

Clinical Performance Measures

Heart Failure

Tools Developed by Physicians for Physicians

Provided by:

American College of Cardiology

American Heart Association

Physician Consortium for Performance Improvement

Purpose

This measurement tool provides physicians with *evidence-based*¹ clinical performance measures, including a data collection flowsheet, that may be useful for quality improvement activities within physician practices. The measures and flowsheet are intended for prospective data collection only. The ability to track changes over time is integral to the concept of continuous quality improvement in patient care. Evidence-based clinical performance measures have been identified as a means for tracking these changes.

These measures are provided for physicians by the **American College of Cardiology (ACC)**, the **American Heart Association (AHA)**, and the **Physician Consortium for Performance Improvement (The Consortium)**. The ACC, a professional society of over 25,000 cardiovascular physicians and scientists committed to providing optimal cardiovascular care, and the AHA, a national voluntary health organization with over 30,000 scientist and physician volunteers dedicated to reducing disability and death from cardiovascular diseases and stroke, have joined with The Consortium to ensure that the cardiovascular community speaks with one voice on clinical performance measurement. The ACC and the AHA have a long-standing partnership in publishing clinical practice guidelines and are now developing physician-level performance measures for implementation in both the inpatient and outpatient setting.

The Consortium is a physician-led initiative that includes methodological experts, clinical experts representing more than 50 national medical specialty societies, state medical societies, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services. The Consortium's vision is to fulfill the responsibility of physicians to patient care, public health, and safety by becoming the leading source organization for evidence-based clinical performance measures and outcomes reporting tools for physicians.

Performance measures must be designed based on their intended purpose.^{2,3} The measures presented here are intended to facilitate individual physician quality improvement. Therefore, there are no minimum sample size requirements, and the suggested feedback is sufficiently detailed to pinpoint areas of concern for the physician. The measures defined in this measurement tool are not intended, and should not be used, for physician comparison.⁴

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Performance measures are not clinical guidelines; rather, measures are derived from evidence-based clinical guidelines and indicate whether or not or how often a process or outcome of care occurs.² Performance measures provide important information to a physician, allowing him or her to enhance the quality of care delivered to patients.

Statistics on Heart Failure

A person aged 40 years or older has a 1 in 5 chance of developing heart failure (HF).⁵ Currently, about 5 million Americans are living with HF, and about 550,000 new cases are diagnosed each year.⁶ The high prevalence combined with multiple complications from this condition increase health care costs significantly.

- From 1979 to 2000, HF deaths increased 148%.⁶
- About 22% of male and 46% of female heart attack victims will be disabled with HF within 6 years.⁶
- In individuals diagnosed with HF, sudden cardiac death occurs at 6 to 9 times the rate in the general population.⁶
- In 2003, the annual direct and indirect costs of HF in the United States are expected to exceed \$24 billion.⁶

Statistics on Current Practice

Despite potential risks and established clinical guidelines, recent data suggest that some patients are not being managed optimally for their disease. It has been reported that in some states:

- Only 70% of Medicare patients with HF received an evaluation of ejection fraction.⁷
- Only 68% of Medicare patients with left ventricular ejection fraction <0.40 were prescribed an angiotensin-converting enzyme (ACE) inhibitor.⁷
- Only 75% of all HF patients who are candidates for ACE inhibitors are prescribed them.⁸

Selected Evidence-Based Clinical Guidelines

Evidence-based clinical practice guidelines are available for the management of heart failure. This measurement set is based on clinical guidelines from:

- American College of Cardiology/American Heart Association⁹

The performance measures found in this document have been developed in agreement with these guidelines, enabling the physician to track his or her performance in individual patient care and across patient populations. *Please note that treatment must be based on individual patient needs and professional judgment.*

For more information and updates, including a list of practicing physicians and other experts who developed this measurement set, please visit The Consortium's Web site

www.ama-assn.org/go/quality

Relevant Physician Specialties, Patient Population, and Settings of Care

These performance measures are designed for:

- Use by any physician who manages the ongoing care of patients with diagnosed HF, aged ≥ 18 years.
- Prospective data collection in the office-based practice setting only.

A note on terminology for this condition: Some HF patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema and report few symptoms of dyspnea or fatigue. Because not all patients have volume overload at the time of initial or subsequent evaluation, the term "heart failure" is preferred over the older term "congestive heart failure."⁹

**American College of Cardiology, American Heart Association, and
Physician Consortium for Performance Improvement
Heart Failure Core Physician Performance Measurement Set^a**

	Clinical Recommendations⁹	Clinical Performance Measures Per Reporting Year	
Left Ventricular Function (LVF) Assessment	<p>In patients with HF, an assessment of left ventricular systolic function with 2-dimensional echocardiography or radionuclide ventriculography is recommended. (Class I Recommendation, Level-C Evidence)</p> <p>In patients with a change in clinical status or clinical event/treatment with significant effect on cardiac function, repeat measurement of ejection fraction is recommended. (Level-C Evidence)</p>	<p>Percentage of patients with quantitative or qualitative results of LVF assessment recorded Numerator = Patients with quantitative or qualitative results of LVF assessment recorded Denominator = All patients aged ≥18 years with HF</p>	
		<p><i>Per Patient:</i> Quantitative or qualitative results of LVF assessment</p>	<p><i>Per Patient Population:</i> Percentage of patients with quantitative or qualitative results of LVF assessment recorded</p>
Weight Measurement <i>Denominator Exclusion:</i> Patient visits in which physician was unable to weigh patient	<p>A thorough physical examination is recommended to identify cardiac and noncardiac disorders that may accelerate the progression of HF. This physical examination may include initial and ongoing assessments of the patient's volume status. (Class I Recommendation, Level-C Evidence)</p>	<p>Percentage of patient visits with weight measurement recorded Numerator = Patient visits with weight measurement recorded Denominator = All patient visits for patients aged ≥18 years with HF</p>	
		<p><i>Per Patient:</i> Number of visits with weight measurement recorded/Number of visits</p>	<p><i>Per Patient Population:</i> Percentage of patient visits with weight measurement recorded</p>
Blood Pressure Measurement	<p>A thorough physical examination is recommended to identify cardiac and noncardiac disorders that may accelerate the progression of HF. (Class I Recommendation, Level-C Evidence)</p>	<p>Percentage of patient visits with blood pressure measurement recorded Numerator = Patient visits with blood pressure measurement recorded Denominator = All patient visits for patients aged ≥18 years with HF</p>	
		<p><i>Per Patient:</i> Number of visits with blood pressure measurement recorded/Number of visits Most recent systolic and diastolic blood pressure values^b</p>	<p><i>Per Patient Population:</i> Percentage of patient visits with a blood pressure measurement recorded Distribution of systolic and diastolic blood pressure values^b</p>
Assessment of Clinical Symptoms of Volume Overload (Excess)	<p>A thorough history is recommended to identify cardiac and noncardiac disorders that may accelerate the progression of HF. This history may include initial and ongoing assessments of the patient's volume status. (Class I Recommendation, Level-C Evidence)</p>	<p>Percentage of patient visits with assessment of clinical symptoms of volume overload (excess) Numerator = Patient visits with assessment of clinical symptoms of volume overload (excess). Assessment for absence or presence of symptoms of volume overload must include: Dyspnea OR; Orthopnea OR; Documentation of standardized scale or completion of assessment tool^c Denominator = All patient visits for patients aged ≥18 years with HF</p>	
		<p><i>Per Patient:</i> Number of visits with assessment of clinical symptoms of volume overload (excess)/ Number of visits</p>	<p><i>Per Patient Population:</i> Percentage of patient visits with assessment of clinical symptoms of volume overload (excess)</p>

a Refers to patients aged ≥18 years with diagnosed HF.

b If BP measurement is repeated during the visit in the same arm and the same position, use the last BP reading. If the sequence of readings is unknown, use the lowest BP reading.

c Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only); Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure™ Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).

**American College of Cardiology, American Heart Association, and
Physician Consortium for Performance Improvement
Heart Failure Core Physician Performance Measurement Set^a**

	Clinical Recommendations⁹	Clinical Performance Measures Per Reporting Year	
Assessment of Activity Level	A thorough history is recommended to identify cardiac and noncardiac disorders that may accelerate the progression of HF. This history may include initial and ongoing assessments of the patient's activity level. (Class I Recommendation, Level-C Evidence)	Percentage of patient visits with assessment of activity level Numerator = Patient visits with assessment of current level of activity OR documentation of standardized scale or completion of assessment tool ^c Denominator = All patient visits for patients aged ≥18 years with HF	
		<i>Per Patient:</i> Number of visits with assessment of activity level/Number of visits	<i>Per Patient Population:</i> Percentage of patient visits with assessment of activity level
Assessment of Clinical Signs of Volume Overload (Excess)	A thorough physical examination is recommended to identify cardiac and noncardiac disorders that may accelerate the progression of HF. This physical examination may include initial and ongoing assessments of the patient's volume status. (Class I Recommendation, Level-C Evidence)	Percentage of patient visits with assessment of clinical signs of volume overload (excess) Numerator = Patient visits with assessment of clinical signs of volume overload (excess). Assessment for presence or absence of signs of volume overload must include: Peripheral edema OR; Rales OR; Hepatomegaly OR; Ascites OR; Assessment of jugular venous pressure OR; S3 or S4 gallop Denominator = All patient visits for patients aged ≥18 years with HF	
		<i>Per Patient:</i> Number of visits with assessment of clinical signs of volume overload (excess)/Number of visits	<i>Per Patient Population:</i> Percentage of patient visits with assessment of clinical signs of volume overload (excess)
Patient Education <i>Denominator Inclusion:</i> Patients with one or more visit(s).	Patient education and close supervision is recommended for patients with HF to reduce the likelihood of noncompliance and lead to the detection of changes in body weight or clinical status early enough for effective treatment to be instituted. Avoidance of patient behaviors that may increase the risk of HF (eg, smoking, alcohol, and illicit drug use) should also be encouraged. (Class I Recommendation, Level-C Evidence)	Percentage of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s) Numerator = Patients provided with patient education at one or more visit(s). Patient education should include one or more of the following: Weight monitoring; Diet (sodium restriction); Symptom management; Physical activity; Smoking cessation; Medication instruction; Minimizing or avoiding use of NSAIDs; Referral for visiting nurse, or specific educational or management programs; Prognosis/end-of-life issues Denominator = All patients aged ≥18 years with HF and with one or more visit(s)	
		<i>Per Patient:</i> Whether or not patient education was provided	<i>Per Patient Population:</i> Percentage of patients who were provided with patient education on disease management and health behavior changes during one or more visit(s)
Beta-Blocker Therapy <i>Denominator Inclusion:</i> Patients with HF and left ventricular systolic dysfunction (LVSD) (left ventricular ejection fraction [LVEF] < 40% or moderately or severely depressed left ventricular systolic function) <i>Denominator Exclusion:</i> Documentation of medical reason(s) for not prescribing beta-blocker; documentation of patient reason(s) ^d for not prescribing beta-blocker	Patients with asymptomatic LVSD (Stage B): Beta-blocker therapy is recommended for all HF patients with recent myocardial infarction (MI) (Level-A Evidence) and patients with reduced ejection fraction (Level-B Evidence) Patients with symptomatic LVSD (Stage C): Beta-adrenergic blockade in all stable patients unless contraindicated (Class I Recommendation, Level-A Evidence)	Percentage of HF patients who also have LVSD who were prescribed beta-blocker therapy Numerator = Patients who were prescribed beta-blocker therapy Denominator = All HF patients aged ≥18 years with LVEF < 40% or with moderately or severely depressed left ventricular systolic function	
		<i>Per Patient:</i> Whether or not patient with LVSD was prescribed beta-blocker therapy	<i>Per Patient Population:</i> Percentage of all patients with LVSD who were prescribed beta-blocker therapy Percentage of patients with LVSD who were prescribed beta-blocker therapy, with all denominator exclusions applied

d Patient reasons for not prescribing beta-blocker, ACE inhibitor, or warfarin: economic, social, and/or religious, etc.

