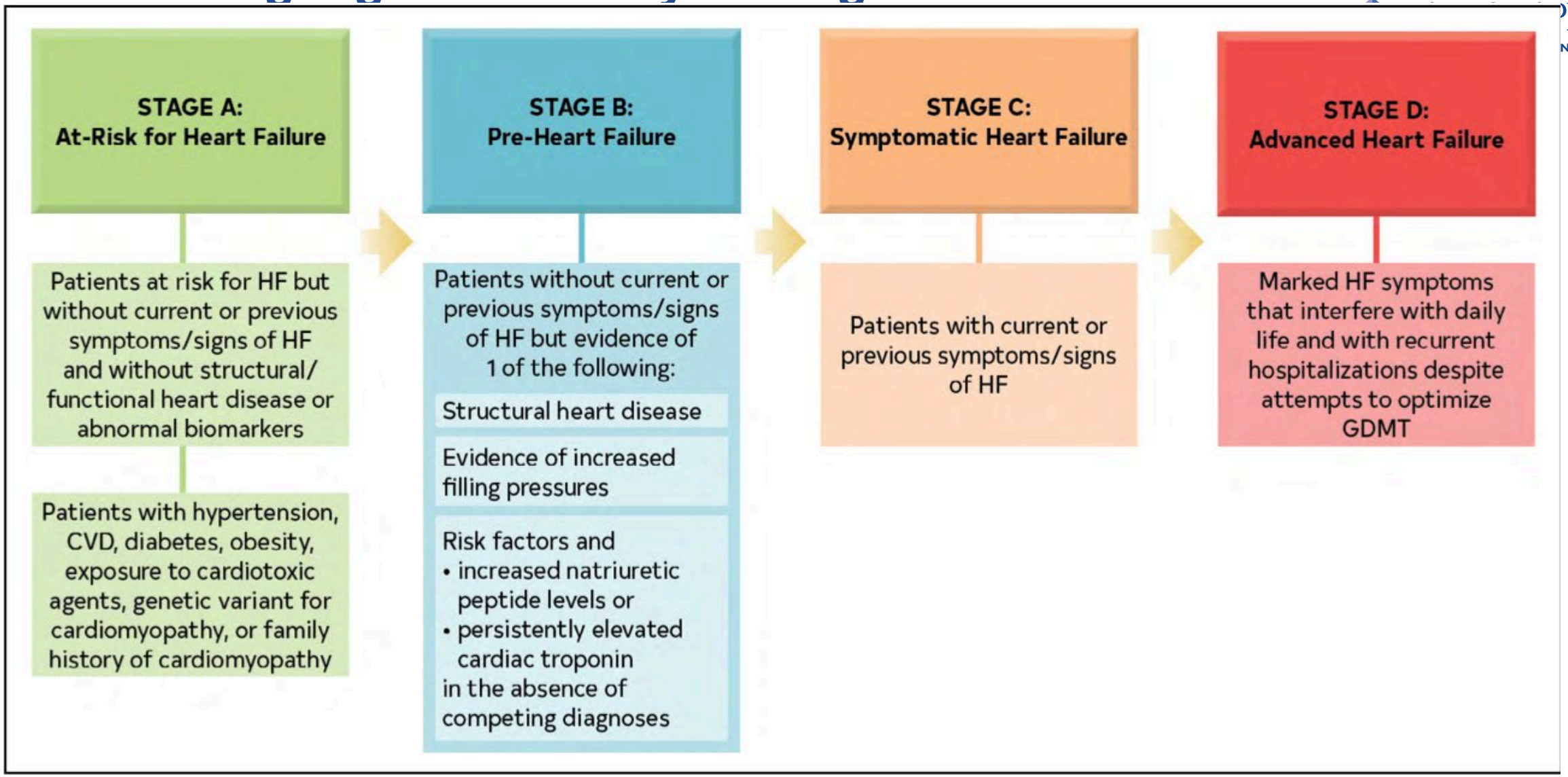


Figure 1. ACC/AHA Stages of HF.

Heidenreich P. et al. *Circulation.* 2022

Common Classification Language

LVEF > 40% requires evidence of increased filling pressures:

- invasive (hemodynamics)
- noninvasive (diastolic function on imaging)
- natriuretic peptides

Type of HF According to LVEF	Criteria
HFrEF (HF with reduced EF)	LVEF ≤40%
HFimpEF (HF with improved EF)	Previous LVEF ≤40% and a follow-up measurement of LVEF >40%
HFmrEF (HF with mildly reduced EF)	LVEF 41%–49% Evidence of spontaneous or provokable increased LV filling pressures (eg, elevated natriuretic peptide, noninvasive and invasive hemodynamic measurement)
HFpEF (HF with preserved EF) **H_2FPEF Score**	LVEF ≥50% Evidence of spontaneous or provokable increased LV filling pressures (eg, elevated natriuretic peptide, noninvasive and invasive hemodynamic measurement)

Heidenreich et al. *Circulation* 2022

Foundational Pillars of GDMT

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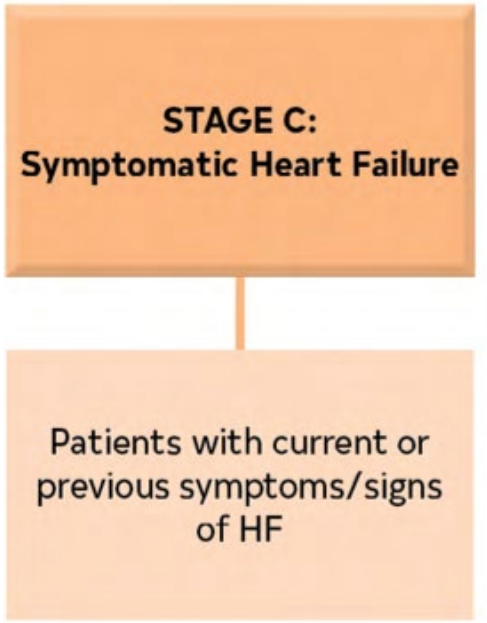
‘New Standard’
Quadruple Therapy

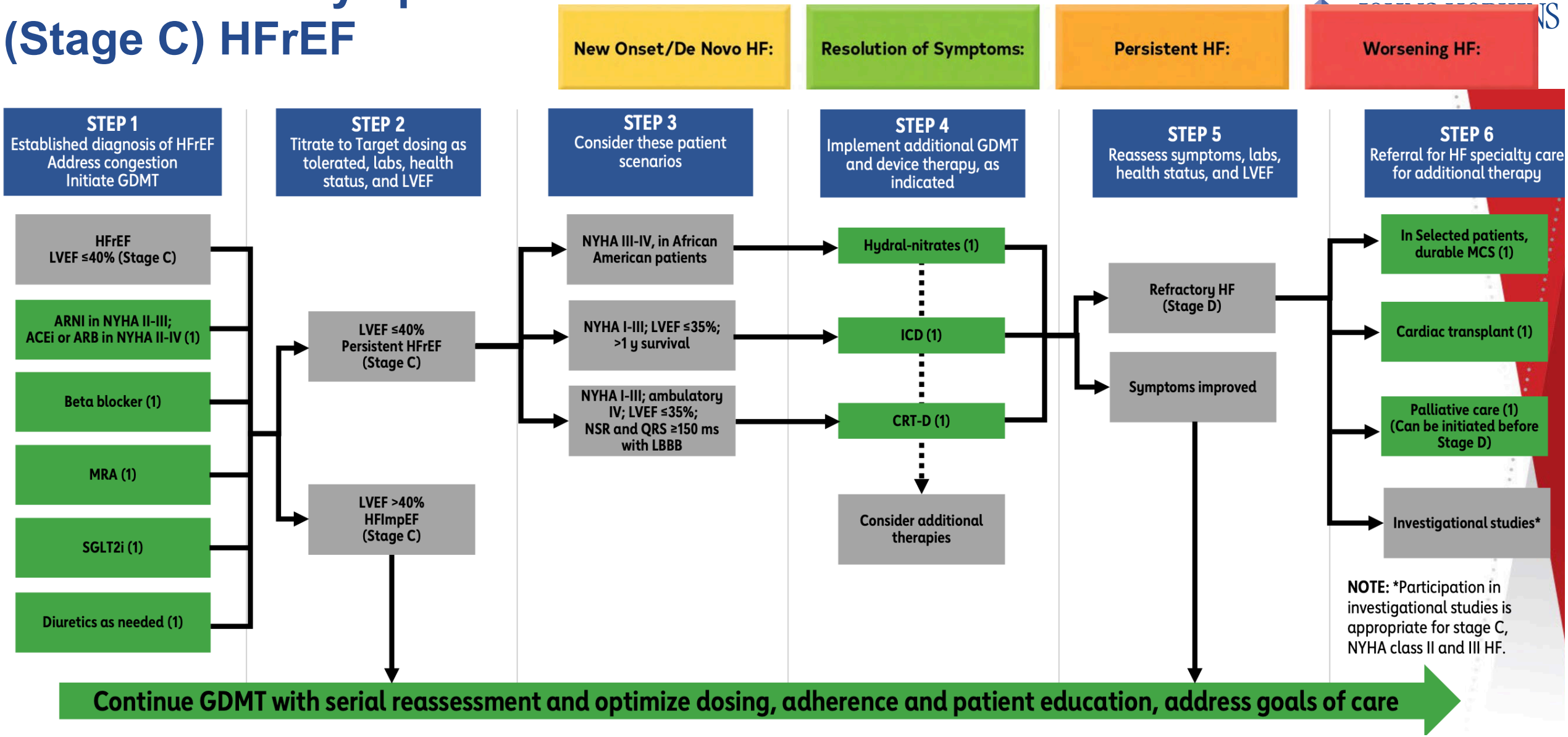
RAAS Antagonist	Beta Blockers	MRA	SGLT2i
ARNI 1. Sacubitril/ valsartan 2. ACE-I 3. ARB	**(3)** Carvedilol Metoprolol succinate Bisoprolol	Eplerenone Spironolactone	Dapagliflozin Empagliflozin (+/- Diabetes) Sotagliflozin

RR ↓ 72.9%
AR ↓ 25.5%
NNT 3.9
24 months

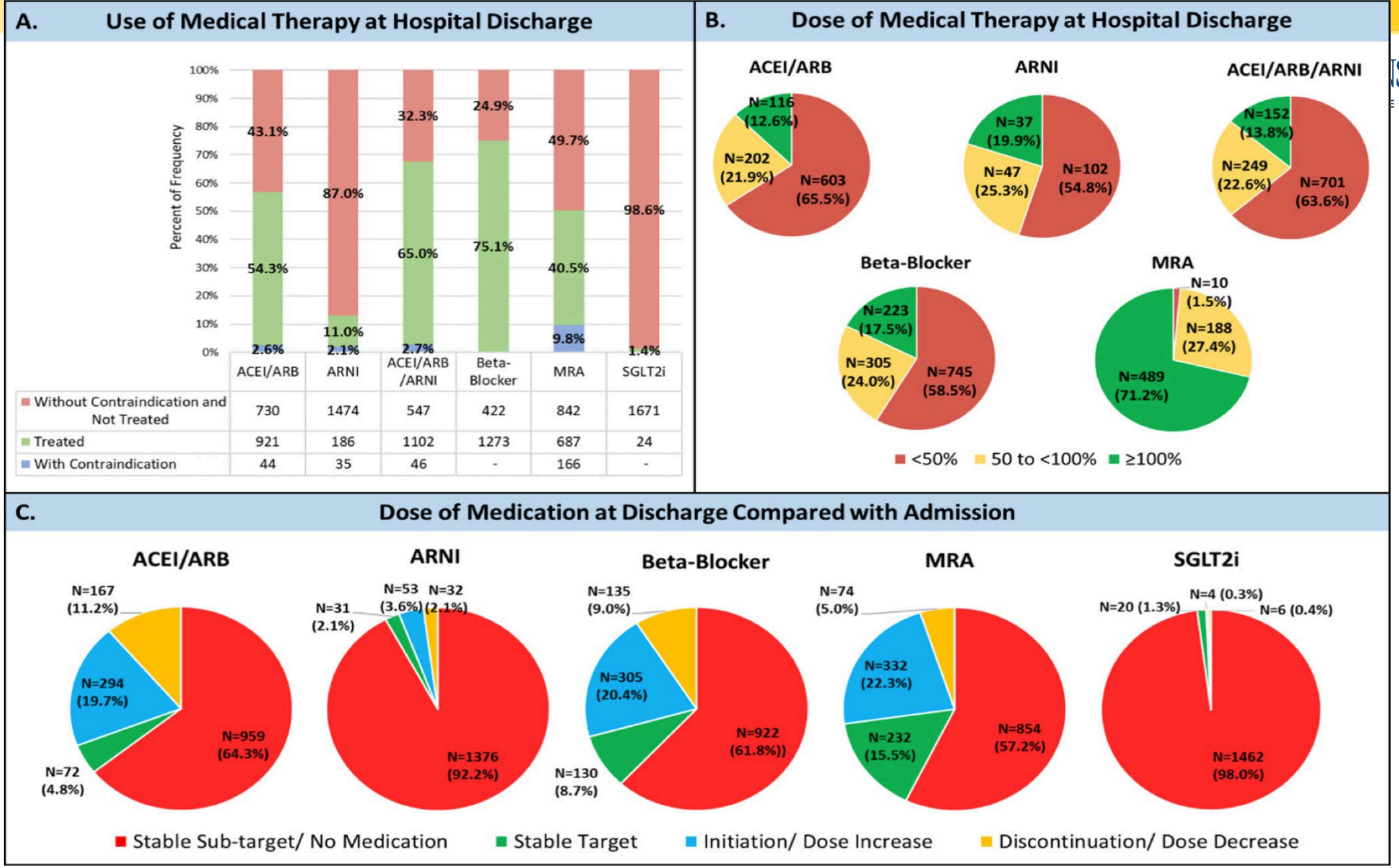


Bassi N JAMA Cardiol 2020
Adapted from Fonarow, G

Patients with Symptomatic (Stage C) HFrEF



Heidenreich et al. Circulation 2022



Greene SJ, et al. *J Card Fail*. 2022;28(7):1063-1077

Newly Diagnosed Hospitalized HFrEF Patients are Eligible for Quad-GDMT

FIGURE 1 Eligibility for Guideline-Directed Medical Therapy Among Patients With Newly Diagnosed Heart Failure With Reduced Ejection Fraction

