Pioneers in Quality On Demand Performance Measurement Update to Advanced Certification in Heart Failure (ACHF)

Recorded: December 2024

(00:01)

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The learning objectives for this session are describe the intent and logic underlying the updated ACHF measure set. Utilize the information provided to understand clinical significance of new required, Get With The Guidelines Heart Failure measures, and answer questions to inform measure use and implementation. Facilitate your organization's implementation of the ACHF measure specifications.

All staff and speakers for this webinar 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.

Myself, Susan Funk, Danielle Hermosillo Natalie Navar, and Dr. Sabra Lewsey.

Now I'll introduce this webinar's speakers. Today's presentation features Danielle Hermosillo, Associate Project Director with The Joint Commission. Natalie Navar, Senior Program Development Manager with the American Heart Association, and Dr. Sabra Lewsey, Assistant Professor of Medicine in Cardiology at Johns Hopkins University School of Medicine. Dr. Lewsey also volunteers as the chair of the AHA Get With The Guidelines Heart Failure Clinician Advisory Group.

Danielle, I will now turn things over to you.

(05:09)

Thank you Susan. As most of you are probably already aware, the Advanced Certification Heart Failure Program will have a few changes to the required performance measures effective January 1st, 2025.

First, I want to explain the process The Joint Commission went through that ultimately led to the decision to update the ACHF measurement requirements. The Joint Commission combined information from multiple sources and settings to ensure the performance measures aligned with updated clinical practice guidelines. TJC identified opportunities to update current requirements by surveying subject matter experts, which included TJC Cardiac Reviewers and conducting a literature review. The lit review included up-to-date evidence-based articles and the most recent 2022 Clinical Practice Guidelines for heart failure care. After multiple discussions with leadership and Subject Matter Experts, TJC identified a few key measures that were determined to have the highest level of supporting evidence. These proposed measures were put through a public comment process and then a Technical Advisory Panel was convened in October 2023 to gather final input and consensus on the most influential and feasible performance measure changes. Once the measures were decided upon the details of collaborating and adopting the two new measures from AHA's Get With The Guidelines Heart Failure were finalized. Now to discuss the two new measures that will be adopted from Get with The Guidelines Heart Failure and some brief rationale as to why they were chosen.

First, AHAHF106 Defect-free Care for Quadruple Therapy Medication for Patients with Reduced Ejection Fraction is supported with a high level of evidence and class one recommendation in the 2022 Clinical Practice Guidelines. Using the defect-free model is more inclusive and provides the ability to monitor quality of care more easily.

The second measure being adopted is AHAHF94 SGLT-2 inhibitors for patients with preserved or mildly Reduced Ejection Fraction. This measure received a Class two A recommendation with a moderate level of evidence in the 2022 Clinical Practice Guidelines. However, since those guidelines were published, more clinical trials and studies have come out in support of this, it will likely receive a higher classification in future guidelines. This measure also highlights a new patient population that none of the other ACHF measures focus on.

The other measures are specific to heart failure patients with Reduced Ejection Fraction, whereas this measure focuses on patients with preserved or mildly Reduced Ejection Fraction. Dr. Lewsey will go into even more detail on the clinical significance in support of these two measures, but now I will hand it over to Natalie with the American Heart Association to review Get with The Guidelines Heart Failure.

Thank you, Danielle. I'm Natalie Navar, Senior Program Development Manager for Get With The Guidelines Heart Failure for the American Heart Association. I'll be providing some more information on Get With The Guidelines.

The AHA has five Get With The Guidelines programs. In addition to heart failure, our programs cover coronary artery disease, resuscitation, stroke, and atrial fibrillation. The QR code on the right will allow you to access further information about this suite of quality improvement programs, should you wish to learn more.

Get With The Guidelines Heart Failure exists for and is demonstrated to improve adherence to evidence-based care of patients hospitalized with heart failure. We seek to improve on the points listed here under why Get With The Guidelines heart failure. Readmission rates of around 31%. Low numbers of patients being discharged on guideline directed medical therapy. Suboptimal post-acute care and care disparities.