**American College of Cardiology, American Heart Association, and
Physician Consortium for Performance Improvement
Heart Failure Core Physician Performance Measurement Set^a**

	Clinical Recommendations^a	Clinical Performance Measures Per Reporting Year	
<p>ACE Inhibitor or ARB Therapy</p> <p><i>Denominator Inclusion:</i> Patients with HF and LVSD (LVEF < 40% or moderately or severely depressed left ventricular systolic function)</p> <p><i>Denominator Exclusion:</i> Documentation of medical reason(s) for not prescribing ACE inhibitor therapy and for not prescribing ARB therapy; documentation of patient reason(s)^e for not prescribing ACE inhibitor therapy and for not prescribing ARB therapy</p>	<p>Patients with asymptomatic LVSD (Stage B):</p> <p>ACE inhibitor therapy is recommended for HF patients with recent MI (Level-A Evidence) and in patients with reduced ejection fraction (Level-B Evidence).</p> <p>Patients with symptomatic LVSD (Stage C):</p> <p>ACE inhibitor therapy in all patients, unless contraindicated. (Class I Recommendation, Level-A Evidence)</p>	<p>Percentage of HF patients who also have LVSD who were prescribed ACE inhibitor or ARB therapy</p> <p>Numerator = Patients who were prescribed ACE inhibitor or ARB therapy</p> <p>Denominator = All HF patients aged ≥18 years with LVEF < 40% or with moderately or severely depressed left ventricular systolic function</p>	
		<p><i>Per Patient:</i></p> <p>Whether or not patient with LVSD was prescribed ACE inhibitor or ARB therapy</p>	<p><i>Per Patient Population:</i></p> <p>Percentage of all patients with LVSD who were prescribed ACE inhibitor or ARB therapy</p> <p>Percentage of patients with LVSD who were prescribed ACE inhibitor or ARB therapy, with all denominator exclusions applied</p>
<p>Warfarin Therapy for Patients with Atrial Fibrillation</p> <p><i>Denominator Inclusion:</i> Patients with HF and paroxysmal or chronic atrial fibrillation</p> <p><i>Denominator Exclusion:</i> Documentation of medical reason(s) for not prescribing warfarin; documentation of patient reason(s)^e for not prescribing warfarin</p>	<p>Anticoagulant use is recommended for patients with HF and concomitant diseases (eg, paroxysmal or chronic atrial fibrillation or a previous thromboembolic event). (Class I Recommendation, Level-A Evidence)</p>	<p>Percentage of HF patients who also have paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy</p> <p>Numerator = Patients who were prescribed warfarin therapy</p> <p>Denominator = All HF patients aged ≥18 years with paroxysmal or chronic atrial fibrillation</p>	
		<p><i>Per Patient:</i></p> <p>Whether or not patient with paroxysmal or chronic atrial fibrillation was prescribed warfarin therapy</p>	<p><i>Per Patient Population:</i></p> <p>Percentage of all patients with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy</p> <p>Percentage of patients with paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy, with all denominator exclusions applied</p>
<p>Laboratory Tests</p> <p>This measure is intended for use only in quality improvement activities with prospective data collection</p>	<p>Evaluation of patients with HF (Class I Recommendation)</p> <p>Initial measurement of the following:</p> <p>complete blood count, urinalysis, serum electrolytes (including calcium and magnesium), blood urea nitrogen, serum creatinine, blood glucose, liver function tests, thyroid-stimulating hormone^e (Level-C Evidence)</p>	<p>Percentage of patients for whom initial laboratory testing was performed</p> <p>Numerator = Patients for whom initial laboratory testing was performed</p> <p>Denominator = All patients aged ≥18 years with HF</p>	
		<p><i>Per Patient:</i></p> <p>Whether or not initial laboratory testing was performed</p>	<p><i>Per Patient Population:</i></p> <p>Percentage of all patients for whom initial laboratory testing was performed</p>

e For this measure, documentation required for only the following tests: complete blood count, serum electrolytes, blood urea nitrogen, serum creatinine, blood glucose, thyroid-stimulating hormone.

References

- 1 Sackett DL, Straus SE, Richardson WS, et al. *Evidence-based Medicine: How to Practice & Teach EBM. 2nd edition.* London, England:Churchill Livingstone;2000.
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- 4 Hofer TP, Hayward RA, Greenfield S, Wagner EH, Kaplan SH, Manning WG. The unreliability of individual physician "report cards" for assessing the costs and quality of care of a chronic disease. *JAMA.* 1999;28:2098-2105.
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**American College of Cardiology, American Heart Association, and
Physician Consortium for Performance Improvement
Heart Failure Core Physician Performance Measurement Set
Prospective Data Collection Flowsheet**

Allergies

Provider No. _____ Patient Name or Code _____ Birth Date ____ / ____ / ____ Gender M F
(mm / dd / yyyy)

Clinical Assessment	Initial Laboratory Tests Performed: (select all that apply)			
	<input type="checkbox"/> CBC <input type="checkbox"/> BUN <input type="checkbox"/> Blood glucose <input type="checkbox"/> Other <input type="checkbox"/> Serum electrolytes <input type="checkbox"/> Serum creatinine <input type="checkbox"/> Thyroid stimulating hormone <input type="checkbox"/> Left ventricular function assessed: ____/____/____ <input type="checkbox"/> Left ventricular systolic dysfunction (left ventricular ejection fraction < 40% or moderately or severely depressed left ventricular systolic function)			
	Results:			
	Date of Visit (mm / dd / yyyy)	____/____/____	____/____/____	____/____/____
	Weight (lb/kg)	<input type="checkbox"/> Unable to weigh	<input type="checkbox"/> Unable to weigh	<input type="checkbox"/> Unable to weigh
	Heart Rate			
	Blood Pressure	L R _____ sitting supine standing	L R _____ sitting supine standing	L R _____ sitting supine standing
	Assessment of Clinical Symptoms of Volume Overload (Excess)	Dyspnea Y or N Fatigue Y or N Orthopnea Y or N	Dyspnea Y or N Fatigue Y or N Orthopnea Y or N	Dyspnea Y or N Fatigue Y or N Orthopnea Y or N
	Level of Activity	<input type="checkbox"/> Standardized scale or assessment tool used ^a	<input type="checkbox"/> Standardized scale or assessment tool used ^a	<input type="checkbox"/> Standardized scale or assessment tool used ^a
	Assessment of Clinical Signs of Volume Overload (Excess)	Peripheral edema Y or N Rales Y or N Hepatomegaly Y or N Ascites Y or N Assessment of jugular venous pressure Y or N S3 or S4 gallop Y or N Other: _____	Peripheral edema Y or N Rales Y or N Hepatomegaly Y or N Ascites Y or N Assessment of jugular venous pressure Y or N S3 or S4 gallop Y or N Other: _____	Peripheral edema Y or N Rales Y or N Hepatomegaly Y or N Ascites Y or N Assessment of jugular venous pressure Y or N S3 or S4 gallop Y or N Other: _____
Education	Patient Education	<input type="checkbox"/> Patient education provided ^b	<input type="checkbox"/> Patient education provided ^b	<input type="checkbox"/> Patient education provided ^b

a Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only), Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).

b Patient education should include one or more of the following: weight monitoring; diet (sodium restriction); symptom management; physical activity; smoking cessation; medication instruction; minimizing or avoiding use of NSAIDs; referral for visiting nurse or specific educational or management programs; or prognosis/end-of-life issues.

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Provider No. _____ Patient Name or Code _____

Adverse Drug Reactions

	Date of Visit (mm / dd / yyyy)				
Medication Management	Beta-Blocker Therapy	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)
	ACE Inhibitor or ARB Therapy	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)
	Warfarin Therapy <input type="checkbox"/> Chronic or paroxysmal atrial fibrillation	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed (medical reasons*) <input type="checkbox"/> Not prescribed (patient reasons*)
*Specify medical (eg, allergy, contraindication) or patient (eg, economic, social, religious) reasons for not prescribing therapy:					
Other Medications					