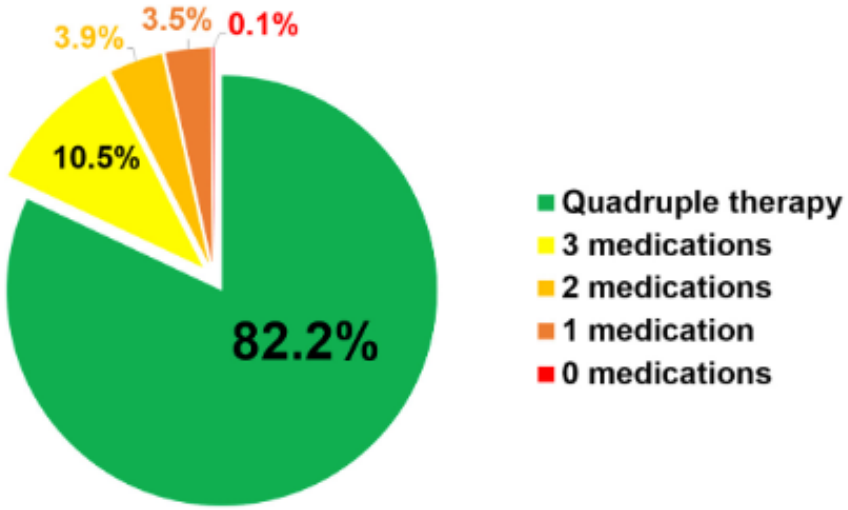


TABLE 2 Discharge Medications by Medication Eligibility Group for Patients Hospitalized From January 2021 to June 2023

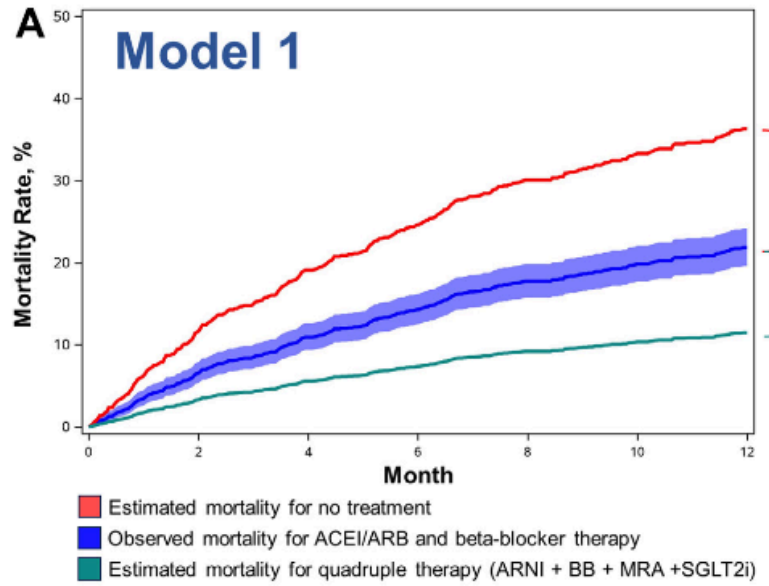
	Overall (N = 14,303)	Eligible for Quadruple Therapy (n = 11,826)	Eligible for Any 3 Medications (n = 1,452)	Eligible for Any 2 Medications (n = 543)	Eligible for 1 or 0 Medications (n = 482)
Proportion of overall population, %	–	82.7	10.2	3.8	3.4
ARNI	3,938 (27.7)	3,694 (31.5)	152 (10.5)	40 (7.4)	52 (10.9)
ACEI/ARB	6,900 (48.3)	6,235 (52.8)	380 (26.2)	97 (17.9)	188 (39.2)
ACEI/ARB/ARNI	10,838 (75.8)	9,929 (84.0)	532 (36.6)	137 (25.3)	240 (49.9)
Beta-blocker	13,181 (92.2)	11,081 (93.7)	1,201 (82.7)	479 (88.4)	420 (87.3)
MRA	5,854 (41.0)	5,495 (46.5)	292 (20.1)	44 (8.1)	23 (4.8)
SGLT2i	3,045 (23.5)	2,792 (26.1)	224 (17.0)	>18 (>3.7)[a]	<11 (<2.5)[a]
Triple therapy (ACEI/ARB/ARNI + BB + MRA)	5,037 (35.2)	4,910 (41.5)	91 (6.3)	20 (3.7)	16 (3.3)
Quadruple therapy (ACEI/ARB/ARNI + BB + MRA + SGLT2i)	1,676 (13.0)	1,636 (15.3)	>18 (>1.4)[a]	<11 (<2.3)[a]	<11 (<2.5)[a]

Values are n (%) among patients with available data. [a]Value is suppressed in accordance with American Heart Association suppression policy for cells with N <11.
Abbreviations as in Table 1.

Greene SJ et al JACC Heart Failure 2024

Projected Benefit of Quad-GDMT at discharge on 12-month mortality

FIGURE 3 Estimated Effects of Suboptimal vs Quadruple Medical Therapy on 12-Month Mortality



Estimated effects of GDMT on 12-month mortality

Absolute risk difference for **no GDMT** versus **ACEI/ARB and beta-blocker**:

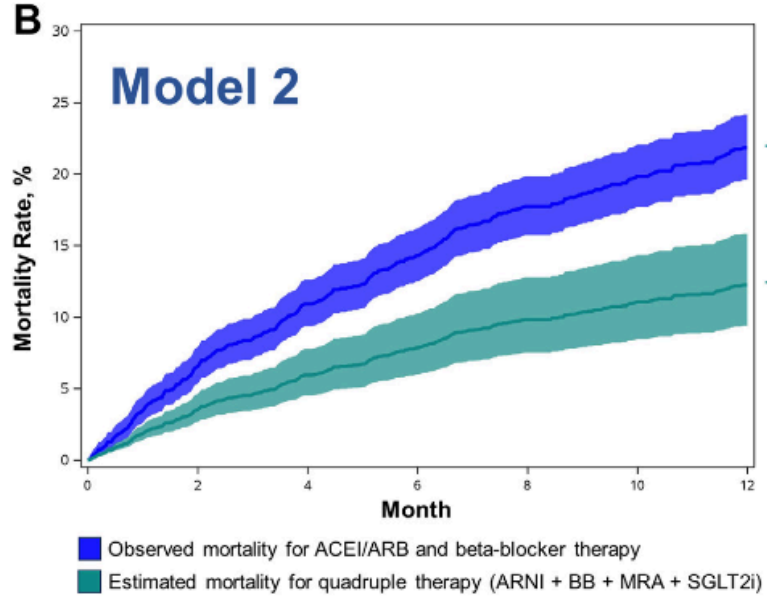
14.5%

Absolute risk difference for **quadruple therapy** versus **ACEI/ARB and beta-blocker**:

10.4%

Absolute risk difference for **quadruple therapy** versus **no GDMT:**

24.8%



Estimated effects of GDMT on 12-month mortality

Absolute risk difference for **quadruple therapy** versus **ACEI/ARB and beta-blocker:**

9.6%
(95% CI 5.6-12.5%)

Greene SJ et al JACC Heart Failure 2024

Clinical Benefit Occurs Early After GDMT Initiation

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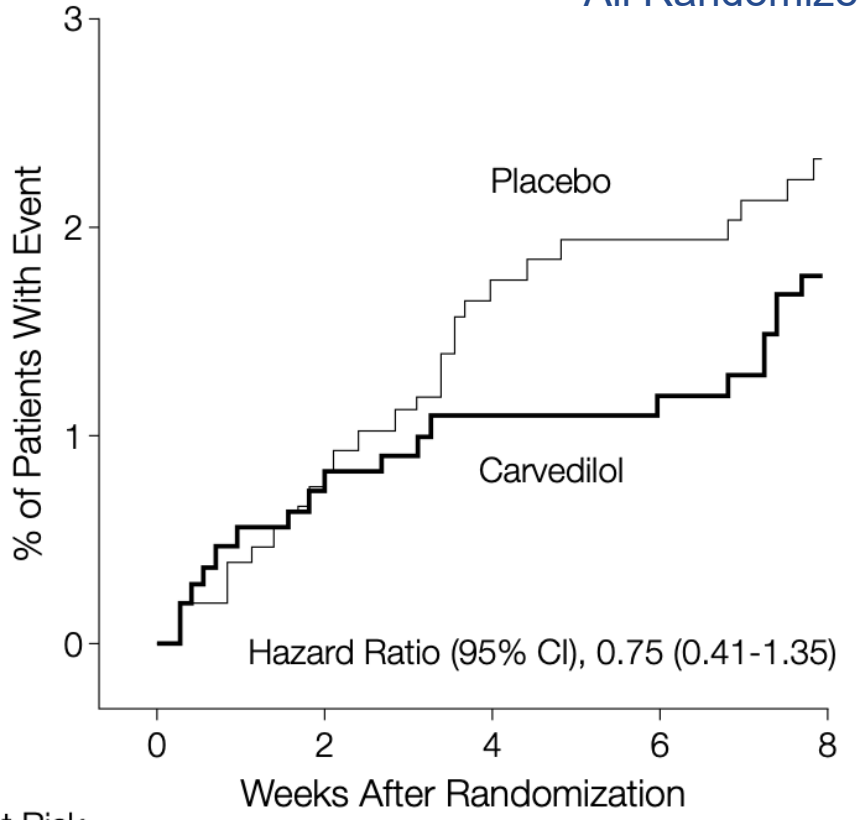
All-Cause Mortality

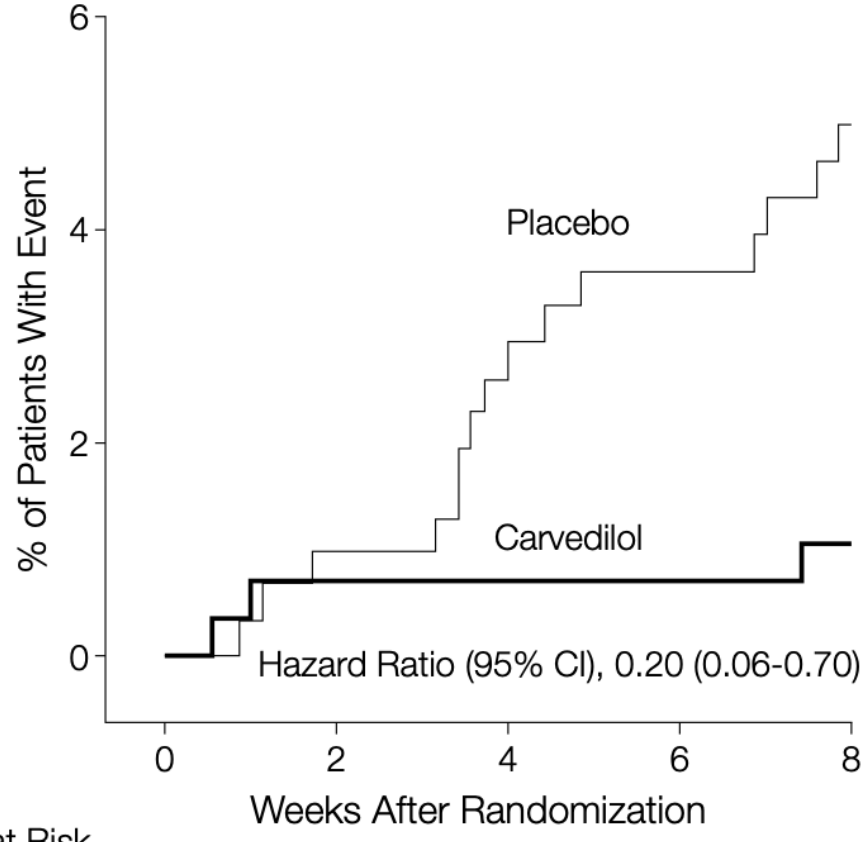
All Randomized Patients



No. at Risk					
Placebo	1133	1100	1054	1023	986
Carvedilol	1156	1119	1079	1048	1009