Get With The Guidelines Heart Failure encompasses over 600 participating hospitals. We collect data on 118 measures and counting. We have almost three million patient records. We have informed 173 publications to date and this year we gave out over 1000 compliance-based awards to participating sites.

Of those 118 measures, we collect data on, those with the highest classes of recommendation and levels of evidence are utilized for designating hospitals as high performers. Hospitals demonstrating certain compliance to these measures are awarded for their commitment to guidelines based care. From a technical standpoint.

In the Get With The Guidelines online platform, ACHF sites have easy to use pre-configured measure bundles and resources. On the left, you'll see a few snips from the operational reports page by clicking the ACHF measures and selecting whether you'd like to run data for only your hospital or against a certain benchmark. And then selecting the timeframe you're interested in reviewing a report will populate showing compliance to those ACHF measures.

Please note that in this snip we show ACHF-01 through 06. This will be updated this month, December 2024. To accurately reflect the ACHF measures that are part of the bundle, I will show you what that report output looks like on my next slide. On the right here though, you'll see snips from the library page. We do link directly to TJC's Quality Measures Specifications manual. We also include a link to the PDF of the full case report form with the ACHF elements included for those sites who participate.

(10:44)

So here at the top is what an example report looks like when you do run those ACHF measures. Note that what I'm showing here does include demographic data. This is not reflective of any one particular site. At the bottom here is a portion of the measure report details. The highlighted columns, patients included and numerator E are the field sites use if submitting their data to TJC Via CMIP. Thank you very much. Now I am delighted to introduce Dr. Sabra Lewsey, who will be presenting on the clinical logic and rationale behind these measures.

Thank you so much, Natalie. My name is Sabra Lewsey. I'm a heart failure cardiologist at the Johns Hopkins Hospital School of Medicine, and I'll be talking today about optimizing heart failure care with Guideline-Directed Medical Therapies brought to you in part by the Joint Commission and the American Heart Association.

I have no disclosures.

Our agenda for today is really focused on three key areas. First, we're going to be reviewing clinical practice updates issued by the 2022 Heart Failure Guidelines and recent trial and expert consensus pathway updates as it pertains to heart failure with Reduced Ejection Fraction, in particular the evolution of quad-based therapy for Heart Failure with Reduced EF, and also what we now consider updated guidelines for Heart Failure with Preserved Ejection Fraction and Mildly Reduced Ejection Fraction. We'll also review value-based assertions for heart failure care, Guideline-Directed Medical Therapies, and really consider the role of the heart failure system of care, embarking upon quality of care metrics for our patients.

So, to put this in context, we know that we have a heavy deed in front of us and that heart failure affects 6.7 million US adults currently, and by the end of this decade, that number will be upwards of eight million. Certainly, heart failure attributes a significant amount of death and a significant amount of cost, and that has unfortunately been the legacy of heart failure. Though current therapies are showing us that we can change this trajectory. We know that both Heart Failure with Reduced Fraction and Heart Failure with Preserved Ejection Fraction can have reduced survival, and so having guideline-directed therapies that can impact heart failure outcomes are critical.

We also know from the last 20 years that heart failure incidents and heart failure burden can be disparate across communities, and that we can see a 20% increased incidence of heart failure among Black men and women compared to White men and women before the age of 50. So, this is also part of our imperative in terms of how we ensure that Guideline-Directed Medical Therapies are equitably implemented across communities.

In terms of the current trajectory for heart failure outcomes, we also know that, though heart failure deaths were declining, we are starting to see an uptick in heart failure deaths in most recent years, and again, we are seeing that this has disparate outcomes in terms of affecting communities of color differently with regards to heart failure mortality.

So, as we go through the 2022 Heart Failure Guidelines, the guidelines provide us with a common framework, really, to improve the care of heart failure patients, where we can have a common language to discuss staging and severity with new emphasis on primary prevention of heart failure. It provides us with a universal classification based on Ejection Fraction and utilization of common diagnostics to really consider the spectrum of heart failure, and it provides us with medical therapies from HFrEF, Heart Failure with Reduced Ejection, through Heart Failure with Preserved Ejection Fraction, really giving us a new arsenal for quadruple-based Guideline-Directed Medical Therapies for Heart Failure with Reduced Fraction, as well as therapies for Heart Failure with Preserved Ejection Fraction and Mildly Reduced Ejection Fraction.

