

ICICE STUDY

HEART FAILURE GUIDELINES

June 2001

General Guidelines

Outpatient records: Abstract all information as indicated in the abstraction tool questions. You may use information **recorded** in the outpatient record that **refers** to occurrences during an inpatient stay (i.e., information recorded by the outpatient provider describing an inpatient event/diagnosis, etc.).

Inpatient records: If the outpatient record contains actual inpatient documentation (e.g., admission notes, exam results, progress notes, discharge summary) use **only** the information contained on the Admission History and Physical (H&P) and the Discharge Summary. Do **not** refer to other inpatient documentation to answer the questions even if it is available. Refer to the question-specific guidelines for further clarification.

Records from other facilities:

If the outpatient record contains copies of records from other facilities where the patient has received care, abstract that information as you would other portions of that record.

When was a history or a diagnosis of heart failure FIRST noted between 5/1/98 and 8/31/00? (This may be an outpatient visit or inpatient admission.)

Enter any date on which it was indicated that the patient had heart failure (e.g., a history of heart failure, a visit or an admission for diabetes noted in the outpatient record, a diagnosis of heart failure). The date of initial diagnosis does not have to be during the study period.

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history when not contradicted by provider
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.
- Refer only to the Admission History and Physical and the Discharge Summary of an inpatient stay.
 - If the patient was admitted with heart failure, enter the admission date. If the admission date isn't available and cannot be calculated, enter the date of discharge.
 - If the patient was diagnosed with heart failure during the hospitalization, enter the date diagnosed if noted on the Discharge Summary. If not available, enter the discharge date.
 - If the patient was not admitted with or for heart failure but was discharged with a diagnosis or history of heart failure, enter the date of discharge.

Accept:

- Heart failure
- Congestive heart failure (CHF)
- Left-sided with right-sided heart failure
- Forward with backward failure
- Left with right ventricular heart failure
- Low output heart failure
- Left-sided heart failure
- Left ventricular heart failure

- Forward failure
- Cardiomyopathy (i.e. ischemic cardiomyopathy, dilated cardiomyopathy, alcoholic cardiomyopathy)

Do not accept:

- ◆ Isolated right heart failure (Right-sided heart failure without left-sided heart failure also mentioned)
- ◆ Failure from diastolic dysfunction
- ◆ Systolic or diastolic dysfunction in the absence of a diagnosis of heart failure
- ◆ Notation of left ventricular dysfunction on an echo, radiologic, or other cardiac procedure.
- ◆ Borderline left ventricular hypertrophy
- ◆ S/P heart transplant
- ◆ R/O, possible, probable or "suggestive of" diagnosis of heart failure
- ◆ A medication as evidence of a diagnosis
- ◆ A diagnosis written as a result of a test or exam
- ◆ A diagnosis or code of heart failure from an inpatient or outpatient facesheet

On the date entered for the prior question, was the heart failure newly diagnosed or was it pre-existing?

Indicate whether the heart failure was initially diagnosed on the date specified (i.e., no prior diagnosis of heart failure either prior to during the study period) or the heart failure was pre-existing on the date specified (i.e., diagnosis of heart failure had been made prior to the specified date).

Note: An exacerbation of heart failure is a worsening of symptoms in a patient previously diagnosed with heart failure. It is not equivalent to a new diagnosis.

If the patient was initially diagnosed on the date entered in the previous question, enter "Newly diagnosed." If the actual date of diagnosis is unknown, enter "Pre-existing." If it is unclear whether heart failure was initially diagnosed on the specified date, select 'NA.'

Inpatient documentation: Refer only to the Admission History and Physical and the Discharge Summary.

Is there evidence that the heart failure was diagnosed prior to 5/1/98?

Indicate whether there is any documentation during the study period that the patient was diagnosed with heart failure prior to the study period.

MEDICATIONS:

Enter the start dates, stop (discontinue) dates, continuation dates, patient refusal and medication allergy dates between 5/1/1998 and 8/31/1999 for all medications listed that are prescribed at least daily.

Enter each medication on the drop-down medication list that was either started (prescribed) stopped (discontinued), continued, or refused. Enter the date (or date unknown), select the medication (if on the list) and select the status.