All-Cause Mortality

High-Risk Patients



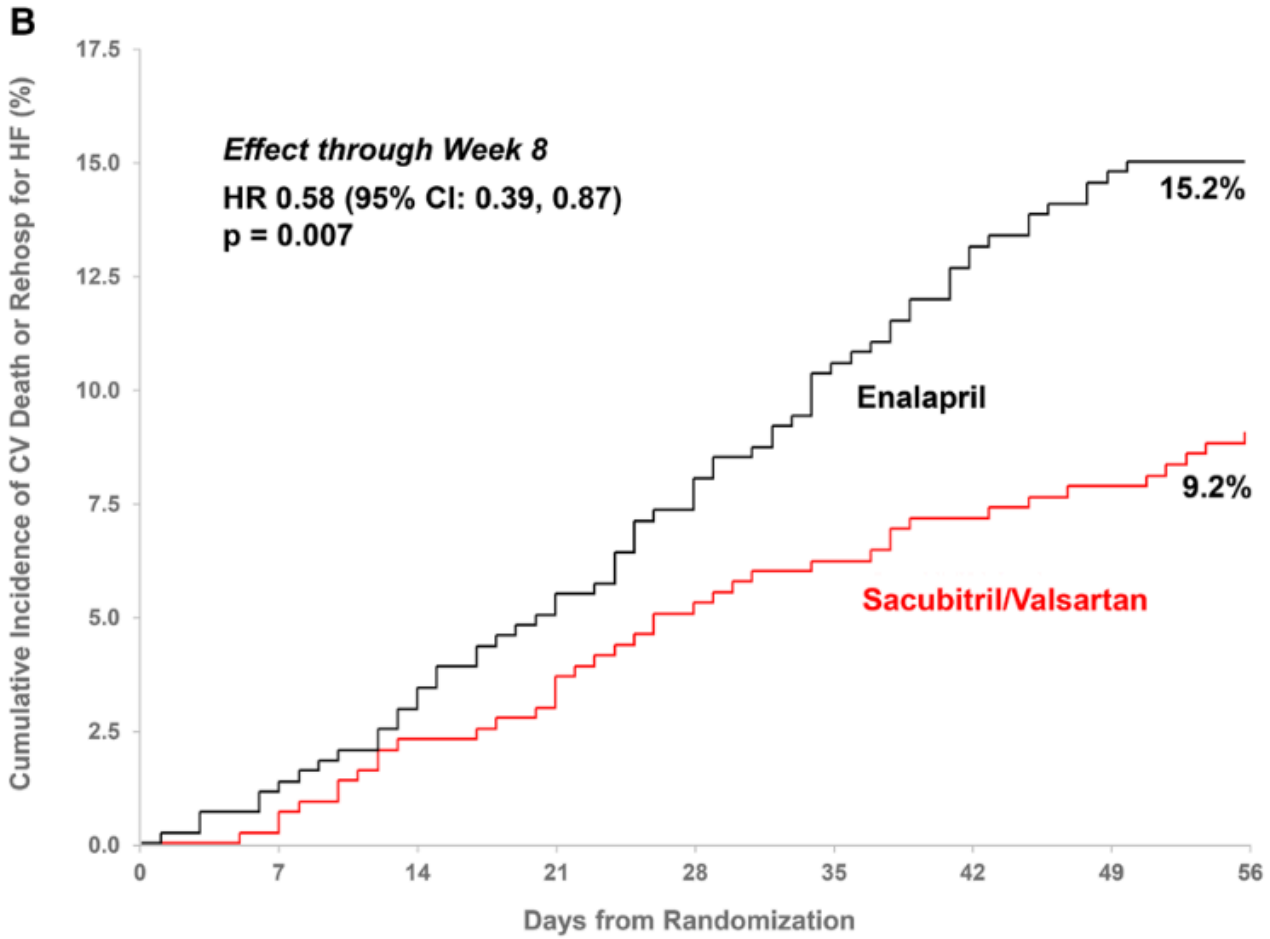
No. at Risk					
Placebo	316	309	295	281	270
Carvedilol	308	299	290	282	268

COPERNICUS: Carvedilol

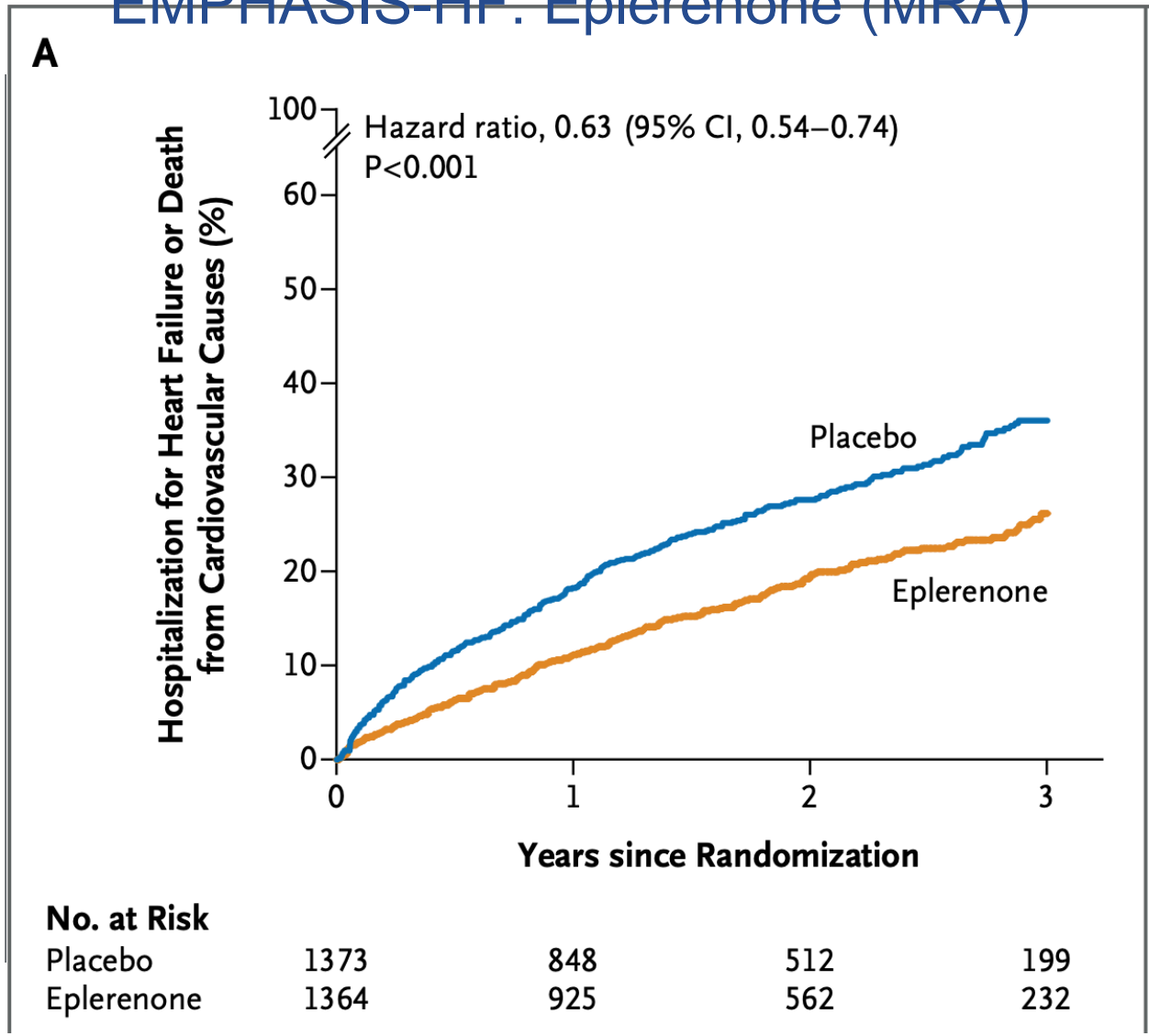
Krum H, et al. *JAMA*. 2003;289(6):712-718

Clinical Benefit Occurs Early After GDMT Initiation

PIONEER-HF: Sacubitril/Valsartan (ARNI)



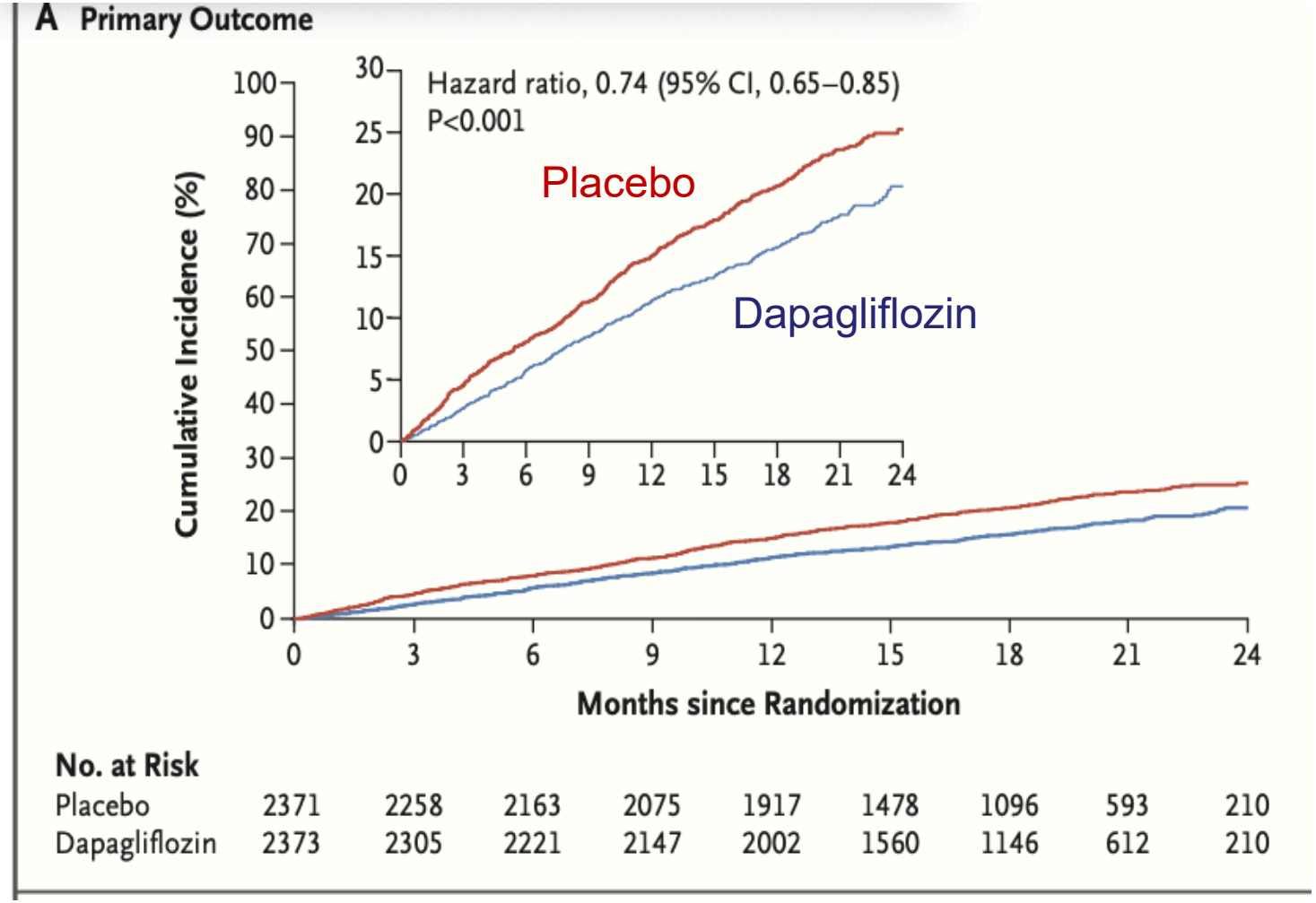
EMPHASIS-HF: Eplerenone (MRA)



Zannad F, et al. *N Engl J Med*. 2011;364(1):11-21
Morrow DA, et al. *Circulation*. 2019;139(19):2285-2288

Clinical Benefit Occurs Early After GDMT Initiation

DAPA-HF: Dapagliflozin



1' Endpoint:
Absolute Risk Reduction (Overall) 4.9%

Beneficial with or without diabetes mellitus

In stage C HFrEF, SGLT2i is recommended to reduce hospitalization and cardiovascular mortality, regardless of the presence of type 2 diabetes
(Class of Recommendation 1a)

McMuray J N Engl J Med 2019;381:1995-2008

STRONG-HF: Initiation & Titration of GDMT

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Figure. Simultaneous or Rapid Sequence Initiation of Comprehensive Disease-Modifying Medical Therapy (CDMMT) for Heart Failure

Early relative risk reduction			Initiation and optimization of medication dosing				
Outcomes	**Change, %**	**CDMMT**	**Day 1**	**Days 7-14**	**Days 14-28**	**Days 21-42**	**After day 42**
CV death or HF hospitalization	-42	ARNI	Initiate at low dose	Continue	Titrate, as tolerated	Titrate, as tolerated	Maintenance or additional titration of the 4 foundational therapies
Death	-25	β-Blocker	Initiate at low dose	Titrate, as tolerated	Titrate, as tolerated	Titrate, as tolerated	Consideration of EP device therapies or transcatheter mitral valve repair
CV death or HF hospitalization	-37	MRA	Initiate at low dose	Continue	Titrate, as tolerated	Continue	Consideration of add-on medications or advanced therapies, if refractory
Death, HF hospitalization,or emergency/ urgent visit for worsening HF	-58	SGLT2i	Initiate	Continue	Continue	Continue	Manage comorbidities

	High-intensity care group (n=542)	Usual care group (n=536)	Adjusted treatment effect (95% CI)	Adjusted risk ratio (95% CI)	p value
Primary endpoint					
All-cause death or heart failure readmission by day 180*	74/506 (15·2%)	109/502 (23·3%)	8·1 (2·9 to 13·2)	0·66 (0·50 to 0·86)	0·0021

Packer & McMurray, *Eur J HF* 2021, Greene S et al, JAMA Cardiol 2021, Khan MS, Butler J, Greene SJ. *Eur J Heart Fail* 2021, Mebazaa A et al. Lancet 2022

Conventional Sequencing

Step 1 — ACE inhibitor or angiotensin receptor blocker

2 — Beta-blocker

3 — Mineralocorticoid receptor antagonist

4 — Angiotensin receptor neprilysin inhibitor

5 — SGLT2 inhibitor

Uptitration to target doses at each step

Typically requires 6 months or more

Rapid Sequencing

Step 1 — Beta-blocker + SGLT2 inhibitor

Step 2 — Angiotensin receptor neprilysin inhibitor

Step 3 — Mineralocorticoid receptor antagonist

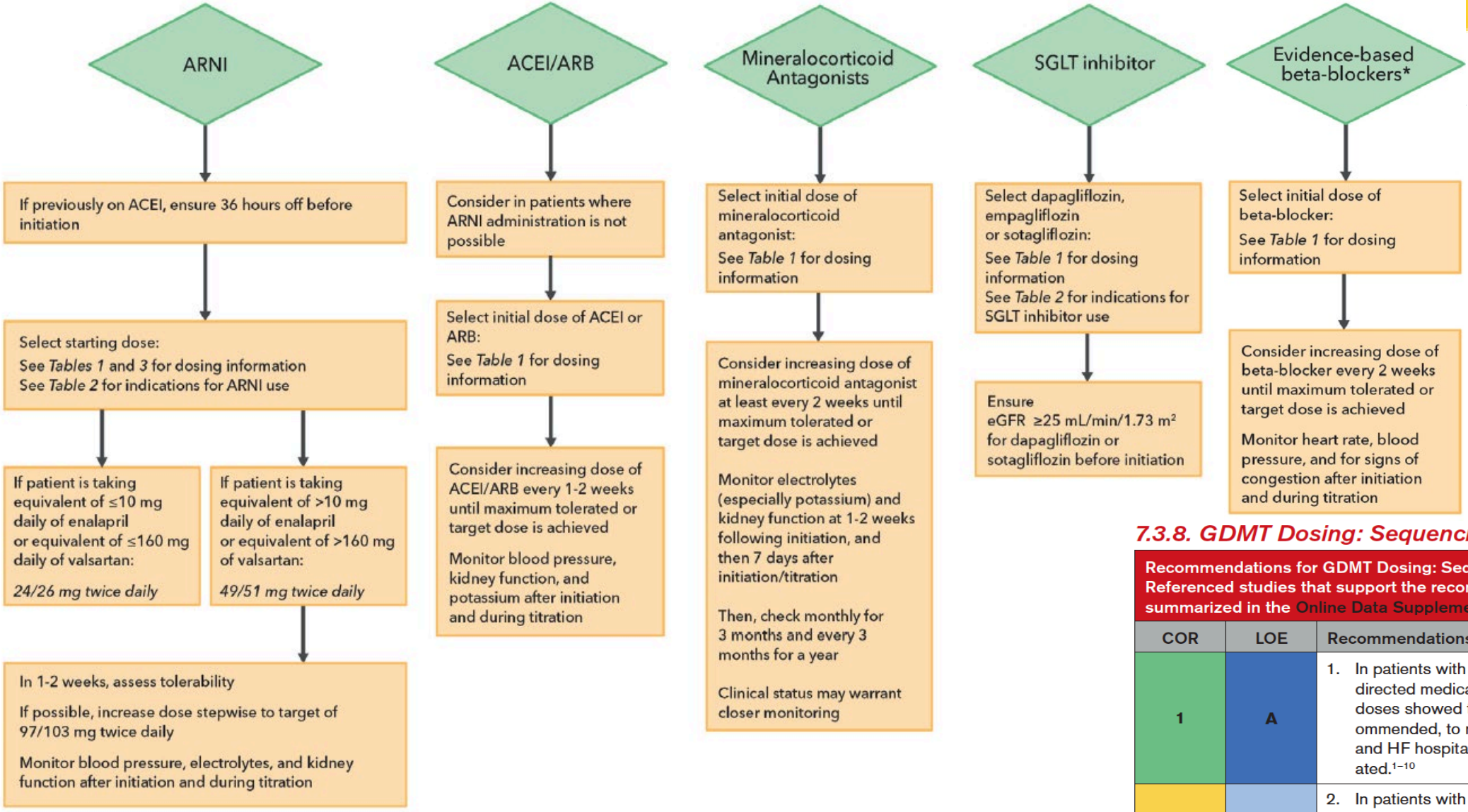
All 3 steps achieved within 4 weeks

Uptitration to target doses thereafter

28 - 56 weeks before GDMT fully implemented

- At each step, clinical inertia stands in the way of success
- Patients exposed to the excess risk of death and clinical worsening during prolonged initiation and titration process

Packer & McMurray, *Eur J HF* 2021; Greene S et al, JAMA Cardiol 2021; Mebazaa A et al. Lancet 2022; Khan MS, Butler J, Greene SJ. *Eur J Heart Fail* 2021



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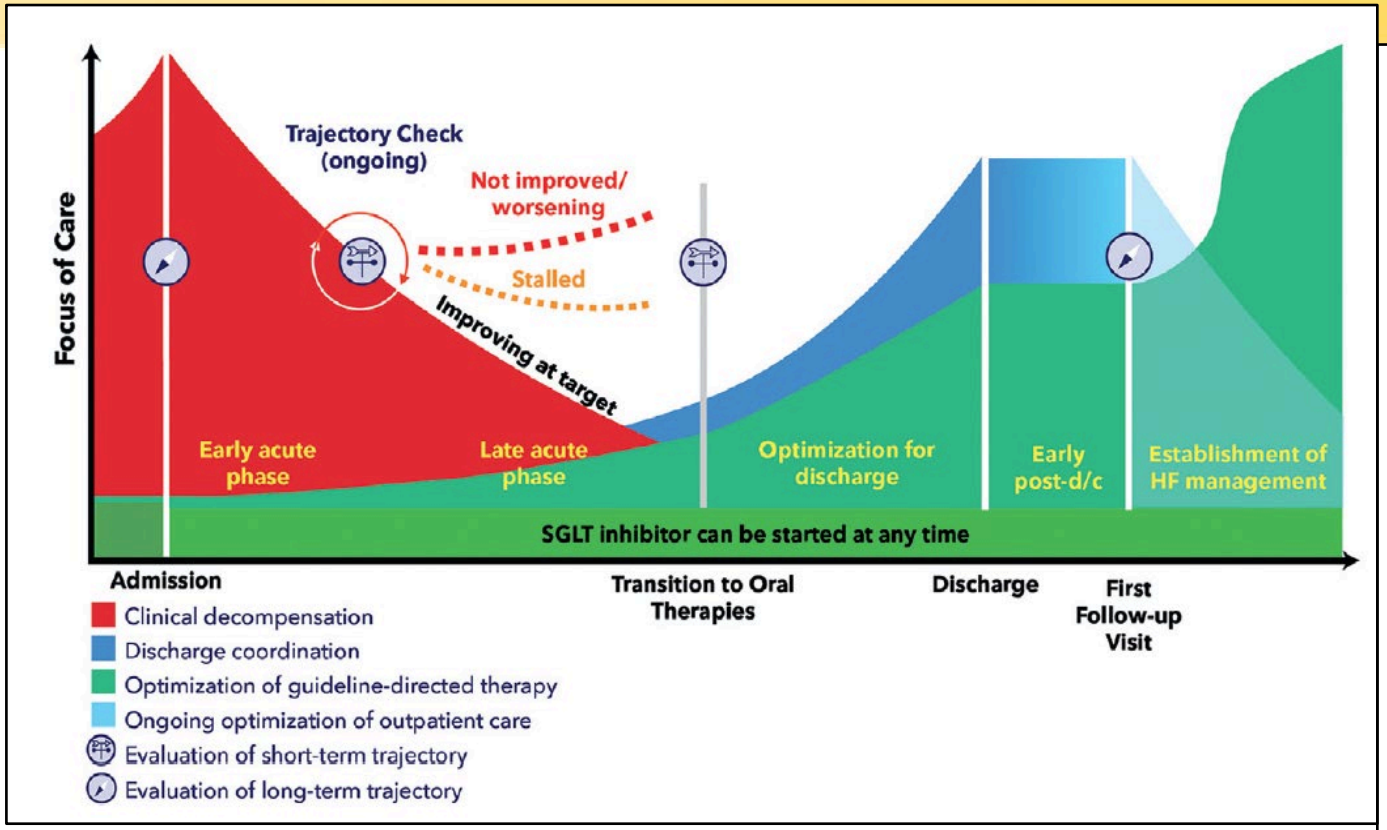
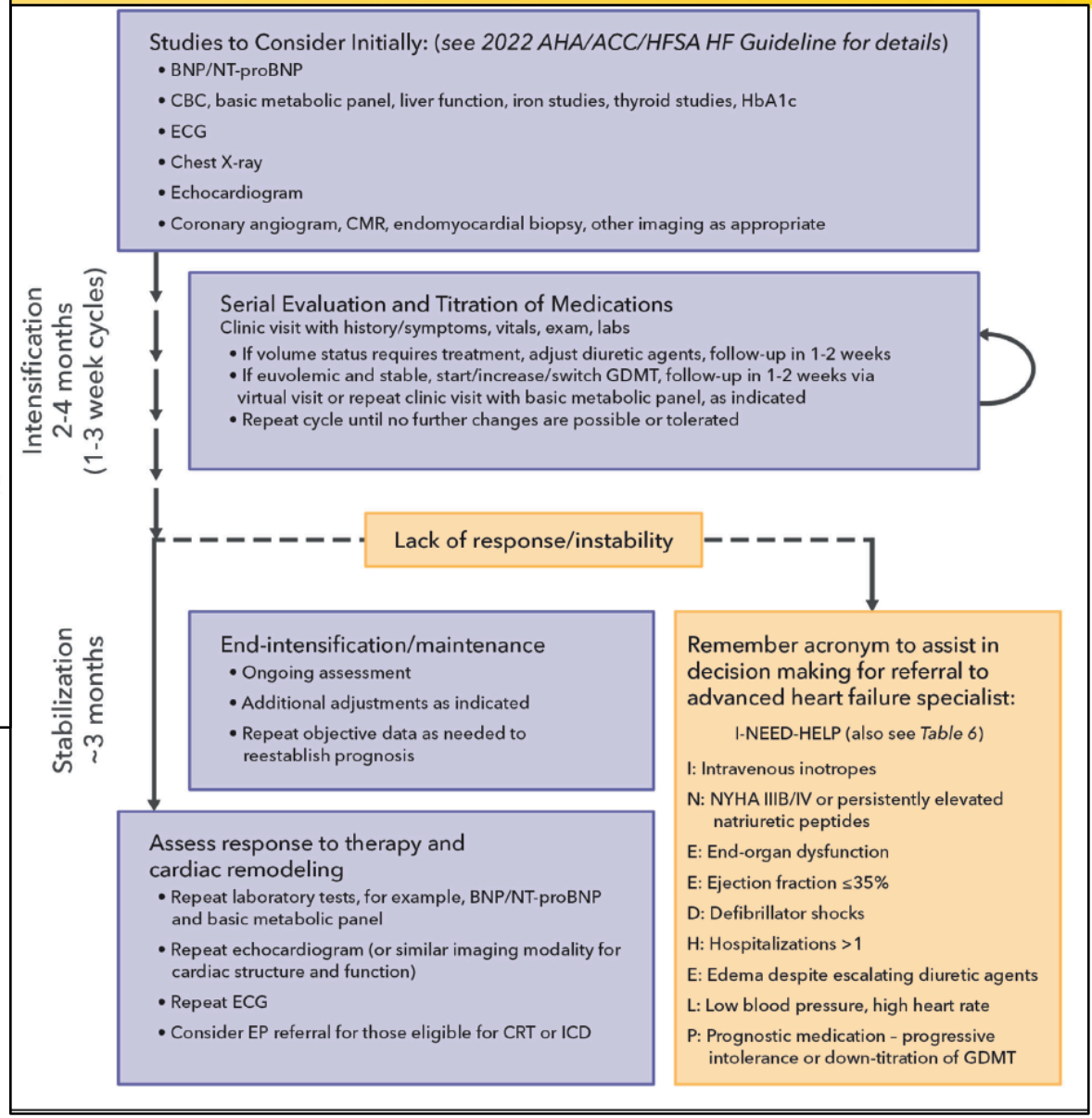
7.3.8. GDMT Dosing: Sequencing and Uptitration