The 2022 guidelines also remind us to minimize interruptions in these Guideline-Directed Medical Therapies at the time of the hospital interface in which patients are interacting with our health systems. It reminds us to address social determinants of health and heart failure disparities. It makes value-based assertions regarding these heart failure therapeutics and really reminds us how to address Goals of Care in a timely way and make timely referrals for advanced therapies.

The guidelines also provide us with considerations for specialized populations and how to consider multidisciplinary care as well as comorbidity management to treat the whole patient.

Calling on that common language of severity and progression, we know that heart failure follows this unidirectional pathway in which our therapies really come to bear with those who are symptomatic or have Stage C heart failure, but the guidelines call us to remember that patients are at risk for heart failure prior to showing the symptoms for Heart Failure with Reduced Fraction or Preserved Ejection Fraction, and so it is imperative on us to remember those who are at risk and pre-heart failure patients and to minimize and mitigate the risk of future heart failure, and it also reminds us that, once patients are symptomatic, that there is a risk for further progression into Stage D heart failure and that our therapies are critical to really enact and implement in a timely way to prevent progression to Stage D or Advanced Heart Failure with Refractory Symptoms.

(15:59)

The guidelines also give us a common language and classification in terms of discussing Heart Failure with Reduced Ejection Fraction, knowing that those with Reduced EF have an Ejection Fraction less than or equal to 40%, and it gives us a basis to say that Heart Failure with Preserved Ejection Fraction or Heart Failure with Mildly Reduced Ejection Fraction has an Ejection Fraction above 40% based on echo criteria, but that there also must be evidence of increased filling pressures, whether that's by invasive hemodynamic monitoring or non-invasive imaging or natriuretic peptides, that will aid us in our diagnostic efficacy with regards to Heart Failure with Preserved and Mildly Reduced Ejection Fraction.

So, in the modern era, Heart Failure Therapy for Heart Failure with Reduced Ejection Fraction truly is quad-based therapy, and that includes the RAAS antagonists, the ARNi complex, ACE inhibitors, and angiotensin receptor blockers. Evidence-based beta blockers being carvedilol, metoprolol succinate, bisoprolol. Mineral corticoid receptor antagonists being eplerenone and spironolactone, and the sodium glucose two transporter inhibitors, dapagliflozin, empagliflozin, and also sotagliflozin.

And why is that? Because we know, with quad-based therapy used together, we have an absolute risk reduction of 25% with heart failure therapies over a short amount of time for those who are symptomatic with Heart Failure with Reduced Fraction.

So, considering our algorithm, when we have a patient before us with symptomatic Stage C Heart Failure with Reduced Ejection Fraction, at the time of diagnosis of Heart Failure with Reduced EF, we have class 1 recommendations to address congestion upfront and to initiate Guideline-Directed Medical Therapies, preferably with the ARNi complex for those with New York Heart Association Class 2 and 3 symptoms, but if the ARNi complex cannot be used, an ACE inhibitor or an ARB can be considered.

Now, the 2022 guidelines do let us now preferentially and de novo use the ARNi complex, and so that is something that is important to note as a change from previous guideline iterations. We then initiate evidence-based beta blockers, Mineral Corticoid Receptor Antagonists, and SGLT2 inhibitors upfront at the time of diagnosis. The guidelines tell us to then continue and serially assess our patients with regards to their heart failure symptoms and to make serial assessments using echo criteria on their Ejection Fraction to see if there is improvement, or if they continue to have symptoms, we then should consider, in appropriately selected patients, Hydralazine and nitrates, implanting a Cardioverter Defibrillator, or Cardiac Resynchronization Therapy.

For those who will continue to have symptom progression in spite of optimization of these medical therapies, those are patients in who we can have class 1 recommendations to consider durable Mechanical Circulatory Support or Cardiac Transplantation, and truly, at any point within this paradigm, but certainly in those who are progressing with symptoms, the guidelines tell us a class 1 recommendation to consider Palliative Care to support our disease management.