GENERAL INFORMATION

- Enter the medication as noted in the record (i.e., generic or brand), including medications administered during a procedure or surgery.
- A medication may be listed in more than one way (e.g., Metoprolol Succinate, Metoprolol Tartrate, Metoprolol Tartrate/Hydrochlorothiazide. If the record states, for example, "metoprolol" and does not specify the form (e.g., succinate vs tartrate), select the first on the list that is NOT a combination drug (i.e., metoprolol in combination with another drug). In this example you would pick metoprolol succinate. Note that "metoprolol tartrate/Hydrochlorothiazide is a combination drug. The "/" is used to indicate more than one drug in a particular medication.
- If a classification (e.g., ACE Inhibitor) is noted rather than the specific drug, select the classification from the medication list.
- Generic combination medications are listed with all components (e.g., aspirin/salicylimide/caffeine).
 - The order of the medications in a combination medication as listed in the drop-down medication list may differ from the order listed in the record. Follow the following procedure when entered a combination medication.
 - Type in the first 3 letters of the first medication of the combination medication as listed in the record and look for the same combination medication on the drop-down list.
 - If you find the same combination, but in a different order, select it. For example, you may find "aspirin/caffeine/salicylimide."
 - If you don't find the same combination, type in the second medication of the combination medication as listed in the record.
 - If you find the same combination, but in a different order, select it.
 - Continue to do this for all medications listed in the combination medication until you have either found the combination medication on the drop-down list or searched for each component medication unsuccessfully.
- If the date on which the medication was started, stopped, continued or refused is unclear or cannot be calculated (e.g., patient stopped medication – no date or time period indicated) check "Date Unavailable."
- Medication lists such as from pharmacy data or medication summaries: Include medications that are not found in the progress notes (i.e., do not duplicate entries). Include both the initial prescription and the "last filled" dates.
 - ◆ Do **not** code the initial prescription as "Start" unless you are certain that it is the very first time the drug is being prescribed for the patient (i.e., it was not just a new prescription)
- Include orders or prescription written on lab reports. You must see the actual name of the drug. Do not make assumptions. Use the date of the note if available. Otherwise use the date of the lab report.
- Summarizing medications: You may summarize orders for Coumadin (warfarin) that are written on lab reports or in the progress notes on a weekly basis (i.e one entry every 7 days). No other medications are to be summarized.

Do **not** enter:

- ◆ Medications that are **administered** during an outpatient or Emergency Room visit.
- ◆ Do not enter medications ordered or administered **during** hospitalization.

- ◆ Medications ordered on a PRN basis (e.g., enter ASA 325 mg qd; do not enter ASA 325 mg prn for pain).
- ◆ Medications that the patient has tried in the past (e.g., previous trial of an ACE Inhibitor) unless the date is specified.
- ◆ Medications ordered to be started or taken **if** a particular situation arises (e.g., if symptoms persist more than 5 days) and it is unknown whether that situation did arise.
- ◆ Medications listed on an ECG report/request.
- ◆ Medications that are part of a study in which the patient is participating and the drug given to the patient is unknown (e.g., Altolomet vs. placebo).

Outpatient, Emergency Room, Telephone and Letter medications:

- Enter all medications prescribed, listed as continued, stopped (discontinued), or refused on the visit/contact date.
- If the date on which a medication is to be initiated is different from the date of the prescription, enter the date the medication is to be initiated.

Inpatient medications:

- Enter all discharge medication prescriptions for **all** inpatient contacts.
- Do **not** enter medications that the patient was taking on admission (current meds) or that were ordered or administered **during** the hospitalization.

Long-term care facility

- Summarize on the monthly visit date as indicated in the "Visit" guidelines below.

Medication Status:

- Select **Start** when:
 - The medication is the initial prescription for a medication (i.e., the patient did not have a prescription for the medication prior to that date).
 - The medication had been discontinued previously and is now being resumed (e.g., Lasix was discontinued on 4/4/99 and was started again on 6/6/00).
 - A medication appears on a Discharge Summary that was started sometime during the inpatient stay.
- Select **Continued** when:
 - A medication that the patient had been taking prior to that date is continued on that date.
 - A medication is listed as a current medication on that date and is not discontinued on that date.
- Select **Stopped** when:
 - A medication is discontinued by the provider
 - A medication that the patient had been taking was discontinued by the provider and was not prescribed again by the provider on that date.

Do **not** accept for "stopped":

- ◆ Medication temporarily stopped when patient has surgery (i.e., the drug is to be stopped for a few days and then resumed after surgery).
 - ◆ Patient refusal to begin taking medication when it is initially prescribed.
 - ◆ Patient noncompliance (i.e., not taking medication as prescribed or has stopped taking the medication).
- Select **Refused** when:
 - The patient refuses to start taking a medication when it is first prescribed.
 - A medication that the patient had been taking was discontinued by the patient for any reason (e.g., ran out of drug, noncompliance, forgot to take it).