Recommendations for GDMT Dosing: Sequencing and Uptitration
Referenced studies that support the recommendations are summarized in the Online Data Supplements.

COR	LOE	Recommendations
1	A	1. In patients with HFrEF, titration of guideline-directed medication dosing to achieve target doses showed to be efficacious in RCTs is recommended, to reduce cardiovascular mortality and HF hospitalizations, unless not well tolerated.[1–10]
2a	C-EO	2. In patients with HFrEF, titration and optimization of guideline-directed medications as frequently as every 1 to 2 weeks depending on the patient's symptoms, vital signs, and laboratory findings can be useful to optimize management.

Maddox T. ACC Expert Consensus Pathway. *JACC* 2024

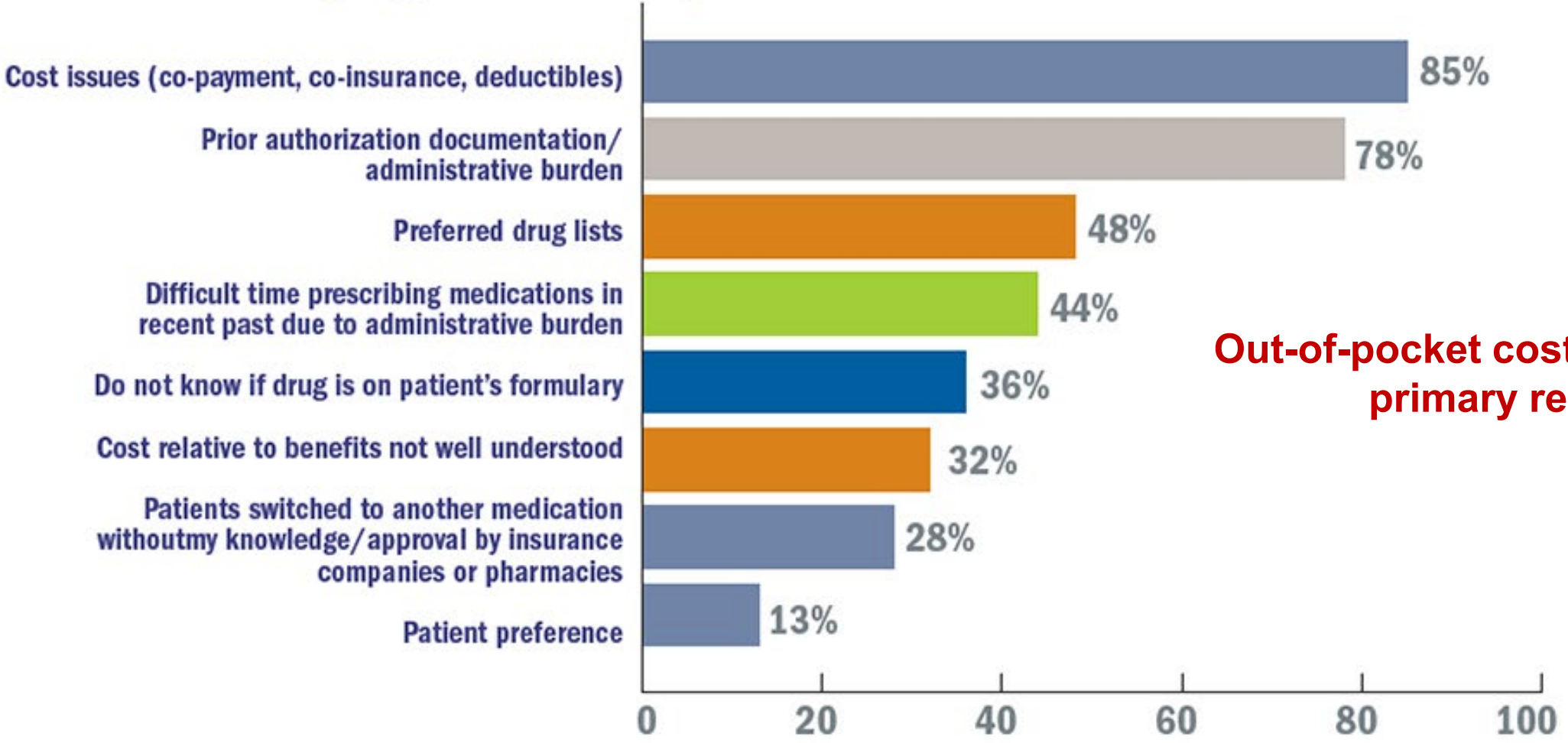




Maintain GDMT during hospitalizations whenever possible, start *de novo* and resume ASAP.

Do NOT stop GDMT:
Mild ↑ Cr
Asymptomatic ↓ BP

Barriers to Trying New Therapies



Out-of-pocket costs are not the primary reason

Credit to Robert L Page II, PharmD

Source: American College of Cardiology. Feb 2017.

Sandhu AT et al. *JAMA Cardiol* 2021; Hussain A et al. *JACC Heart Fail* 2023; Greene SJ & Pierce JB. JACC *Heart Fail* 2023

GDMT is High Value Care

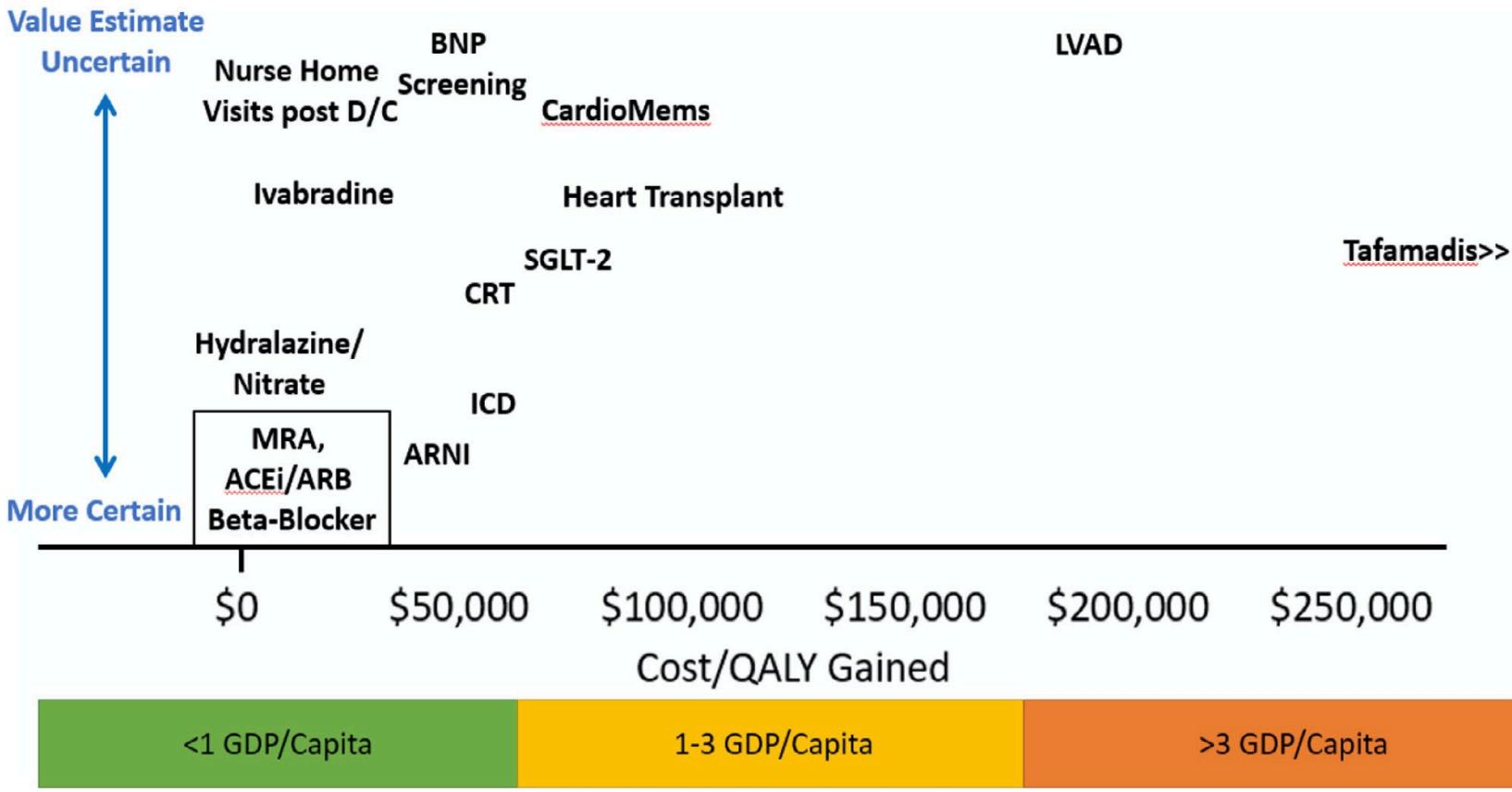
With previous or current symptoms of chronic HFrEF, in whom ARNi is not feasible, tx with ACEi or ARB provides high economic value.
Value Statement: High Value (A)

With chronic symptomatic HFrEF, tx with an ARNi instead of an ACEi provides high economic value.
Value Statement: High Value (A)

With HFrEF and NYHA class II to IV symptoms, MRA therapy provides high economic value.
Value Statement: High Value (A)

With HFrEF, with current or previous symptoms, beta-blocker therapy provides high economic value.
Value Statement: High Value (A)

Self-identified African American patients with NYHA class III to IV HFrEF who are receiving optimal medical therapy with ACEi or ARB, beta blockers, and MRA, the combination of hydralazine and isosorbide dinitrate provides high economic value.
Value Statement: High Value (B-NR)



Class 1 recommended medical therapies for HFrEF have very high economic value (low cost).

Heidenreich, P. A. et al 2022. *J Cardiac Failure;*
Heidenreich, P. A. et al. (2022). 2022 AHA/ACC/HFSA Guideline for Heart Failure. *Circulation*.

Addressing SDOH & Disparities in Vulnerable Populations

JOHNS HOPKINS

COR	RECOMMENDATIONS
1	In patients presenting with HF, a thorough history and physical examination should be obtained and performed to identify cardiac and noncardiac disorders, lifestyle and behavioral factors, and social determinants of health that might cause or accelerate the development or progression of HF.

COR	RECOMMENDATIONS
1	Evidence of health disparities should be monitored and addressed at the clinical practice and the health care system levels.

COR	RECOMMENDATIONS
1	In vulnerable patient populations at risk for health disparities, HF risk assessments and multidisciplinary management strategies should target both known risks for CVD and social determinants of health, as a means toward elimination of disparate HF outcomes.

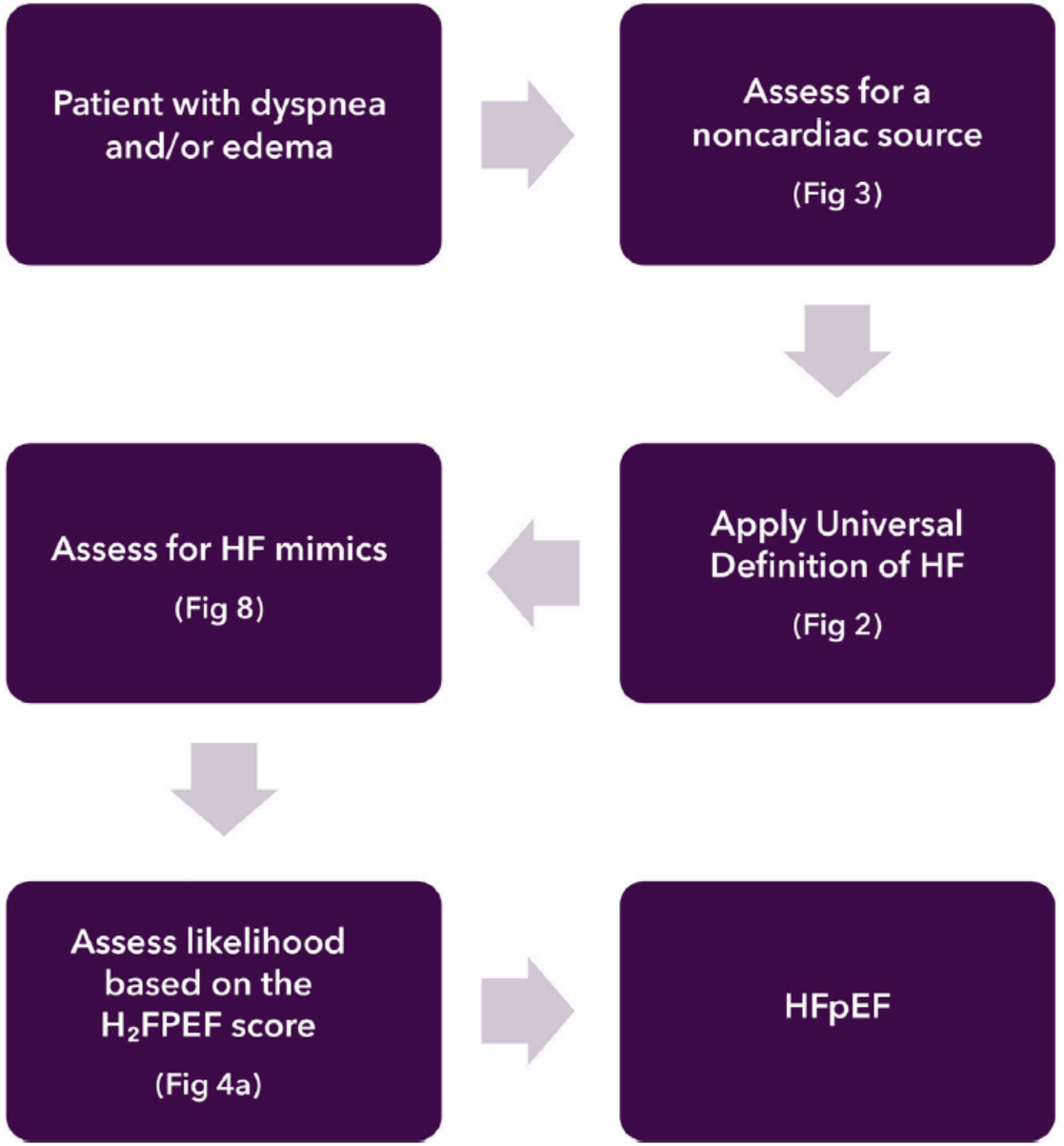
Social Barriers		
Financial burden of HF treatments[55]	COmprehensive Score for financial Toxicity–Functional Assessment of Chronic Illness Therapy (COST-FACIT)	PharmD referral to review prescription assistance eligibilities
Food insecurity[56,57]	Hunger Vital Sign, 2 items US Household Food Security Survey Module, 6 items	Determine eligibility for the Supplemental Nutrition Assistance Program (SNAP) Connect patients with community partners such as food pantries/food banks Home meal deliveries Registered dietitian nutritionist evaluation for potential malnutrition
Homelessness or housing insecurity[58–60]	Homelessness Screening Clinical Reminder (HSCR)	Referral to local housing services Connect patients with community housing partners
Intimate partner violence or elder abuse[61,62]	Humiliation, Afraid, Rape, Kick (HARK) questionnaire Partner Violence Screen (PVS) Woman Abuse Screening Tool (WAST)	Referral to social work services and community support partners
Limited English proficiency or other language barriers[63]	Routinely inquire in which language the patient is most comfortable conversing	Access to interpreter services covering a wide range of languages, ideally in person or, alternatively, via video platform Printed educational materials in a range of appropriate languages
Low health literacy[64]	Short Assessment of Health Literacy (SAHL) Rapid Estimate of Adult Literacy in Medicine–Short Form (REALM-SF) Brief Health Literacy Screen (BHLS), 3 items	Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit Written education tools provided at sixth grade reading level or below Graphic educational documents
Social isolation or low social support[65]	Patient-Reported Outcomes Measurement Information System (PROMIS) Social Isolation Short Form	Determine eligibility for home care services Support group referral
Transport limitations	No validated tools currently available.	Referral to social work services Determine eligibility for insurance or state-based transportation, or reduced-cost public transportation Maximize opportunities for telehealth visits and remote monitoring

Class I recommendation to assess, monitor, and address SDOH and disparities impacting HF patients with multidisciplinary management, across phases of care.

See alt text for image description

TABLE 7 Essential Skills for an HF Team

- HF diagnosis and monitoring for progression
- Treatment prescription, titration, and monitoring
- Patient and caregiver education on disease and treatments
- Lifestyle prescription (eg, diet, exercise), education, and monitoring
- Access to genetic testing and counseling programs
- Psychological and social support assessment, treatment, and monitoring
- Palliative and end-of-life counseling and care
- Coordination of care for concomitant comorbidities
- Nutritional counselling



A

H_2FPEF

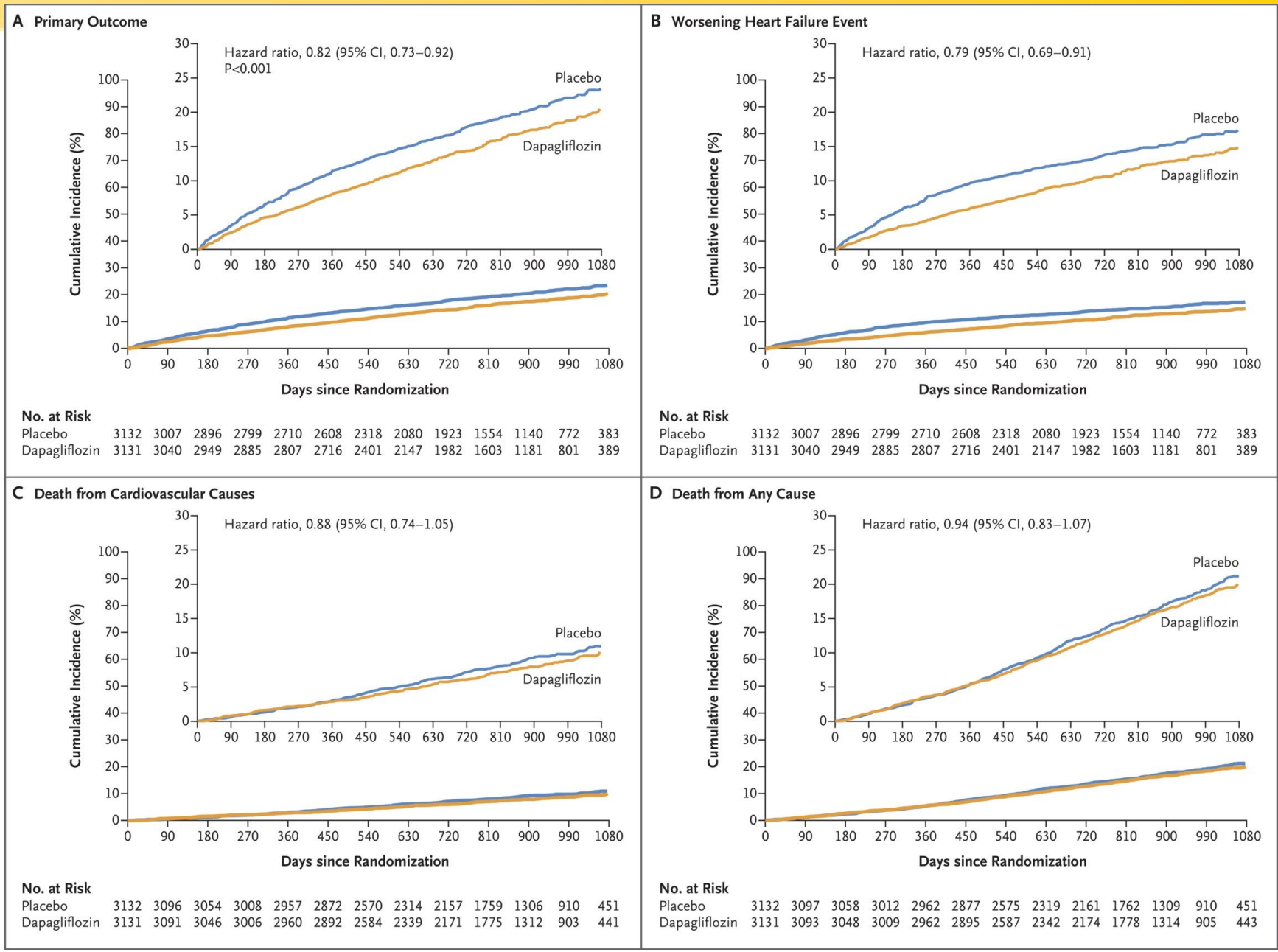
H_2	**H**eavy (BMI >30 kg/m²) On ≥2 anti**H**ypertensives	2 1
F	Atrial **F**ibrilllation	3
P	**P**ulmonary hypertension (PASP >35 mm Hg on Doppler echocardiography	1
E	**E**lder (age >60 years)	1
F	**F**illing pressure (E/e' >9 on Doppler echocardiography)	1

≥6 points: highly diagnostic of HFpEF

TABLE 2 Selected Randomized Controlled Trials in Individuals With HFpEF

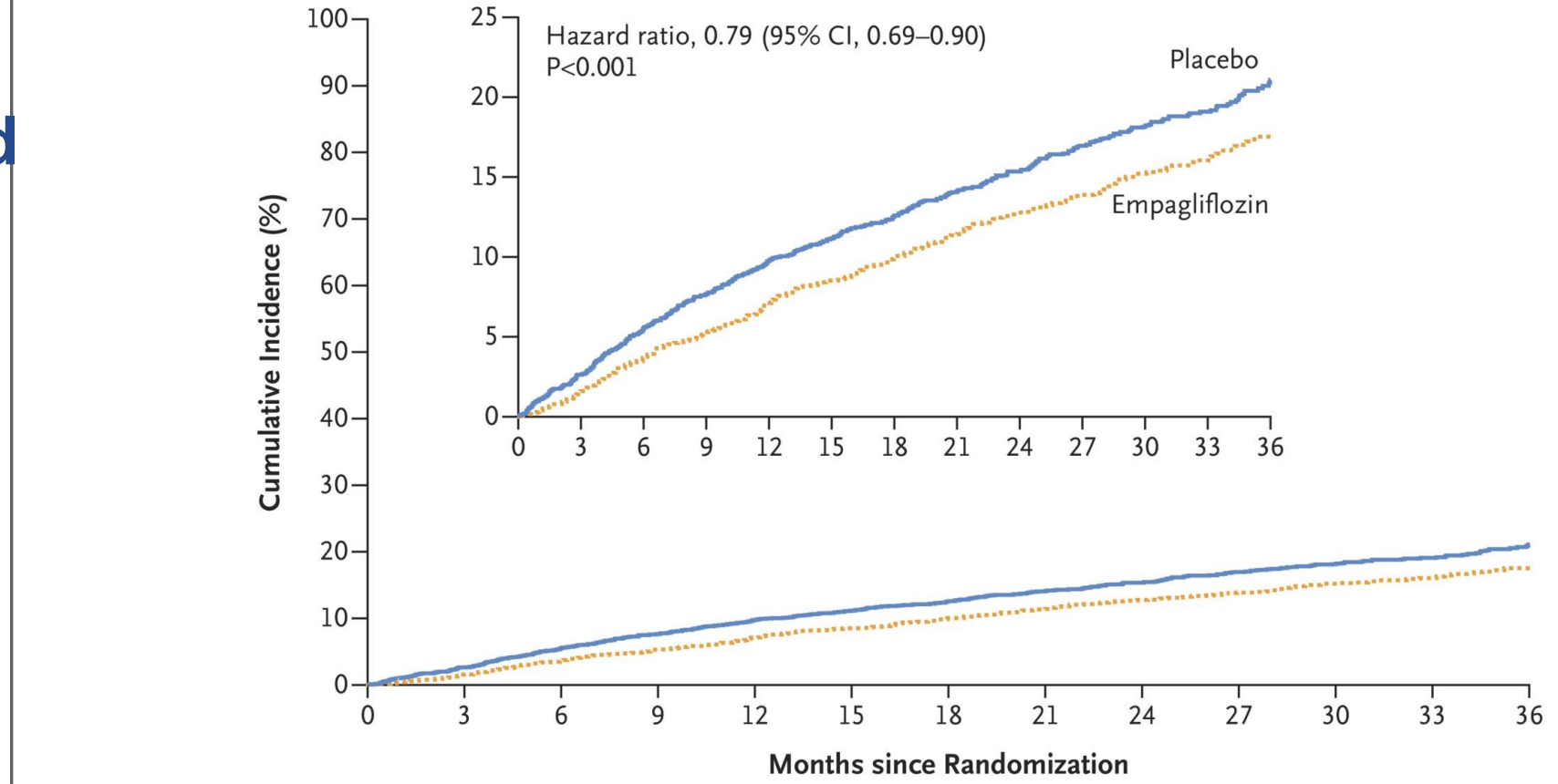
	DELIVER[6]	EMPEROR-PRESERVED[7]	TOPCAT*[16]	PARAGON-HF[19]	CHARM-PRESERVED[24]
Size	N = 6,263	N = 5,988	N = 3,445	N = 4,822	N = 3,023
Agent	Dapagliflozin	Empagliflozin	Spironolactone	Sacubitril/valsartan	Candesartan
Median age, y	72	72	69†	73	67
Female sex	44%	45%	52%	52%	40%
Median follow-up, y	2.3	2.2	3.3	2.9	3.1
EF entry criteria	>40%	>40%	≥45%	≥45%	>40%
Mean baseline LVEF	54%	54%	56%†	58%	54%
Proportion with T2DM	45%	49%	33%	43%	29%
HF medical therapy					
Diuretic agent	77%	NR	82%	95%	75%
ACE inhibitor or ARB	73%	81%	84%	86%	19%‡
ARNI	5%	2%	N/A	N/A	N/A
Beta-blocker	83%	86%	78%	80%	56%
MRA	43%	37%	N/A	26%	12%
Primary composite outcome, HR or rate ratio (95% CI)	Worsening HF and CV death: HR: 0.82 (0.73-0.92)	Hospitalization for HF and CV death: HR: 0.79 (0.69-0.90)	Hospitalization for HF, aborted cardiac arrest, CV death: HR: 0.89 (0.77-1.04)	Total hospitalizations for HF and CV death: Rate ratio: 0.87 (0.75-1.01)	Hospitalization for HF and CV death: HR: 0.86 (0.74-1.00)
Hospitalization for HF, HR or rate ratio (95% CI)	HR: 0.77 (0.67-0.89)	HR: 0.71 (0.60-0.83)	HR: 0.83 (0.69-0.99)	Rate ratio: 0.85 (0.72-1.00)	HR: 0.84 (0.70-1.00)
Urgent visit for HF, HR (95% CI)	0.76 (0.55-1.07)	NR	NR	NR	NR
CV death, HR (95% CI)	0.88 (0.74-1.05)	0.91 (0.76-1.09)	0.90 (0.73-1.12)	0.95 (0.79-1.16)	0.95 (0.76-1.18)

SGLT2i in HFpEF: DELIVER Trial



Solomon SD et al. N Engl J Med2022;387:1089-1098

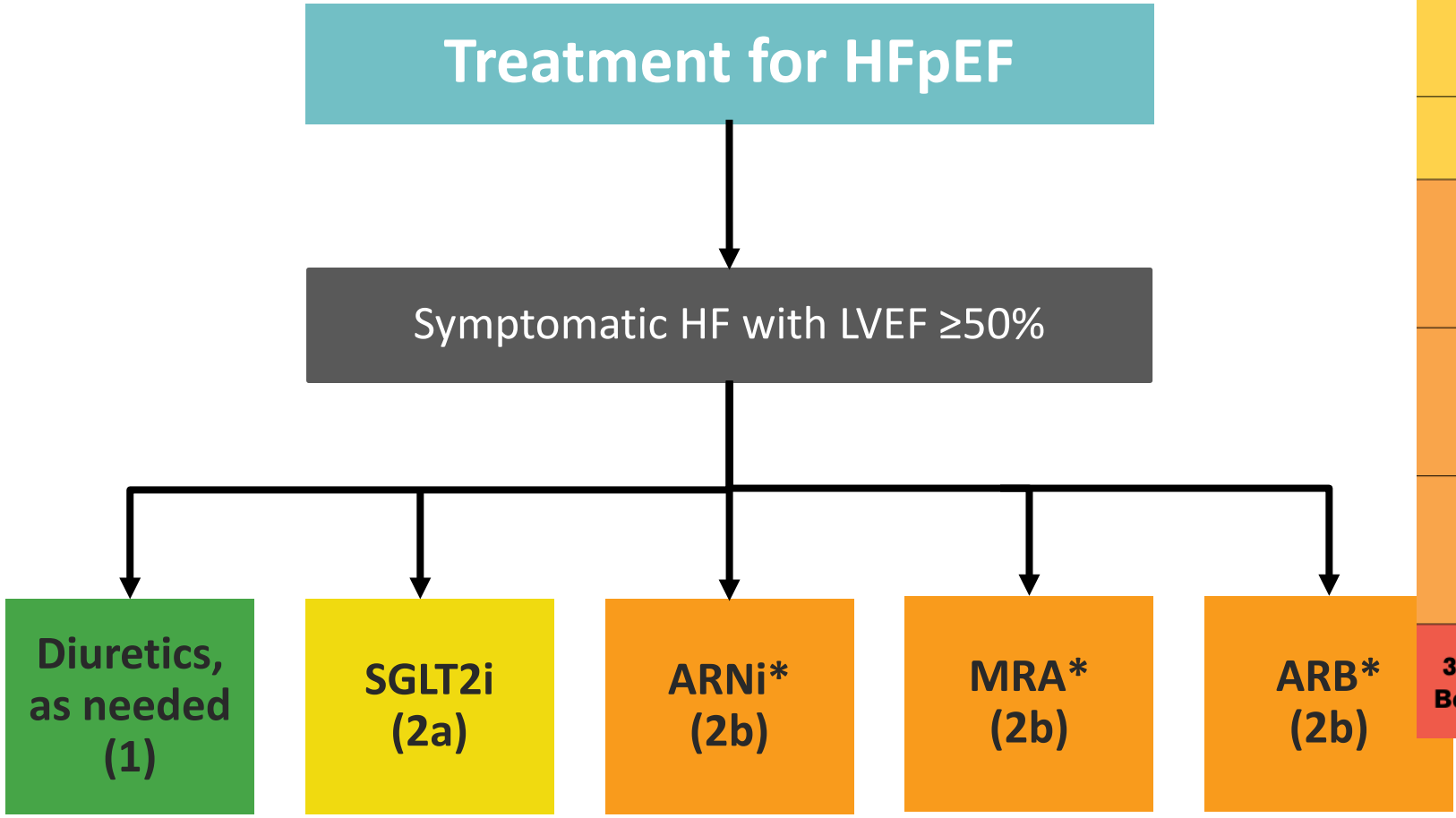
SGLT2i in HFpEF: EMPEROR- Preserved Trial



No. at Risk													
Placebo	2991	2888	2786	2706	2627	2424	2066	1821	1534	1278	961	681	400
Empagliflozin	2997	2928	2843	2780	2708	2491	2134	1858	1578	1332	1005	709	402

Anker SD et al. N Engl J Med2021;385:1451-1461

Patients with (Stage C) *Preserved* LVEF

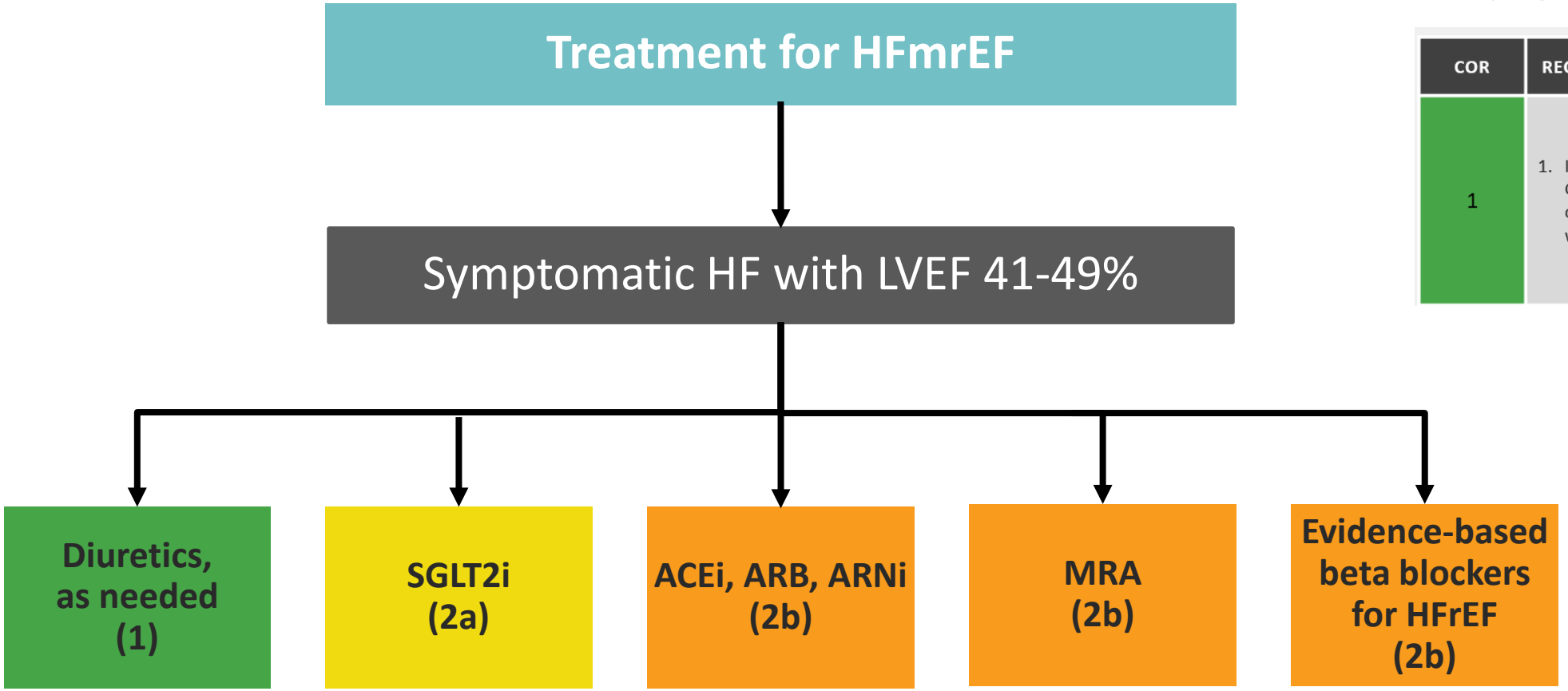


1	C-LD	1. Patients with HFpEF and hypertension should have medication titrated to attain blood pressure targets in accordance with published clinical practice guidelines to prevent morbidity.[1–3]
2a	B-R	2. In patients with HFpEF, SGLT2i can be beneficial in decreasing HF hospitalizations and cardiovascular mortality.[4]
2a	C-EO	3. In patients with HFpEF, management of AF can be useful to improve symptoms.
2b	B-R	4. In selected patients with HFpEF, MRAs may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum.[5–7]
2b	B-R	5. In selected patients with HFpEF, the use of ARB may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum.[8,9]
2b	B-R	6. In selected patients with HFpEF, ARNi may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum.[10,11]
3: No-Benefit	B-R	7. In patients with HFpEF, routine use of nitrates or phosphodiesterase-5 inhibitors to increase activity or QOL is ineffective.[12,13]

Heidenreich et al. *Circulation* 2022

NOTE: *Greater benefit in patients with LVEF closer to 50%

Patients with (Stage C) *Mildly Reduced* LVEF

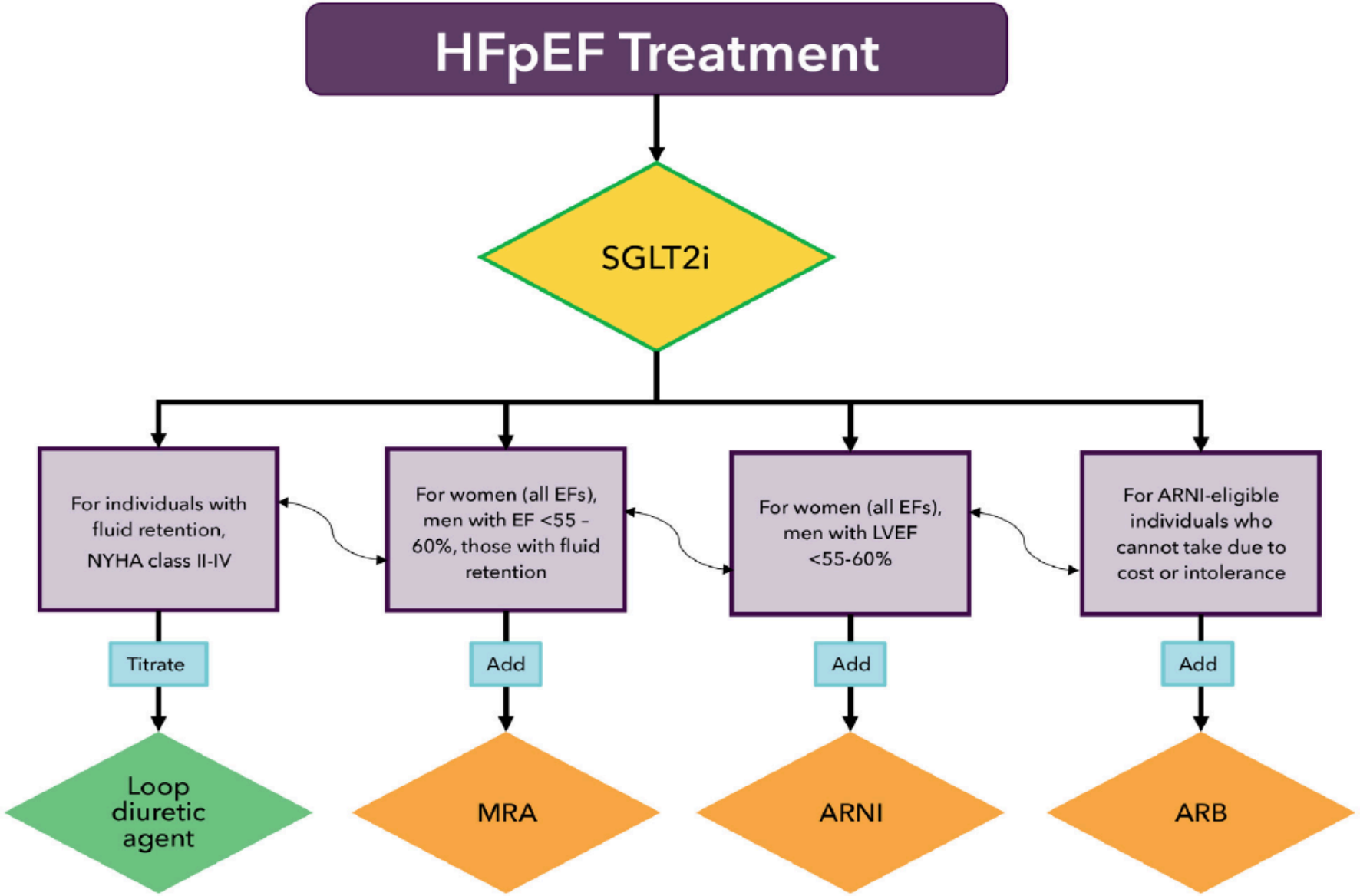


Patients With HF*imp*EF

COR	RECOMMENDATIONS
1	1. In patients with HFimpEF after treatment, GDMT should be continued to prevent relapse of HF and LV dysfunction, even in patients who may become asymptomatic. (1)

Abbreviations: ARB indicates angiotensin receptor blocker; ARNi, angiotensin receptor-neprilysin inhibitor; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; LV, left ventricle; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; and SGLT2i, sodium-glucose cotransporter-2 inhibitor.

Heidenreich et al. *Circulation* 2022


HFpEF Treatment
SGLT2i
For individuals with fluid retention, NYHA class II-IV
For women (all EFs), men with EF <55 – 60%, those with fluid retention
For women (all EFs), men with LVEF <55-60%
For ARNI-eligible individuals who cannot take due to cost or intolerance
Titrate
Add
Add
Add
Loop diuretic agent
MRA
ARNI
ARB

Summary

- HF GDMT is life-saving, disease modifying therapy
- HF GDMT for HFrEF is quad-based therapy, Class I.
  - **AHAHF106**: Defect-Free Care for Quad Tx Meds for HFrEF
- HF GDMT for HFpEF & HFmrEF cornerstone is SGLT2i, Class IIa.
  - **AHAHF94:** SGLT-2i at d/c for HFpEF/HFmrEF
- Clinical Benefits Occur Early after GDMT
  - HF Hospitalization starts Time 0
  - Initiation prior to discharge is life-saving
  - Rapid titration following discharge is life-saving

Measures to be Removed

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Measure Name	Rationale for Removal
ACHF-01 Beta-blocker Therapy Prescribed for LVSD at Discharge *still applicable to CCCC	• Topped out since 2018 • New more meaningful measures exist: AHAHF106 Defect-free Care Quad Therapy
All seven Optional Outpatient Measures *ACHFOP-03 and ACHFOP-06 still applicable to CCCC	• Lack of HCO use • Only 1-2 HCOs submit data since 2015 • Not feasible

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Certification Measurement Information Process (CMIP)

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CMIP Data Entry

1 Introduction Summary | 2 CPG | 3 PI Plan | 4 Performance Measures | 5 Data Submission | 6 PM Reports | 7 Intracycle Attestation | 8 Intracycle Conference Call | 9 CMIP Submission | Administration

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Certification Program

- Acute Myocardial Infarction
- Advanced Heart Failure
- Advanced Primary Stroke Center
- Joint Replacement - Hip
- Joint Replacement - Knee
- Maternal Levels of Care Verification
- Pneumonia

Data Submission for Advanced Heart Failure

Save | < Prev | Next > | Cancel

Performance Measure Short Name: [redacted]

Data Submission Level: ○ HCO ◉ Site [redacted]

Direction of Improvement: Positive

Data Submission Requirements:
For initial programs submitting data for the first time, data must be entered for a minimum of 4 recent months prior to the initial on-site review. Once certified, please refer to the performance measure requirements as detailed in the Certification Manual Performance Improvement and Performance Measurement chapter.

Data Quality Edit Information

☐ Show all Data

Clear Data Entry	Reporting Time Period	Collecting Time Period	Data Source	Numerator # of Cases	Denominator # of Cases	Zero Cases Attestation	Result	Update Date
☐	Q2 2024	May				☐		
☐	Q2 2024	Apr				☐		
☐	Q1 2024	Mar	Manual Entry	6	6	☐	100.00%	05/15/2024
☐	Q1 2024	Feb	Manual Entry	6	6	☐	100.00%	04/15/2024
☐	Q1 2024	Jan	Manual Entry	11	11	☐	100.00%	03/15/2024
☐	Q4 2023	Dec	Manual Entry	9	9	☐	100.00%	02/16/2024
☐	Q4 2023	Nov	Manual Entry	10	10	☐	100.00%	01/24/2024
☐	Q4 2023	Oct	Manual Entry	6	6	☐	100.00%	12/27/2023

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Summary

Clinical significance of the new required GWTG-HF measures

Background on measures to be removed from ACHF

Overview of how to submit data to CMIP and how to ask questions

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Additional Resources

Use this link to access TJC specifications manual:
https://manual.jointcommission.org/Home/WebHome?tab=hospitals

Reference the DSC Manual for ACHF standards and performance measurement requirements – updated every six months

Current Heart Failure clinical practice guidelines:
2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines.

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Questions?

Contact the AHA for any questions related to the two new GWTG-HF measure specifications: gwtgsupport@heart.org

Regarding ACHF Joint Commission performance measures, submit via this platform: https://manual.jointcommission.org/Home/Questions/AskQuestion?t=1719334305

Regarding the On Demand webinar operations and CE inquiries: pioneersinquality@jointcommission.org

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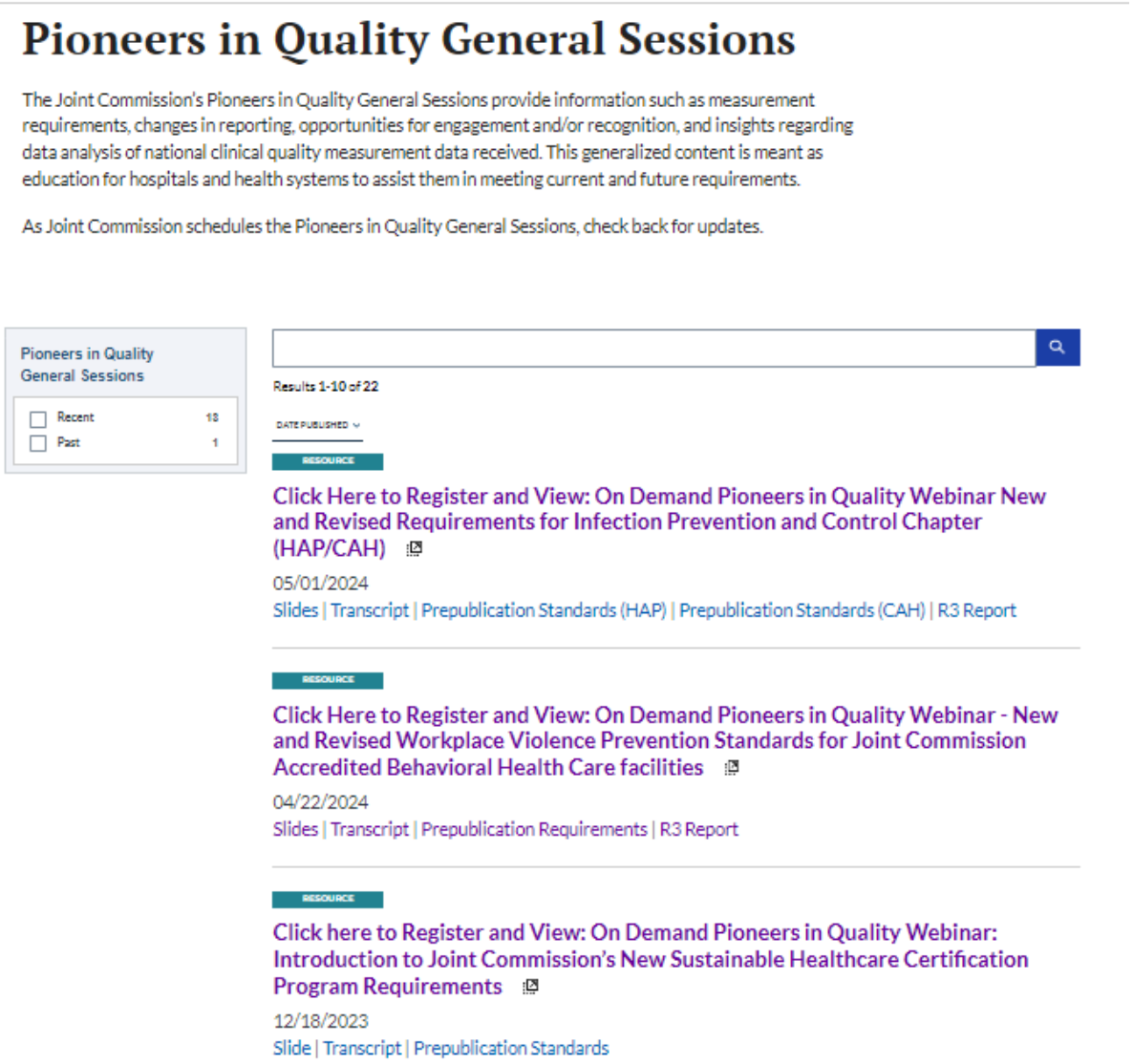

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The Joint Commission's Pioneers in Quality General Sessions provide information such as measurement requirements, changes in reporting, opportunities for engagement and/or recognition, and insights regarding data analysis of national clinical quality measurement data received. This generalized content is meant as education for hospitals and health systems to assist them in meeting current and future requirements.

As Joint Commission schedules the Pioneers in Quality General Sessions, check back for updates.

Pioneers in Quality General Sessions

Recent 13
Past 1

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DATE PUBLISHED

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Slides | Transcript | Prepublication Standards (HAP) | Prepublication Standards (CAH) | R3 Report

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04/22/2024

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