However, when we consider how Guideline-Directed Medical Therapies is implemented, we recognize that we are falling short. This is evidence taken from trial data for hospitalized patients with Heart Failure with Reduced Ejection Fraction, and in panel A, we can see those with contraindication to Guideline-Directed Medical Therapies as indicated in blue. Those who are treated with Guideline-Directed Medical Therapies at the time of discharge in green, and those not treated with Guideline-Directed Medical Therapies and without contraindication marked in red, showing us that there's significant opportunity for individuals to get on Guideline-Directed Medical Therapies who may be eligible for those therapies. We know that patients prescribed therapies at discharge, as evidenced in panel B, aren't reaching guideline-recommended or target dosing. Certainly, coming off of a heart failure hospitalization, some of that may be expected, but it shows us the opportunity and the need, really, to get patients on all Guideline-Directed Medical Therapies for heart failure at the time of their hospitalization.

(20:07)

So when we consider this analysis of over 30,000 patients from the Get With The Guidelines registry, with newly diagnosed hospitalized Heart Failure with Reduced Ejection Fraction, we see that over 80% of them are eligible for quad-based Guideline-Directed Medical Therapies, but what we also recognize is that a significant proportion of these patients are not getting on Guideline-Directed Medical Therapies at the time of discharge.

When we actually model to see what impact could we have if these patients had been put on quad-based Guideline-Directed Medical Therapies at the time of discharge, we see that there could have been a 24% absolute risk reduction in comparison to no Guideline-Directed Medical Therapies, and a 10% absolute risk reduction in comparison to having been discharged on only ACE or ARB and beta blocker. So that really shows us that those patients who are only getting out of the door of the hospital on two therapies are really having a missed opportunity in terms of reducing their risk, and they're being exposed to excess risk by not getting on quad-based therapy when they are eligible.

When we consider the timeline, the timeline for initiation really is imperative with regards to early initiation of guideline therapies, and we've seen this bear out across trials over the decades, really, at this point. When we consider beta blocker trials, this is the Copernicus trial looking at initiation of carvedilol. We see within weeks of initiation of therapy that there is separation of the survival curves on all randomized patients and high-risk patients with regards to the benefit of early initiation of this therapy.

When we consider the ARNi complex in the PIONEER-HF trial, again, we see separation of the curves after days from randomization, suggesting that there is early benefit for the initiation of this Guideline-Directed Medical Therapies in comparison to ACE inhibitor alone. When we consider Eplerenone in the EMPHASIS-HF trial, again, we see early separation of the curves way prior to the first year with initiation of this Guideline-Directed Medical Therapies on top of background therapy.

And most recently with the SGLT2 inhibitors, we've again seen this bear out where early initiation, dapagliflozin or empagliflozin, in comparison to not having these therapies, there's early separation of the curves regardless of diabetes status with early benefit for patients with heart failure receiving these therapies.

If we consider the recent STRONG-HF trial, which looked at initiation and titration of Guideline-Directed Medical Therapies across multiple hospitals, multiple countries, and across a wide span of age ranges of patients enrolled, they randomly assigned patients to a high-intensity strategy versus usual care. That high-intensity strategy was to get patients to max dosing of Guideline-Directed Medical Therapies within two weeks of discharge and then have regularly scheduled outpatient follow-up within two months post-discharge. So, a narrow window of time from the initial heart failure hospitalization, and what they showed is patients in the high-intensity arm had a significant reduction in all-cause death or heart failure readmission by just 180 days.

So, again, this reminds us that early initiation and titration of Guideline-Directed Medical Therapies has benefit with regards to reducing hospitalization and reducing risk for mortality for our patients with heart failure.

This schematic reminds us that the Conventional Sequencing really takes quite a bit of time. In Conventional Sequencing, we think of getting one therapy on at a time, getting the RAAS antagonist on, then getting the beta blocker on, then bringing the patient back and getting the next stage of therapy on, and this can take several months to even a year of bringing patients back to get them on therapy. Unfortunately, this may expose patients to excess risk by not getting them on quad-based therapy upfront at the time of their hospitalization at the time of discharge. To the right of the slide shows us another schematic for how we can consider Rapid Sequencing, but the idea is the same that the time window in which we get patients to quad-based therapy has to be narrow and well-aligned with them being hospitalized and close to discharge.