- Select **Allergic** when:
 - The medication is listed or noted to be an allergy for this patient either on an allergy list/problem list (with or without a date)
 - Enter each medication allergy only once.
- Select **"Other/No data"** when:
 - Some other status was indicated
 - The status is unclear

VISITS

In the table below, enter the date of each outpatient office visit, outpatient ancillary visit, outpatient, urgent care facility visit, emergency room visit, telephone or letter contact, inpatient admission or long-term care facility summarized visit and indicate the lowest systolic pressure, the lowest diastolic pressure, the heart rate, the NYHA status and whether heart failure was addressed at that visit.

GENERAL INFORMATION

- Enter each visit date and associated information as indicated below.
- If there are multiple visits on the same day (e.g., 2 providers, an ER visit and an inpatient admission) enter the date for each visit and indicate the visit type.
- The following visits/situations should be summarized. See General Guidelines and guidelines below for specific instructions.
 - Inpatient stay in long-term care facility (i.e. nursing home, rehabilitation institution TCU-Transitional Care Unit, Sub-Acute Unit)

Do **not** enter any of the following as a separate visit date:

- ◆ Imbedded visits. These are visits with a provider/ER/Radiology that are mentioned within one of the visits listed above (e.g., description of an inpatient visit within an outpatient visit, notation of a prior coronary angiogram within an ER visit, notation of a past mammogram result in an outpatient visit).
- ◆ A visit **only** for **administration** of a medication, an immunization or an allergy injection (i.e., no assessment, plan or other documentation).
- ◆ Any of the following types of visits:
 - Dialysis visits
 - Coumadin visit/clinic (specifically for anticoagulation – INR, coumadin dose)
 - Physical or occupational therapy
 - Orthotics/prosthesis clinic/visit
 - Psychotherapy
 - Cardiac rehab
 - Dental
 - Audiology clinic
 - Ear irrigation
- ◆ A visit to **remove** a Holter monitor as long as no other services (e.g., BP, prescription, assessment, etc.) were provided.
 - ◆ Treatment plans, transfer forms that are a summary of care, and on which there is no indication that the patient was seen on that date.
 - ◆ The patient leaves the office/clinic before they are seen by a healthcare worker (e.g., signs in with receptionist and leaves before being seen, in the office to pick up copy medical record only).
 - ◆ A referral to the provider (e.g., "Pt to see diabetic counselor," " will try to arrange for visit to dietitian").

TYPE OF VISIT

- Outpatient Medical
 - Visit to a provider's office during which the patient is assessed and/or treated. This includes: MD, nurse practitioner (NP), physician's assistant (PA), RN, LPN, medical technician, etc.)
 - Ophthalmologist or optometrist visit
 - Podiatrist visits
 - Visit to provider's office for blood pressure check
 - Medical consults: enter as a contact date when the consulting provider (see first bullet above) provides a report of a contact with the patient.
 - Enter the date of the consult. If the report is in the form of a letter that does not indicate the actual date of the contact or allow you to estimate the date (e.g., saw the patient last week), and it is a recent or current consult, then use the date of the letter.

- Outpatient ancillary
 - Visit to or progress note by ancillary providers such as diabetic counselor (CDE), registered dietitian (RT), pharmacist, and physical therapist.
 - Psychotherapy session/visit (regardless of the reason for the visit) with the following providers: Counselor, ACSW, MC, Marriage Counselor, MSW (Masters in social work)
 - Cardiac rehabilitation center visits

- Outpatient procedure
 - Dates on which only an outpatient procedure was performed (i.e., the patient was not admitted to the hospital).). Include procedures during which a blood pressure was taken.
 - Includes but is not limited to:
 - Arthroscopy Breast biopsy or FNA (fine needle aspiration)
 - Bone scan
 - Bronchoscopy
 - Cardiac catheterization/angioplasty
 - Cataract extraction
 - Colonoscopy
 - Cystoscopy
 - Diagnostic D&C
 - Electromyographic testing (EMG)
 - Electrophysiologic study (EPS)
 - Endometrial biopsy
 - Endoscopic retrograde cholepancreatography - ERCP
 - Esophogastroduedenoscopy (EGD), upper endoscopy
 - Herniorraphy – hernia repair
 - Holter monitor placement (**not** removal)
 - Hysterectomy, vaginal
 - Laparoscopy (any type)
 - Liver biopsy
 - Lung biopsy
 - Mammogram
 - Mastectomy
 - Prostate biopsy
 - Radiation therapy
 - Radioactive implantation procedure
 - Renal biopsy
 - Sigmoidoscopy (Flex sig)
 - Stress (exercise or pharmacological) testing (e.g., treadmill, ETT, thallium, echo)
 - Transurethral resection of prostate (TURP)
 - Tubal ligation
 - Ultrasound (Doppler)

Do **not** accept the following outpatient visits, procedures or surgeries as an Outpatient Medical visit.

- ◆ Plain x-rays
 - ◆ Sleep studies
 - ◆ Electrocardiogram (ECG) only
 - ◆ Visits for lab test only (e.g., blood drawn, urine sample taken)
 - ◆ Outpatient procedure that occurs during an outpatient office visit in which the patient was assessed and/or treated (e.g., chief complaint, assessment, plan, etc.) This should be entered as an Outpatient Medical visit.
- Urgent Care Facility/Emergency Room
 - Visits to an urgent care facility.
 - Visits to a walk-in clinic/sick call clinic
 - Emergency room/department visits
 - Include all visits whether or not the patient was admitted to the hospital or discharged from the emergency room.
 - Code an Emergency room contact regardless of the length of time the patient is in the E.R. or the fact that the E.R. stay runs over the midnight hour.

Do **not** accept for Urgent Care Facility/Emergency Room

- ◆ A visit when the patient leaves the facility without being seen by the healthcare provider.
 - ◆ Urgent/walk-in/drop-in visits to a provider's office
- Telephone/Letter/Email
 - Enter the date on which the provider and the patient had phone contact or on which the provider wrote a letter/note/email to the patient.
 - Include calls initiated by the patient or the provider. Include calls on which the office either spoke with the patient or family member.
 - The contact may or may not refer to the heart failure problem
 - Multiple telephone contacts/letters/emails may be summarized into one entry per week. Include all data from all telephone contacts on the date of the first telephone contact of that week.
 - Include:
 - Telemonitoring calls
 - Pacemaker checks

Do **not** include for telephone/letter:

- ◆ A note of a phone conversation that is physician-to-physician or office-to-office contact (i.e., not a contact with the patient).
 - ◆ A call or letter that is **ONLY** for any (or any combination) of the reasons listed below.
 - Calls to the patient re "no show"
 - Calls/letters to schedule labwork or appointment
 - Calls/letters to get or to give lab/test results
 - Calls that document only a BP taken by the patient
 - Cancellation of appointment
 - Change of phone, address, pharmacy phone
 - Request for copy of medical record
 - Provider office or patient "left message"
- Inpatient admission
 - Refer only to the Admission History and Physical and the Discharge Summary.

- Long-term care facility
 - Includes nursing home, rehabilitation institution, TCU-Transitional Care Unit, Sub-Acute Unit
 - If the patient is a resident of a long-term care facility at the beginning of the study period, enter 5/1/1998 as a visit and summarize all data from the long-term care facility for the month of May 1998 on that visit date.
 - If the admission date is within the study period enter the admission date as a visit date and summarize all data for that month on the admission date.
 - If the patient remains in the institution more than one month, for all months following the month of admission or the beginning of the study period, enter the first **day** of the month (e.g., 10/01/1999) as the visit date. Then summarize all data for the month on that date. For example, code each visit date (first day of the month) with each diagnosis noted and all medications ordered during the entire month.

- Other/No data
 - Includes Home Health visits
 - A survey or questionnaire completed by the patient and there is no other indication of whether it was completed at a visit or by phone.
 - If there is no way to determine the type of visit, use this selection

SYSTOLIC AND DIASTOLIC PRESSURE

- Enter a diastolic and systolic measurement for each contact date.
- If more than one is recorded, enter the lowest measurement for diastolic and the lowest measurement for systolic on that visit date regardless of the position in which it is taken.
- If there is no BP recorded at an outpatient/urgent care/ER visit, you may enter a patient reported BP taken on the visit date. If date of patient reading is not indicated, assume it is the date of the telephone call.
- Inpatient records: Enter the lowest measurements recorded on the Admission History and Physical and/or Discharge Summary.
- If you are summarizing visits from a long term care facility, enter the lowest systolic and the lowest diastolic for the month regardless of whether they are on the same date.
- If the visit type is "Telephone/letter" you are not required to enter the SBP or DBP value and you do not need to check the "NA" checkbox.

HEART RATE

This question will only accept a numerical value for the heart rate.

- If there is no heart rate recorded at an outpatient/urgent care/ER visit, you may enter a patient reported heart rate taken on the visit date. If date of patient reading is not indicated, assume it is the date of the visit.
- If a range is recorded (e.g., 60-65), enter the lowest rate in the range (60, in this example.)
- Inpatient records: Enter the lowest heart rate recorded on either the Admission History and Physical or the Discharge Summary.
- If you are summarizing visits from a long term care facility, enter the lowest heart rate recorded for that month.
- If the visit type is "Telephone/letter" you are not required to enter the heart rate and you do not need to check the "NA" checkbox.

Accept:

- Numeric recording of heart rate
- Apical pulse (AP)
- Numeric recording of peripheral pulse rate
- ECG

Do **not** accept:

- ◆ RRR (regular rate & rhythm)
- ◆ Type of rhythm on ECG (e.g., NSR, heart block, atrial fibrillation)
- ◆ Tachycardia, bradycardia

NYHA CLASS

The New York Heart Association (NYHA) functional classification is used to characterize the patient's activity limitations from left ventricular failure.

Enter the functional class (i.e., 1, 2, 3 or 4) **noted as such** by the provider on the visit. The functional class may be noted as I, II, III or IV. The following descriptions are for your information only. Do **not** classify the patient based on this information. The Class must be stated by the provider as 1, 2, 3, or 4 (I, II, III, IV).

If a range is given (e.g., 3-4), use the lower number.

Inpatient records: Refer only to the Admission History and Physical and the Discharge Summary.

If you are summarizing visits from a long term care facility, enter the lowest NYHA functional status for that month.

<u>Class</u>	<u>Definition</u>
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- | | |
|----|---|
| 1. | No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, or dyspnea. For example, the patient is able to ascend one flight of stairs without symptoms, or walk one block with a mild to moderate incline. |
| 2. | Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue or dyspnea. For example, the amount of activity in the example for Class I results in fatigue or dyspnea. |
| 3. | Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue or dyspnea. For example, walking from the kitchen to the living room causes fatigue or dyspnea. |
| 4. | Unable to carry on any physical activity without symptoms. Symptoms are present even at rest. If any physical activity is undertaken, symptoms are increased. |

HEART FAILURE ADDRESSED

Indicate whether the provider addressed the patient's heart failure at the visit or at any time during the month for a summarized long term care visit.

Enter "Yes" only if the patient has a diagnosis or history of Heart Failure at that visit.

Accept:

- Heart failure is the purpose of the visit (e.g., "patient here for follow-up on CHF").
- Heart failure is addressed in the assessment, or plan.
- Medications for heart failure are reviewed and/or prescribed and/or renewed.
- Test or procedures are performed during a visit to the provider specifically to evaluate the heart failure
- "Congestive" or "low output" issues, symptoms are addressed.

NEW DIAGNOSIS DOCUMENTATION

Enter the date closest to and within 3 months of (prior to or after) the date of a new diagnosis of heart failure when the following were noted.

For each of the history items below, enter the date closest to (prior to or after) the date of initial diagnosis of heart failure.

- For questions asking for the presence or absence of the disease, look for any evidence that the provider noted that the patient **had** or **did not have** the condition (e.g., history of, no history of).
- If the condition is not mentioned at all, enter "no data."

Inpatient documents: Refer to the Admission History and Physical and the Discharge Summary only.

Accept:

- A diagnosis/history or the absence of a diagnosis/history.
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.
- Mention of test or order for test that will be or was to be used to confirm or rule-out the condition.

Presence/absence of a history or diagnosis of coronary artery disease (CAD) (including angina, myocardial infarction and revascularization)

Accept:

- No history of CAD
- R/O CAD
- Angina
- Angina, stable
- Angina, unstable
- R/O angina
- Acute MI
- R/O acute MI
- Acute Coronary Artery Syndrome
- Atherosclerotic heart disease (ASHD)
- Arteriosclerotic or Atherosclerotic Coronary Vascular Disease (ASCVD)
- Atherosclerotic calcification of the coronary arteries
- Coronary mineralization or calcification
- Coronary vessel disease (e.g., 1-vessel disease, 3-vessel disease)
- IHD: Ischemic heart disease
- Prior history of CABS, PTCA or other revascularization
- Result of stress test notes either moderate or greater risk for CAD
- Stenosis of 50% or more on 2 or more coronary arteries on a coronary angiogram

Do **not** accept:

- ◆ Findings of ischemia on an ECG in the absence of a diagnosis
- ◆ History of hyperlipidemia
- ◆ Organic heart disease

Presence/absence of a history or diagnosis of hypertension (HTN)

- No history of hypertension
- HTN
- HBP – use only when it is clear that this is being used as a diagnosis or an absence of a diagnosis of hypertension and is **not** just an indication that the patient’s BP is elevated at that visit.
- Accelerated hypertension
- Arterial hypertension
- Either systolic/diastolic hypertension
- Essential/idiopathic/malignant hypertension
- Primary/secondary hypertension
- Stage I, II, III, or IV hypertension
- Borderline hypertension
- Labile hypertension

Do **not** accept

- ◆ High BP recording
- ◆ Hi normal BP
- ◆ Hypertensive cardiovascular disease
- ◆ Hypertensive heart disease
- ◆ Hypertensive reaction
- ◆ Pregnancy induced hypertension (PIH)
- ◆ Gestational HTN
- ◆ R/O hypertension, “?HTN”, etc.

Presence/absence of a history or diagnosis of hyperlipidemia

Accept:

- No history of hyperlipidemia
- High blood triglycerides
- High cholesterol
- High blood cholesterol
- Arrow-up/elevated triglycerides
- Arrow-up/elevated cholesterol
- Arrow-up/elevated blood cholesterol
- Acquired hyperlipoproteinemia
- Dyslipidemia
- Hyperlipidemia
- High triglycerides
- Notation by the provider in the progress notes of the results of lipids tests (cholesterol, LDL, HDL, triglycerides)

Do **not** accept:

- ◆ A lab report that includes results of lipid tests (cholesterol, LDL, HDL, triglycerides)

Presence/absence of a history or diagnosis of valvular heart disease

Accept:

- Presence or absence of any of the valvular conditions listed below.
- Mention **by the provider** of the results on an echocardiogram that describe the function or status of the valves.

VALVULAR CONDITIONS:

- Mitral [valve] stenosis/prolapse/regurgitation/insufficiency
- Aortic [valve] stenosis/regurgitation/insufficiency
- Tricuspid [valve] stenosis/regurgitation/insufficiency
- Pulmonary [valve] stenosis/regurgitation/insufficiency

Presence/absence of a history or diagnosis of thyroid disease

Accept:

- Hyperthyroidism
- Hypothyroidism
- Myxedema
- Euthyroid sick syndrome (ESS)
- Thyroiditis, Hashimoto's/subacute/silent
- Goiter, Euthyroid/simple/nontoxic diffuse, nontoxic nodular
- Notation by the provider in the progress notes of the results of TSH or T4 tests.

Do **not** accept:

- ◆ A lab report that includes results of thyroid tests (TSH, T4)

Presence/absence of current symptoms of chest pain or angina

Note: the provider must address **current** chest pain/angina, for example:

- No c/o angina/chest pain (cp)
- Has not had any further angina/chest pain (cp)
- Presence or c/o any of the conditions listed below under "accept."

Accept:

- Angina pectoris
- Exertional angina
- Accelerated angina
- Prinzmetal's angina
- Chest pain of cardiac etiology
- Stage 1-IV angina in the absence of a diagnosis of unstable angina
- Angina – unstable
- Rest angina
- Chest pain related to use of sublingual nitroglycerine (NTG, SLNTG)
- Chest pain of unknown origin

Do **not** accept:

- ◆ History of angina/chest pain in the absence of a comment about current symptoms

Current medications/No current medications

Enter the date closest to and within 3 months of (prior to or after) the date of the initial diagnosis of heart failure on which the provider reviewed the patient's current medications.

Accept:

- List of current medications
- "Patient is currently on....."
- "No medications"

Presence/absence of current alcohol use

Enter the date closest to and within 3 months of (prior to or after) the date of the initial diagnosis of heart on which the provider addressed whether or not the patient currently drinks alcohol.

Accept:

- Number of drinks per day/week
- Notation that patient consumes alcohol
- Screening questionnaire (CAGE, MAST, HSS, AUDIT, SAAST, SMAST)
- Social/occasional drinker
- Does not abuse alcohol
- +ETOH. - ETOH
- Alcohol abuse, ETOH abuse (+)
- Alcoholic/Alcoholism
- ETOHIC
- ETOH Dependence
- Problem drinker
- Evidence of recent DUI charges
- Notation that the patient does not consume alcohol
- Denies alcohol use
- A circle or a zero with a line through it followed by ETOH

Smoking status

Enter the date closest and within 3 months of (prior to or after) the date of initial diagnosis of heart disease on which the patient's smoking status was noted by the provider.

Smoking **status** applies to cigarette, cigar or pipe smoking.

Note: this question is looking to determine whether anything is noted regarding if or what the patient smokes. The following question refers **ONLY** to cigarette smoking.

- Non-smoker
- Quit smoking - may mention actual year or how many years ago.
- Smoker (-)
- "No habits"
- Smoker
- Current number of packs per day (PPD) or per year
- Current smoker, Smoker (+)
- Currently in a smoking cessation program
- Trying to quit
- Advised to quit smoking
- Patient's response to smoking status question on a history questionnaire

Do **not** accept:

- ◆ A note on an inpatient facesheet or admissions sheet regarding smoking status (i.e., it must be noted by a healthcare provider).
- ◆ Marijuana smoking in the absence of cigarette smoking

What was noted as the smoking status on the date entered in the previous question (cigarette smoking only. If not specified assume cigarette smoking)?

- Non-smoker
 - Smoker (-)
 - "No habits"
 - Non-smoker
 - Quit smoking - may mention actual year or how many years ago.
- Smoker (-)
 - Smoker
 - Current number of packs per day (PPD) or per year
 - Current smoker, Smoker (+)
 - Currently in a smoking cessation program
 - Trying to quit
 - Advised to quit smoking

Do **not** accept:

- ◆ Cigar or pipe smoking
- ◆ Marijuana smoking in the absence of cigarette smoking

Was the patient's weight noted on the date when heart failure was newly diagnosed?

Indicate whether the patient's actual weight (in pound or kilograms) was entered on the date of initial diagnosis of heart failure.

COMORBIDITIES

General Guidelines for Comorbidities:

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history when not contradicted by provider
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.
- Refer only to the Admission History and Physical and the Discharge Summary of an inpatient stay.

Do not accept:

- ◆ R/O, possible, probable or "suggestive of" diagnosis
- ◆ "Symptoms consistent with" a diagnosis
- ◆ A medication as evidence of a diagnosis
- ◆ A diagnosis written as a result of a test or exam

Enter the first date after 5/1/98 on which the patient presented with or had a history of atrial fibrillation (MD note or ECG impression).

Enter the first date during the study period on which atrial fibrillation was noted in the history or as a diagnosis or was noted as the rhythm on an ECG report.

Atrial fibrillation:

- Atrial fibrillation (Af)
- AFIB/A Fib
- Paroxysmal atrial fibrillation
- Chronic fibrillation
- Combination of Atrial fib and Atrial flutter at time of visit

Accept:

- Notation that the patient has a history of or at some time in the past was in atrial fibrillation
- Atrial fibrillation is a problem at a visit/admission (i.e., addressed or noted in the "assessment" or listed as an impression)
- The provider notes at the visit or on admission that the patient is in atrial fibrillation
- A past or current ECG shows atrial fibrillation

Do **not** accept:

- ◆ Atrial flutter

What is the earliest date on which the patient was diagnosed with or noted to have a diagnosis or history of coronary artery disease (CAD)?

Enter the first date during the study period on which the patient was noted to have a diagnosis or history of CAD. If an imbedded date is within the study period, and is the earliest date, use the imbedded date. For example, if a note on 10/10/1998 states that the patient was diagnosed with CAD (or had an MI, or was seen by another provider for CAD, etc.) on 05/02/1998, enter 05/02/1998.

Accept:

- Angina
- Angina, stable
- Angina, unstable
- Acute MI

- Acute Coronary Artery Syndrome
- Atherosclerotic heart disease (ASHD)
- Arteriosclerotic or Atherosclerotic Coronary Vascular Disease (ASCVD)
- Atherosclerotic calcification of the coronary arteries
- Coronary mineralization or calcification
- Coronary vessel disease (e.g., 1-vessel disease, 3-vessel disease)
- IHD: Ischemic heart disease
- Prior history of CABS, PTCA or other revascularization
- Result of stress test notes either moderate or greater risk for CAD
- Stenosis of 50% or greater on 2 or more coronary arteries on a coronary angiogram

Do **not** accept:

- ◆ R/O CAD. If there is a conflict in the chart (R/O versus history of/diagnosis of) assume that the patient has the history/diagnosis on the date indicated.
- ◆ R/O angina
- ◆ R/O MI (AMI)
- ◆ Findings of ischemia on an ECG in the absence of a diagnosis
- ◆ History of hyperlipidemia
- ◆ Organic heart disease

On the date entered in the previous question was the CAD newly diagnosed or was it pre-existing?

Indicate whether the CAD was initially diagnosed on the date specified (i.e., no prior diagnosis of CAD) or the CAD was pre-existing on the date specified (i.e., diagnosis of CAD had been made prior to the specified date).

The CAD is new on the **first** date on which the patient presents with angina or an MI or is given a diagnosis of any of the synonyms listed. Once the patient has been diagnosed with any one of these conditions, thereafter they have pre-existing CAD.

If it is unclear whether CAD was initially diagnosed on the specified date, select 'NA.'

Is there evidence that there was a diagnosis of CAD prior to 5/1/98?

Indicate whether there is any documentation during the study period that indicates the patient was diagnosed with CAD prior to the study period.

Enter the first date after 5/1/98 on which angina was noted to be a current problem.

Enter the first date during the study period on which the patient presented with angina, angina was a reason for the visit, or the provider addressed angina as a current problem.

Angina – stable

- Angina
- Stable angina
- Angina pectoris
- Exertional angina
- Accelerated angina
- Prinzmetal's angina
- Chest pain of cardiac etiology
- Stage 1-IV angina in the absence of a diagnosis of unstable angina

Angina – unstable

- Unstable angina
- Rest angina

Do **not** accept:

- ◆ R/O angina
- ◆ R/O unstable angina

When was the patient diagnosed with an acute myocardial infarction (MI, AMI)? If actual diagnosis date unknown, enter date of note. (Prior date OK.)

Enter the first date during the study period on which an acute MI (AMI) was diagnosed. You may enter a date prior to the beginning of the study period if it is available or you can calculate/estimate it based on the instructions in General Abstraction Guidelines. If you are unable to calculate or estimate the date, enter the date of the note.

Accept:

- Acute MI (AMI)
- Myocardial infarction (MI)

Do **not** accept:

- ◆ R/O MI

Indicate whether the patient had a history or diagnosis of any of the following conditions.

For each of the conditions listed below, indicate whether the patient had a history or diagnosis of that condition (e.g., noted in the past or current history, noted as the reason for a visit or an admission, noted as an impression or a diagnosis of that condition). The date of initial diagnosis does not have to be during the study period.

Inpatient documentation: refer to the Admission History and Physical and Discharge Summary only.

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history
- Notation on a Problem List or intake form
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.

Do **not** accept:

- ◆ A rule-out (RO), possible, probable or "suggestive of" diagnosis except where noted (i.e., AIDs). If there is a conflict in the chart (R/O versus history of/diagnosis of) assume that the patient has the history/diagnosis on the date indicated.
- ◆ A medication as evidence of a diagnosis

Hypertension

- Hypertension (HTN)
- HBP – use only when it is clear that this is being used as a diagnosis (i.e., discussion, treatment, etc) and is **not** just an indication that the patient's BP is elevated at that visit – or visit's
- Accelerated hypertension
- Arterial hypertension
- Either systolic or diastolic hypertension
- Essential/idiopathic/malignant hypertension
- Primary/secondary hypertension

- Stage I, II, III, or IV hypertension
- Borderline hypertension
- Labile hypertension

Do **not** accept:

- ◆ A high BP recording
- ◆ Hi normal BP
- ◆ Hypertensive cardiovascular disease
- ◆ Hypertensive heart disease
- ◆ Hypertensive reaction
- ◆ Pregnancy induced hypertension (PIH)
- ◆ Gestational HTN
- ◆ R/O hypertension, "HTN", etc.

Peripheral Vascular Disease (PVD)

- Peripheral vascular disease (PVD)
- Peripheral atherosclerotic disease
- Intermittent claudication
- Arterial insufficiency
- Untreated thoracic or abdominal aneurysm
- Gangrene

Do **not** accept:

- Deep Vein Thrombosis (DVT)

Asthma

- Hyperresponsiveness of the airways to a variety of inhaled stimuli
- Occupational asthma
- Allergic Asthma
- Chronic obstructive asthma
- Extrinsic/intrinsic Asthma
- Allergic asthma
- Idiosyncratic asthma
- Occupational asthma
- Bronchial asthma
- Bronchial induced asthma
- Bronchospasm in a patient with a history of asthma
- Reactive airway disease (RAD)
- Reversible hyper-reactive lung disease
- Reversible airway disease
- Reversible obstructive airway disease
- Chronic obstructive asthma

Chronic Obstructive Pulmonary Disease (COPD)

- Chronic bronchitis
- Simple obstructive lung disease
- COLD - chronic obstructive lung disease
- COPD
- Obstructive airways disease
- Emphysema

Chronic lung disease other than asthma or COPD

- Asthmatic bronchitis [chronic]
- Chronic bronchitis
- Bronchiectasis
- Chronic pulmonary fibrosis
- Cystic fibrosis
- Tuberculosis (TB)

Connective tissue disease

- Rheumatoid arthritis (RA)
- Infectious arthritis
- Mixed connective tissue disease
- Osteomyelitis
- Lyme disease
- Reiter's syndrome
- Psoriatic arthritis
- Ankylosing spondylitis
- Gout
- Gouty arthritis
- Pseudogout
- Calcium pyrophosphate dihydrate (CPPD)
- Crystal deposition disease
- Relapsing polychondritis (RP)
- Vasculitis
- Lupus Erythematosus – Discoid (DLE) or Systemic (SLE)
- Progressive systemic sclerosis (PSS)
- Scleroderma
- Polymyositis
- Dermatomyositis
- Sclerodermatomyositis
- Inclusion body myositis (IBM)
- Polymyalgia rheumatica
- Temporal arteritis
- Giant cell arteritis
- Cranial arteritis
- Polyarteritis nodosa
- Polyarteritis
- