

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

PMT FORM SELECTION		Legend: Elements in bold are required	
HF		Patient ID: _____	
<b>DEMOGRAPHICS</b>		<b>Demographics Tab</b>	
Gender	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Unknown
Date of Birth	____/____/____ (MM/DD/YYYY)	Patient Postal Code	____ - ____
Payment Source	<input type="checkbox"/> Medicaid (Title 19) <input type="checkbox"/> Medicare (Title 18) <input type="checkbox"/> Private/HMO/Other	<input type="checkbox"/> Medicare – Private/HMO/Other <input type="checkbox"/> No Insurance/Not Documented	
External Tracking ID	_____		
<b>RACE AND ETHNICITY</b>		<b>Demographics Tab</b>	
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> UTD	
Hispanic Ethnicity	<input type="radio"/> Yes	<input type="radio"/> No/UTD	
If yes,	<input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino, or Spanish Origin	
<b>ARRIVAL AND ADMISSION INFORMATION</b>		<b>Admission Tab</b>	
Internal Tracking ID	_____	Physician/Provider NPI	_____
Arrival Date/Time	____/____/____ ____: ____	Admit Date	____/____/____
Transferred in (from another ED?)	<input type="radio"/> Yes	<input type="radio"/> No	
Point of Origin for Admission or Visit	<input type="radio"/> 1. Non-Healthcare Facility Point of Origin <input type="radio"/> 2. Clinic <input type="radio"/> 4. Transfer from a Hospital (Different Facility) <input type="radio"/> 5. Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	<input type="radio"/> 6. Transfer from another Health Care Facility <input type="radio"/> 7. Emergency Room <input type="radio"/> 9. Information not available <input type="radio"/> F. Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program	
Discharge Date/Time	____/____/____ ____: ____		
<b>MEDICAL HISTORY</b>		<b>Admission Tab</b>	
<b>Medical History (Select all that apply):</b>			
<input type="checkbox"/> None <input type="checkbox"/> Atrial Flutter (Chronic or Recurrent) <input type="checkbox"/> COPD or Asthma  <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Dialysis (Chronic) <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> ICD only <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Prior MI <input type="checkbox"/> Renal Insufficiency – Chronic (SCr>2.0) <input type="checkbox"/> Sleep Disordered Breathing (Type): <input type="checkbox"/> Obstructive <input type="checkbox"/> Central	<input type="checkbox"/> Anemia <input type="checkbox"/> CAD  <input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD) <input type="checkbox"/> Depression <input type="checkbox"/> <b>Emerging Infectious Disease</b> <input type="checkbox"/> <b>SARS-COV-1</b> <input type="checkbox"/> <b>SARS-COV-2</b> <input type="checkbox"/> <b>MERS</b> <input type="checkbox"/> <b>Other infectious respiratory pathogen</b> <input type="checkbox"/> Familial hypercholesterolemia <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prior CABG	<input type="checkbox"/> Atrial Fib (Chronic or Recurrent) <input type="checkbox"/> CardioMEMs (implantable hemodynamic monitor) <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only)  <input type="checkbox"/> Diabetes <input type="radio"/> Type I <input type="radio"/> Type II <input type="radio"/> ND <b>Duration:</b> <input type="radio"/> <5 years <input type="radio"/> 5 - <10 years <input type="radio"/> 10 - <20 years <input type="radio"/> >= 20 years <input type="radio"/> Unknown	

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

<input type="checkbox"/> Mixed <input type="checkbox"/> Unknown/Not Documented <i>Equipment Used at Home:</i> <input type="checkbox"/> O2 <input type="checkbox"/> CPAP <input type="checkbox"/> Adaptive Servo-Ventilation <input type="checkbox"/> None <input type="checkbox"/> Unknown/Not Documented	<input type="checkbox"/> Prior PCI  <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Ventricular Assist Device	
History of cigarette smoking? (In the past 12 months)		<input type="radio"/> Yes <input type="radio"/> No
<b>Heart Failure History</b>		
<b>Etiology:</b> Check if history of:	<input type="checkbox"/> Ischemic/CAD	<input type="checkbox"/> Non-Ischemic <input type="checkbox"/> Hypertensive <input type="checkbox"/> Alcohol/Other Drug <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Viral <input type="checkbox"/> Postpartum <input type="checkbox"/> Familial <input type="checkbox"/> Other Etiology <input type="checkbox"/> Unknown/Idiopathic
Known history of HF prior to this admission?	<input type="radio"/> Yes	<input type="radio"/> No
# of hospital admissions in past 6 mo. for HF:	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> >2	<input type="radio"/> Unknown
	<input type="checkbox"/> Patient Listed for Transplant	
<b>DIAGNOSIS</b>		
<i>Admission Tab</i>		
Heart Failure Diagnosis	<input type="checkbox"/> Heart Failure, primary diagnosis, with CAD <input type="checkbox"/> Heart Failure, primary diagnosis, no CAD <input type="checkbox"/> Heart Failure, secondary diagnosis	
Atrial Fibrillation (At presentation or during hospitalization)	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Documented New Onset?
Atrial Flutter (At presentation or during hospitalization)	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Documented New Onset?
New Diagnosis of Diabetes	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
Basis for Diagnosis	<input type="checkbox"/> HbA1c <input type="checkbox"/> Oral Glucose Tolerance	<input type="checkbox"/> Fasting Blood Sugar <input type="checkbox"/> Test Other
Characterization of HF at admission or when first recognized	<input type="radio"/> Acute Pulmonary Edema <input type="radio"/> Dizziness/Syncope <input type="radio"/> Dyspnea <input type="radio"/> ICD Shock/Sustained Ventricular Arrhythmia	<input type="radio"/> Pulmonary Congestion <input type="radio"/> Volume overload/Weight Gain <input type="radio"/> Worsening fatigue <input type="radio"/> Other
Other Conditions Contributing to HF Exacerbation <i>Select all that apply</i>	<input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pneumonia/respiratory process <input type="checkbox"/> Noncompliance - medication	<input type="checkbox"/> Worsening Renal Failure <input type="checkbox"/> Ischemia/ACS <input type="checkbox"/> Uncontrolled HTN <input type="checkbox"/> Noncompliance – Dietary <input type="checkbox"/> Other
<b>Active bacterial or viral infection at admission or during hospitalization</b>	<input type="checkbox"/> Seasonal cold or flu <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> MERS <input type="checkbox"/> Other infectious respiratory pathogen	<input type="checkbox"/> Bacterial infection <input type="checkbox"/> None
<b>MEDICATIONS AT ADMISSION</b>		
<i>Admission Tab</i>		

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

Medications Used Prior to Admission: <i>[Select all that apply]</i>					
<input type="checkbox"/> Patient on no meds prior to admission <input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Aldosterone Antagonist <input type="checkbox"/> Angiotensin receptor blocker (ARB) <input type="checkbox"/> Angiotensin Receptor Neprilysin Inhibitor (ARNI) <input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Aspirin <input type="checkbox"/> Antiplatelet agent (excluding aspirin)	<input type="checkbox"/> Anticoagulation Therapy <input type="radio"/> Warfarin <input type="radio"/> Direct Thrombin Inhibitor <input type="radio"/> Factor Xa Inhibitor <input type="radio"/> Other <input type="checkbox"/> Anti-hyperglycemic medications: <input type="checkbox"/> DPP-4 Inhibitors <input type="checkbox"/> GLP-1 receptor agonist <input type="checkbox"/> Insulin <input type="checkbox"/> Metformin <input type="checkbox"/> SGLT2 Inhibitor <input type="checkbox"/> Sulfonylurea <input type="checkbox"/> Thiazolidinedione <input type="checkbox"/> Other Oral Agents <input type="checkbox"/> Other injectable/subcutaneous agents	<input type="checkbox"/> Beta-Blocker <input type="checkbox"/> Ca channel blocker <input type="checkbox"/> Digoxin <input type="checkbox"/> Diuretic <input type="checkbox"/> Thiazide/Thiazide-like <input type="checkbox"/> Loop <input type="checkbox"/> Hydralazine <input type="checkbox"/> Ivabradine <input type="checkbox"/> Lipid lowering agent (Any) <input type="checkbox"/> Statin <input type="checkbox"/> Other Lipid lowering agent <input type="checkbox"/> Nitrate <input type="checkbox"/> Omega-3 fatty acid supplement <input type="checkbox"/> Renin Inhibitor <input type="checkbox"/> Other			
EXAMS/LABS AT ADMISSION					
Admission Tab					
Symptoms (Closest to Admission) <i>Select all that apply</i>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Orthopnea <input type="checkbox"/> Palpitations	<input type="checkbox"/> Dyspnea at rest <input type="checkbox"/> Fatigue <input type="checkbox"/> PND	<input type="checkbox"/> Dyspnea on Exertion <input type="checkbox"/> Decreased appetite/early satiety <input type="checkbox"/> Dizziness/lightheadedness/syncope		
Vital signs (Closest to Admission)	Height	_____ <input type="radio"/> inches <input type="radio"/> cm			<input type="checkbox"/> Not Documented
	Weight	_____ <input type="radio"/> Lbs. <input type="radio"/> Kgs.			<input type="checkbox"/> Not Documented
	Waist Circumference	_____ <input type="radio"/> inches <input type="radio"/> cm			<input type="checkbox"/> Not Documented
	BMI	_____ (Automatically Calculated)			
	Heart Rate	_____ bpm			<input type="checkbox"/> Not Documented
	BP-Supine	_____ / _____ mmHg (systolic/diastolic)			<input type="checkbox"/> Not Documented
	Respiratory Rate	_____ breaths per minute			
Exam (Closest to Admission)	JVP:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	If Yes, _____ cm
	Rales:	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown	If Yes, <input type="radio"/> <1/3 <input type="radio"/> ≥1/3 <input type="radio"/> N/A	
	Lower Extremity Edema	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Unknown	If Yes, <input type="radio"/> Trace <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+ <input type="radio"/> N/A	
Lipids	TC: _____ mg/dL	HDL: _____ mg/dL	LDL: _____ mg/dL	TG: _____ mg/dL	<input type="checkbox"/> Lipids Not Available
Labs (Closest to Admission)	Na	_____ <input type="radio"/> mEq/L	<input type="radio"/> mmol/L	<input type="radio"/> mg/dL	<input type="checkbox"/> Unavailable
	BNP	_____ <input type="radio"/> pg/mL	<input type="radio"/> pmol/L	<input type="radio"/> ng/L	<input type="checkbox"/> Unavailable
	K	_____ <input type="radio"/> mEq/L	<input type="radio"/> mmol/L	<input type="radio"/> mg/dL	<input type="checkbox"/> Unavailable
	Hgb	_____ <input type="radio"/> g/dL	<input type="radio"/> g/L		<input type="checkbox"/> Unavailable
	Albumin	_____ <input type="radio"/> g/dL	<input type="radio"/> g/L		<input type="checkbox"/> Unavailable
	NT-proBNP	_____ <input type="radio"/> pg/mL	<input type="radio"/> ng/L		<input type="checkbox"/> Unavailable
	SCr	_____ <input type="radio"/> mg/dL	<input type="radio"/> μmol/L		<input type="checkbox"/> Unavailable
	BUN	_____ <input type="radio"/> mg/dL	<input type="radio"/> μmol/L		<input type="checkbox"/> Unavailable
	Troponin (Peak)	_____ <input type="radio"/> ng/mL <input type="radio"/> ug/L	<input type="radio"/> T <input type="radio"/> I	<input type="radio"/> Normal <input type="radio"/> Abnormal	<input type="checkbox"/> Unavailable
	Ferritin	_____ ng/mL			
	HbA1C	_____ %			<input type="checkbox"/> Unavailable
	Fasting Blood Glucose (mg/dL)	_____			<input type="checkbox"/> Unavailable
	EKG QRS Duration (ms)	_____			<input type="checkbox"/> Unavailable

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

	<b>EKG QRS Morphology</b>	<input type="radio"/> Normal <input type="radio"/> LBBB	<input type="radio"/> RBBB <input type="radio"/> NS-IVCD	<input type="radio"/> Paced <input type="radio"/> Unavailable
<b>CLINICAL CODES</b>		<b>Clinical Codes Tab</b>		
ICD-10-CM Principal Diagnosis Code		_____		
ICD-10-CM Other Diagnoses Codes	1.	2.	3.	
	4.	5.	6.	
	7.	8.	9.	
	10.	11.	12.	
ICD-10-PCS Principal Procedure Code		_____	Date: __/__/____	<input type="checkbox"/> Date UTD
ICD-10-PCS Other Principal Procedure Codes	1.	Date: __/__/____	<input type="checkbox"/> Date UTD	
	2.	Date: __/__/____	<input type="checkbox"/> Date UTD	
	3.	Date: __/__/____	<input type="checkbox"/> Date UTD	
	4.	Date: __/__/____	<input type="checkbox"/> Date UTD	
	5.	Date: __/__/____	<input type="checkbox"/> Date UTD	
<b>IN-HOSPITAL CARE</b>		<b>In-Hospital Tab</b>		
<b>Procedures</b>				
<input type="checkbox"/> No Procedures <input type="checkbox"/> Cardiac Cath/Coronary Angiography <input type="checkbox"/> CardioMEMs (implantable hemodynamic monitor) <input type="checkbox"/> Coronary Artery Bypass Graft <input type="checkbox"/> CRT-P (cardiac resynchronization therapy-pacing only) <input type="checkbox"/> Dialysis or Ultrafiltration unspecified <input type="checkbox"/> ICD only <input type="checkbox"/> Mechanical Ventilation <input type="checkbox"/> PCI <input type="checkbox"/> Right Cardiac Catheterization <input type="checkbox"/> Transplant (Heart) <input type="checkbox"/> Atrial Fibrillation Ablation or Surgery <input type="checkbox"/> Cardiac Valve Surgery <input type="checkbox"/> Cardioversion <input type="checkbox"/> CRT-D (cardiac resynchronization therapy with ICD) <input type="checkbox"/> Dialysis <input type="checkbox"/> Intra-aortic Balloon Pump <input type="checkbox"/> Left Ventricular Assist Device <input type="checkbox"/> Pacemaker <input type="checkbox"/> PCI with stent <input type="checkbox"/> Stress Testing <input type="checkbox"/> Ultrafiltration				
EF - Quantitative	_____ %	Obtained:	<input type="radio"/> This Admission <input type="radio"/> Within the last year <input type="radio"/> > 1 year ago	
EF - Qualitative	<input type="radio"/> Not Applicable <input type="radio"/> Normal or mild dysfunction <input type="radio"/> Qualitative moderate/severe dysfunction <input type="radio"/> Performed/results not available <input type="radio"/> Planned after discharge <input type="radio"/> Not performed	Obtained:	<input type="radio"/> This Admission <input type="radio"/> Within the last year <input type="radio"/> > 1 year ago	
Documented LVSD?	<input type="radio"/> Yes	<input type="radio"/> No		
LVF Assessment?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not done, Reason Documented	
Oral Medications during hospitalization <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> ARNI <input type="checkbox"/> ARB	<input type="checkbox"/> Aldosterone Antagonist <input type="checkbox"/> Hydralazine Nitrate	<input type="checkbox"/> ACE Inhibitor <input type="checkbox"/> Beta Blocker	
Parenteral Therapies during hospitalization <i>Select all that apply</i>	<input type="checkbox"/> None <input type="checkbox"/> Dopamine <input type="checkbox"/> Iron <input type="checkbox"/> Milrinone <input type="checkbox"/> Nesiritide	<input type="checkbox"/> Nitroglycerine <input type="checkbox"/> Vasopressin antagonist <input type="checkbox"/> Other IV Vasodilator	<input type="checkbox"/> Dobutamine <input type="checkbox"/> Loop Diuretics <input type="checkbox"/> Intermittent Bolus <input type="checkbox"/> Continuous Infusion	
Was the patient ambulating at the end of hospital day 2?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Was DVT prophylaxis initiated by the end of hospital day 2?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Contraindicated
If yes,	<input type="checkbox"/> Low dose unfractionated heparin (LDUH)	<input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Direct thrombin inhibitor <input type="checkbox"/> Venous foot pumps (VFP)		

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

	<input type="checkbox"/> Low molecular weight heparin (LMWH) <input type="checkbox"/> Warfarin <input type="checkbox"/> Other	<input type="checkbox"/> Intermittent pneumatic compression devices (IPC)
<b>Was DVT or PE (pulmonary embolus) documented?</b>		<input type="radio"/> Yes <input type="radio"/> No/Not Documented
<b>Influenza Vaccination</b>	<input type="radio"/> Influenza vaccine was given during this hospitalization during the current flu season <input type="radio"/> Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of influenza vaccine <input type="radio"/> Allergy/Sensitivity to influenza or if medically contraindicated <input type="radio"/> Vaccine not available <input type="radio"/> None of the above/Not Documented/UTD	
<b>Pneumococcal Vaccination</b>	<input type="radio"/> Pneumococcal vaccine was given during this hospitalization <input type="radio"/> Pneumococcal vaccine was received in the past, not during this hospitalization <input type="radio"/> Documentation of patient's refusal of pneumococcal vaccine <input type="radio"/> Allergy/sensitivity to pneumococcal vaccine <input type="radio"/> None of the above/Not Documented/UTD	
<b>DISCHARGE INFORMATION</b>		
Discharge Date/Time		____/____/____ ____:____ <input type="checkbox"/> MM/DD/YYYY only
Get With The Guidelines® HF Estimated Mortality Rate		____ %    [Calculated in the PMT]
<b>For patients discharged on or after 04/01/2011: What was the patient's discharge disposition on the day of discharge?</b>	1 – Home 2 – Hospice – Home 3 – Hospice – Health Care Facility 4 – Acute Care Facility 5 – Other Health Care Facility 6 – Expired 7 – Left Against Medical Advice/AMA 8 – Not documented or Unable to Determine (UTD)	
<b>If other Health Care Facility:</b>	<input type="radio"/> Skilled Nursing Facility (SNF) <input type="radio"/> Inpatient Rehabilitation Facility (IRF) <input type="radio"/> Long Term Care Hospital (LTCH) <input type="radio"/> Intermediate Care Facility (ICF) <input type="radio"/> Other	
If Home, special discharge circumstances:	<input type="radio"/> Home Health Care <input type="radio"/> Homeless	<input type="radio"/> International <input type="radio"/> Prison/Incarcerated <input type="radio"/> None/UTD
Primary Cause of Death	<input type="radio"/> Cardiovascular <input type="radio"/> Acute Coronary Syndrome	<input type="radio"/> Non-Cardiovascular <input type="radio"/> Worsening Heart Failure <input type="radio"/> Sudden Death <input type="radio"/> Other
<b>When is the earliest physician/APN/PA documentation of comfort measures only?</b>	<input type="radio"/> Day 0 or 1 <input type="radio"/> Day 2 or after <input type="radio"/> Timing unclear <input type="radio"/> Not Documented	
Symptoms (closest to discharge)	<input type="radio"/> Worse <input type="radio"/> Unchanged	<input type="radio"/> Better, Symptomatic <input type="radio"/> Better, Asymptomatic <input type="radio"/> Unable to determine
Vital Signs (closest to Discharge)	Weight	____ ○Lbs.    ○Kgs. <input type="checkbox"/> Not Documented
	Heart Rate	____ bpm <input type="checkbox"/> Not Documented
	BP-Supine	____ / ____ mmHg (systolic/diastolic) <input type="checkbox"/> Not Documented
	Respiratory Rate	____ breaths per minute
Exam (Closest to Discharge)	JVP:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown    If Yes, ____ cm
	Rales:	<input type="radio"/> Yes <input type="radio"/> Unknown    If Yes, <input type="radio"/> <1/3 <input type="radio"/> ≥1/3 <input type="radio"/> N/A
	Lower Extremity Edema	<input type="radio"/> Yes <input type="radio"/> Unknown    If Yes, <input type="radio"/> Trace <input type="radio"/> 2+ <input type="radio"/> 4+ <input type="radio"/> N/A
Labs (Closest to Discharge)	Na	____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL <input type="checkbox"/> Unavailable
	BNP	____ <input type="radio"/> pg/mL <input type="radio"/> pmol/L <input type="radio"/> ng/L <input type="checkbox"/> Unavailable
	SCr	____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L <input type="checkbox"/> Unavailable
	BUN	____ <input type="radio"/> mg/dL <input type="radio"/> μmol/L <input type="checkbox"/> Unavailable
	NT-BNP (pg/mL)	____ <input type="checkbox"/> Not Documented
	K	____ <input type="radio"/> mEq/L <input type="radio"/> mmol/L <input type="radio"/> mg/dL <input type="checkbox"/> Unavailable
<b>DISCHARGE MEDICATIONS</b>		
Angiotensin Converting Enzyme Inhibitor (ACEI)		

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
<b>Contraindications or Other Documented Reason(s) For Not Providing ACEI:</b>	<input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason			
Angiotensin Receptor Blocker (ARB)				
<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
<b>Contraindications or Other Documented Reason(s) For Not Providing ARB:</b>	<input type="checkbox"/> Hypotensive patient who was at immediate risk of cardiogenic shock <input type="checkbox"/> Hospitalized patient who experienced marked azotemia <input type="checkbox"/> Other <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason			
Angiotensin Receptor Neprilysin Inhibitor (ARNI)				
<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindications or Other Documented Reason(s) for Not Providing ARNI at Discharge:	<input type="checkbox"/> ACE inhibitor use within the prior 36 hours <input type="checkbox"/> Renal dysfunction defined as creatinine > 2.5 mg/dL in men or > 2.0 mg/dL in women	<input type="checkbox"/> Allergy <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hypotension <input type="checkbox"/> Other medical reasons <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		
<b>Reasons for not switching to ARNI at discharge:</b>	<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> ARNI was prescribed at discharge	
If Yes,	<input type="checkbox"/> New Onset Heart Failure <input type="checkbox"/> Not previously tolerating ACEI/ARB	<input type="checkbox"/> NYHA Class I <input type="checkbox"/> NYHA Class IV		
Acetylsalicylic acid (ASA)				
<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
Anticoagulation Therapy				
<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	<b>Class:</b> <input type="checkbox"/> Warfarin <input type="checkbox"/> Direct Thrombin Inhibitor		<input type="checkbox"/> Factor Xa Inhibitor <input type="checkbox"/> Other	
	Medication:	Dosage:	Frequency:	
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes, Contraindication(s):	<input type="checkbox"/> Allergy to or complication r/t anticoagulation therapy (hx or current) <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Risk for bleeding or discontinued due to bleeding <input type="checkbox"/> Serious side effect to medication <input type="checkbox"/> Terminal illness/Comfort Measures Only			
Clopidogrel				
<b>Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Dosage:	Frequency:		
<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No	
Other Antiplatelet(s)				

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700



# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
Beta-Blocker				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	<b>Class of Beta Blocker:</b>			
	<input type="radio"/> Evidence-Based Beta Blocker <input type="radio"/> Non-Evidence-Based Beta Blocker <input type="radio"/> Unknown Class			
	Medication:	Dosage:	Frequency:	
Contraindicated?	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindications or Other Documented Reason(s) For Not Providing Beta Blockers:	<input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Fluid Overload <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		<input type="checkbox"/> Patient recently treated with an intravenous positive inotropic agent <input type="checkbox"/> Asthma <input type="checkbox"/> Other	
Aldosterone Antagonist				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Medication:	Dosage:	Frequency:	
Contraindicated?	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindications or Other Documented Reason(s) for Not Providing Aldosterone Antagonist at Discharge	<input type="checkbox"/> Allergy due to aldosterone receptor antagonist <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Other Medical Reasons <input type="checkbox"/> Other Contraindications		<input type="checkbox"/> Renal dysfunction defined as creatinine >2.5 mg/dL in men or >2.0 mg/dL in women <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason	
Anti-hyperglycemic Medications:				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Class:	Medication:		
	Class:	Medication:		
	Class:	Medication:		
Was there a documented reason for not prescribing a medication with proven CVD benefit?	<input type="radio"/> Yes		<input type="radio"/> No/Not Documented	
Lipid Lowering Medication(s):				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
If Yes,	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
	Class:	Medication:	Dosage:	Frequency:
Contraindicated?	<input type="radio"/> Yes		<input type="radio"/> No	
Omega-3 fatty acid supplement:				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindicated?	<input type="radio"/> Yes		<input type="radio"/> No	
Hydralazine Nitrate				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindicated?	<input type="radio"/> Yes		<input type="radio"/> No	
Contraindications or Other Documented Reason(s) For Not Providing Hydralazine Nitrate:	<input type="checkbox"/> Medical Reason <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason			
Ivabradine				
Prescribed?	<input type="radio"/> Yes		<input type="radio"/> No	

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

<b>Contraindicated?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Contraindications or Other Documented Reason(s) For Not Providing Ivabradine:</b>	<input type="checkbox"/> Allergy to Ivabradine <input type="checkbox"/> NYHA class I or IV <input type="checkbox"/> New Onset of HF <input type="checkbox"/> Not in sinus rhythm <input type="checkbox"/> Patient 100% atrial or ventricular paced		<input type="checkbox"/> Not treated with maximally tolerated dose beta blockers or beta blockers contraindicated <input type="checkbox"/> Other Medical Reasons <input type="checkbox"/> Patient Reasons <input type="checkbox"/> System Reasons		
<b>Other Medications at Discharge</b>					
<input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Amiodarone <input type="checkbox"/> Dofetilide <input type="checkbox"/> Sotalol <input type="checkbox"/> Other	<input type="checkbox"/> Ca Channel Blocker <input type="checkbox"/> Digoxin <input type="checkbox"/> Diuretic <input type="checkbox"/> Loop Diuretic <input type="checkbox"/> Thiazide Diuretic	<input type="checkbox"/> Nitrate <input type="checkbox"/> Ranolazine <input type="checkbox"/> Renin Inhibitor <input type="checkbox"/> Other Anti-Hypertensive <input type="checkbox"/> Other			
<b>OTHER THERAPIES</b>			<b>Discharge Tab</b>		
<b>ICD Therapy</b>					
<b>Counseling?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Reason for not counseling</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Documented Medical Reason(s) for Not Counseling?</b>	<input type="checkbox"/> ICD or CRT-D device in patient <input type="checkbox"/> Multiple or significant comorbidities		<input type="checkbox"/> Limited Life Expectancy <input type="checkbox"/> other reasons not eligible for ICD (e.g. EF>35%, new onset HF) <input type="checkbox"/> Other reasons for not counseling		
<b>Placed or Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Reason(s) for Not Placing or Prescribing?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Documented Reason(s) for Not Placing or Prescribing ICD Therapy?</b>	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Patient Reason <input type="checkbox"/> System Reason		<input type="checkbox"/> Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset HF		
<b>CRT Therapy</b>					
<b>CRT-D Placed or Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>CRT-P Placed or Prescribed?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Reason for not Placing or Prescribing?</b>	<input type="radio"/> Yes		<input type="radio"/> No		
<b>Documented Reason(s) for Not Placing or Prescribing CRT Therapy?</b>	<input type="checkbox"/> Contraindications <input type="checkbox"/> Not receiving optimal medical therapy <input type="checkbox"/> Not NYHA functional Class III or ambulatory Class IV <input type="checkbox"/> Patient Reason		<input type="checkbox"/> Any other physician documented reason including AMI in prior 40 days, recent revascularization, recent onset of HF <input type="checkbox"/> QRS duration <120 ms <input type="checkbox"/> System Reason		
<b>RISK INTERVENTIONS</b>			<b>Discharge Tab</b>		
<b>Smoking Cessation Counseling Given</b>	<input type="radio"/> Yes		<input type="radio"/> No		
Smoking Cessation Therapies Prescribed (select all that apply)	<input type="checkbox"/> Counseling Only <input type="checkbox"/> Over the Counter Nicotine Replacement Therapy		<input type="checkbox"/> Prescription Medications <input type="checkbox"/> Other <input type="checkbox"/> Treatment Not Specified		
<b>DISCHARGE INSTRUCTIONS</b>			<b>Discharge Tab</b>		
Activity Level	<input type="radio"/> Yes	<input type="radio"/> No	Diet (Salt restricted)	<input type="radio"/> Yes	<input type="radio"/> No
Follow-up	<input type="radio"/> Yes	<input type="radio"/> No	Medications	<input type="radio"/> Yes	<input type="radio"/> No
Symptoms Worsening	<input type="radio"/> Yes	<input type="radio"/> No	Weight Monitoring	<input type="radio"/> Yes	<input type="radio"/> No
<b>Follow-up Visit Scheduled</b>	<input type="radio"/> Yes	<input type="radio"/> No	<b>Date/Time of first follow-up visit:</b>	____/____/____ ____:____	
<b>Location of first follow-up visit:</b>			<input type="radio"/> Office Visit <input type="radio"/> Home Health Visit	<input type="radio"/> Telehealth <input type="radio"/> Not Documented	
<b>Medical or Patient Reason for no follow-up appointment being scheduled?</b>			<input type="radio"/> Yes	<input type="radio"/> No	

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700



# HF PATIENT MANAGEMENT TOOL

April 2020

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700

Follow-up Phone Call Scheduled	<input type="radio"/> Yes	<input type="radio"/> No	Date/Time of first follow-up phone call:	___/___/___
Follow-up appointment scheduled for diabetes management?	<input type="radio"/> Yes	<input type="radio"/> No	Date of diabetes management follow-up visit:	___/___/___
<b>OTHER RISK INTERVENTIONS</b>			<b>Discharge Tab</b>	
TLC (Therapeutic Lifestyle Change) Diet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Obesity Weight Management	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Activity Level/Recommendation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referred to Outpatient Cardiac Rehab Program	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Anticoagulation Therapy Education	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Was Diabetes Teaching provided?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
PT/INR Planned Follow-Up	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referral to Sleep Study	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Referral to Outpatient HF Management Program	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
If Yes,	<input type="checkbox"/> Telemanagement		<input type="checkbox"/> Home Visit	<input type="checkbox"/> Clinic-based
Referral to AHA My HF Guide/Heart Failure Interactive Workbook	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Provision of at least 60 minutes of Heart Failure Education by a qualified educator	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Advanced Care Plan/Surrogate Decision Maker Documented Or Discussed?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented	<input type="radio"/> Not Applicable
Advance Directive Executed	<input type="radio"/> Yes		<input type="radio"/> No	
<b>POST DISCHARGE TRANSITION</b>			<b>Discharge Tab</b>	
Care Transition Record Transmitted	<input type="radio"/> By the seventh post-discharge day <input type="radio"/> Exists, but not transmitted by the seventh post-discharge day <input type="radio"/> No Care Transition Record/UTD			
Care Transition Record Includes	<input type="checkbox"/> All were included (Check all yes)			
	Discharge Medications	<input type="radio"/> Yes	<input type="radio"/> No	
	Follow-up Treatment(s) and Service(s) Needed	<input type="radio"/> Yes	<input type="radio"/> No	
	Procedures Performed During Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	
	Reason for Hospitalization	<input type="radio"/> Yes	<input type="radio"/> No	
Treatment(s)/Service(s) Provided	<input type="radio"/> Yes	<input type="radio"/> No		
<b>ADMIN/JOINT COMMISSION</b>			<b>Admin/Joint Commission Tab</b>	
CPT Code	_____	Date: ___/___/___	<input type="checkbox"/> Unknown	
What is the patient's source of payment for this episode of care?			<input type="radio"/> Yes	<input type="radio"/> No
Was this Case Sampled?			<input type="radio"/> Yes	<input type="radio"/> No
During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, PR, SCIP)?			<input type="radio"/> Yes	<input type="radio"/> No
Standardized order sets used?			<input type="radio"/> Yes	<input type="radio"/> No
Patient adherence contract/compact used?			<input type="radio"/> Yes	<input type="radio"/> No
Discharge checklist used?			<input type="radio"/> Yes	<input type="radio"/> No
PMT used concurrently or retrospectively or combination?	<input type="radio"/> Concurrently	<input type="radio"/> Retrospectively	<input type="radio"/> Combination	
<b>END OF FORM</b>				

NOT FOR USE WITHOUT PERMISSION. ©2019 American Heart Association and Quintiles. For questions, call 888-526-6700