The expert consensus pathway from the ACC this year has also reminded us and given us a prescriptive method for getting quad-based therapy on upfront, titrating in one to two week intervals, and getting patients to maximum therapy. So this reminds us that, from the time that patients are in the hospital, put on quad-based therapy, and then discharged, that their follow-up needs to be in close alignment to get them to target therapies in short order to give them maximum benefit with regards to reducing heart failure hospitalizations and really reducing mortality risk, improving their health status and improving quality of life.

(25:22)

This image to the left of the slide highlights the focal point, the intensity of the initial heart failure hospitalization, where we are very focused on the active symptoms in terms of decongesting our patient and getting them on a stable path towards discharge with up-titration initiation and up-titration of Guideline-Directed Medical Therapies, but truly, they should be on those therapies at the time of discharge with very early post-discharge follow-up and establishment of heart failure management in close alignment to the time of discharge so that these therapies can continue to be titrated. The expert consensus pathway reminds us that, really, optimal initiation and intensification should be happening within the first two months to four months of treatment, but then continued stabilization after that, and that patient should be in close follow-up from hospitalization through early post-acute care so that there's a seamless transition with regards to the initiation and titration of these therapies.

The guidelines also remind us that, during hospitalizations whenever possible, we need to prevent the stopping of Guideline-Directed Medical Therapies. We should start therapies that have not been previously utilized in patients de novo and we should resume them if there have been any pauses in care for any reason, certainly prior to discharge.

When we consider reasons as to why these therapies are not started, this slide reflects a survey of cardiovascular providers and reasons as to why new therapies were not started or barriers to new therapies. Systems-based factors seem to be the primary cause of that with regards to cost issues, prior authorization, administrative burden, not having assurance about what's in alignment with a preferred drug list, or difficulty getting that medication prescribed for insurance reasons. What is important to note from what we saw previously, is that medical eligibility and patient preference is less likely to be the barrier to starting new therapies based on what our data has shown us so far. And so, as much as possible, our systems of care really need to leverage ways to overcome barriers to initiating these therapies during the time of hospitalization and ensuring these therapies are on at the time of discharge and that they can be continued throughout the phases of care post-discharge and into stabilized heart failure management.

The 2022 Guidelines also remind us that Class 1 medical therapies for heart failure are high-valued therapies. The RAAS antagonists, beta blockers, MRAs all fall under high economic value, and that means that the cost relative to the quality of life gained tells us that they are high economic value, further bolstering why we need to get these therapies on upfront and early. As we acquire more data about SGLT2 inhibitors, we'll likely also see the quality of life gained outweighing the cost for these therapies.

The 2022 guidelines also give us an imperative to address and assess and monitor for social determinants of health that may be impacting the ability of our patients to access and maintain care for their heart failure. There are class 1 recommendations with regards to assessing and monitoring for social determinants of health. The guidelines also give us ways to actually evaluate these social barriers and potential interventions to ensure better implementation of Guideline-Directed Medical Therapies, and so this also reminds us that, at the time of hospitalization, it really is a critical window and that there's an imperative on us as clinical practice providers and as health systems to assess and address Social Determinants of Health that may impact guideline-directed medical care and quality care for heart failure.

In order to do that, it really requires a multidisciplinary team that has the range of skills to bring all of these things together for our heart failure patients with regards to diagnosis and monitoring, treatment, prescription titration, and monitoring of these guideline therapies across the phases of care from hospitalization to outpatient heart failure management, in addition to the education for the patient and caregiver, lifestyle modification and monitoring, and psychological and social support, as well as screening and monitoring for social determinants of health. This, in addition to Palliative Care, care coordination for comorbidities, and nutritional counseling really provide the holistic system of care that we need for heart failure patients to have quality care.

(30:08)

So, changing our focus a bit to Heart Failure with Preserved Ejection Fraction. The guidelines do give us a set of instructions for how to really consider the patient with Heart Failure with Preserved Ejection Fraction, and, again, noting that we'll use that universal definition of heart failure using the Ejection Fraction to stratify and determine those who would have heart failure with Preserved Ejection Fraction, and really having to have evidence of elevated intracardiac filling pressures. This is an algorithm from the expert consensus pathway that helps us to better delineate with regards to who may have Heart Failure with Preserved Ejection Fraction or reminds us of some of the clinical tools that we can use to assess that.

Considering Heart Failure with Preserved Ejection Fraction, there have been several trials that have examined SGLT2 inhibitors, dapagliflozin and empagliflozin, MRAs, spironolactone, the ARNi complex, and ARBs with regards to Heart Failure with Preserved Ejection Fraction outcomes and reduction of hospitalization, and from that, we have determined that there are helpful Guideline-Directed Medical Therapies for HFpEF that can impact patient outcomes.

If we consider the SGLT2 inhibitors, the DELIVER trial looking at dapagliflozin and a primary composite outcome in terms of heart failure hospitalization, worsening heart failure hospitalization, and mortality, we see reduction in risk with initiation of SGLT2 inhibitors, and again, we see separation of those curves early, reminding us that early initiation of these therapies is critical, and similarly with empagliflozin, we see separation of these curves early after initiation of therapy in patients with Heart Failure with Preserved Ejection Fraction, reminding us of the role in improving outcomes, particularly being driven by reduction in risk for future heart failure hospitalizations.

And so our 2022 guidelines remind us that, in addition to the Class 1 recommendation for diuretics for decongestion, that SGLT2 inhibitors have a Class 2A recommendation and should be used in patients hospitalized with Heart Failure with Preserved Ejection Fraction, and that we should also consider the initiation of the ARNi complex, MRAs, and ARBs in appropriately selected patients to assist with heart failure HFpEF comorbidities and HFpEF management.

For Heart Failure with Mildly Reduced Ejection Fraction, we're reminded to use Class 1 recommendation for diuretics for decongestion, a Class 2A recommendation to initiate SGLT2 inhibitors, and a Class 2B recommendation for RAAS antagonists, MRAs, and also for evidence-based beta blockers that we similarly use for Heart Failure with Reduced Ejection Fraction.

The expert consensus pathway also reminds us to have SGLT2 inhibitors as backbone therapy for Heart Failure with Preserved Ejection Fraction, and then to use the loop diuretics for decongestion and initiation of the 2B therapies of RAAS antagonists and MRAs in appropriate conditions in appropriately selected patients.

So, in summary, I hope we were able to impress upon you that Heart Failure Guideline-Directed Medical Therapies for heart failure is lifesaving and disease-modifying therapy. Quad-based therapy is Class 1 recommended for Heart Failure with Reduced Fraction. We know and we have seen based on the data that early initiation is imperative and that quad-based therapy works together to reduce risk and that initiating patients on this therapy early and during the time of their heart failure hospitalization reduces their long-term exposure and reduces their risk of future hospitalizations, and that is why there has been elevation of the defect-free care for quad therapy for patients with heart failure Reduced Ejection Fraction.

In addition, in summary, for Heart Failure with Preserved Ejection Fraction and Heart Failure with Mildly Reduced Ejection Fraction, SGLT2 inhibitors are the cornerstone of therapy in addition to decongestion with diuretics and SGLT2 inhibitors now have a class 2A recommendation. We have elevated the measure for SGLT2 inhibitors at discharge for Heart Failure with Preserved Ejection Fraction and Mildly Reduced Ejection Fraction. In summary, we know that the clinical benefits of guideline therapy occur early, that the heart failure hospitalization is a critical period in which we are at time zero to really get these therapies together quickly and at the time of discharge so that they continue in the early post-acute phase of the heart failure hospitalization, that it's imperative to initiate these therapies as lifesaving therapies with rapid titration, and that this is where we really need to bring the entire heart failure system of care to optimize outcomes for our patients to reduce mortality, reduce heart failure hospitalizations, and improve their quality of life. Now, Danielle, back to you.

(35:03)

Thank you Dr. Lewsey for that thorough background supporting these two measures and explaining why they are so important for the ACHF program to include as required performance measures.

Now that we've covered the new measures that will improve the quality of care our patients with heart failure receive, I'd like to review the few measures TJC is removing from the ACHF program.

The measures that will be removed from ACHF starting January 1st, 2025, are ACHF01 Beta-blocker at discharge and all seven optional outpatient measures. The reason for removing ACHF01 is that it has been topped out since 2018 and there are more meaningful measures that exist now that can replace this measure. For example, the AHAHF106 Defect-Free Care Quad Therapy measure. The reason I say remove instead of retire is because this measure is only being removed from the ACHF requirements. This measure will still be active in the Joint Commission specifications manual because it is used in the comprehensive Cardiac center certification. ACHF01 will also be removed from the ACHF measure bundle that is applied in the Get with The Guidelines Heart Failure Registry. The outpatient measures, which were always optional, are also being removed because since 2015, only one to two health organizations have submitted data on these measures. They have been difficult for organizations to collect data on. Therefore, not many have used them similarly to ACHF-01 two of these outpatient measures are included in the CCCC program and that will still be the case. These measures are the ACHFOP-03 Hospital outpatient MRA and ACHFOP-06 Hospital Outpatient Discussion of Advanced Directives, Advanced Care Planning.

Certified ACHF organizations will submit their data for the two new Get With The Guidelines. Heart Failure measures into The Joint Commission Certification Measurement Information Process tool, also known as CMIP.

The data entry process into CMIP for the two new Get With The Guidelines. Heart failure measures is the same as your current process for the already existing Joint Commission ACHF measures. The new measures will appear in the Advanced Heart Failure section in the organization CMIP portal, you'll select the appropriate measure from the dropdown in the performance measure, short name, the new Get with The Guidelines Heart Failure measures will be added as options to this dropdown. Then proceed to enter numerator and denominator values for the corresponding month in the table below. These values can be generated from the Get With The Guidelines Heart Failure Registry, as Natalie showed on her slide.

The key difference with these two measures is that the measure specifications will not be located in the TJC Specification Manual because they are AHA measures. Measure specifications can be accessed by contacting the AHA at gwtgsupport@heart.org, and this is also listed at one of the later slides in the slide deck.

In summary, this presentation provided information on the clinical significance of the new required Get with The Guidelines. Heart Failure measures, some background on the performance measures to be removed from ACHF, and an overview on how to submit data to The Joint Commission's CMIP platform.

Additional resources relevant to the advanced certification heart failure are listed on this slide. The Joint Commission specifications manual can be found at the listed website address, here on the slide, please reference the Disease Specific Care manual for ACHF Standards and Performance measurement requirements, which is updated every six months and the 2022 Heart Failure Clinical Practice Guidelines, which we referenced a few times throughout this webinar. And this is also the reading activity, which is provided at the link here on this slide. Thank you very much. And now I will turn it back over to Susan.

Excellent. Thanks so much, Danielle, since these new measures are stewarded by the American Heart Association, any questions specific to these Get With The Guidelines Heart Failure measures or specifications, please contact the AHA at gwtgsupport@heart.org. To ask questions about The Joint Commission ACHF measures, please submit via the Wiki platform at the address provided on the slide. If you downloaded this slide deck, you can access it via the Hyperlink, Joint Commission staff monitor this portal closely. If you have questions about the webinar operations or obtaining CEs, please submit them via email to pioneersinquality@jointcommission.org.

Additionally, if you still have questions on the content covered in this webinar within the CE survey, we've provided a section for you to submit remaining questions. Depending on how many questions come in, we will create an FAQ document and post in the coming weeks. We will notify anyone who registered for this webinar during the eligibility period when we post this document.

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Before this webinar concludes a few words about the CE survey, we use your feedback to inform future content and assess the quality of our educational programs. As explained earlier in the webinar, a QR code will appear on the next slide. You can use your mobile device to scan and access the survey. If you prefer to take the CE survey later. An automated email also delivers the link to the survey. At the end of the survey, when you click submit, you'll be redirected to a page from which you can print or download a blank CE certificate that you complete by adding your own name and credentials. In case you miss that opportunity to download, an automated email will also be sent to you. That includes the link to the certificate.

Thank you Danielle, Natalie, and Sabra for your presentations and thanks to all of you that attended this On Demand webinar. We'll leave this slide up for a few moments so participants can scan the survey QR code. Have a great day.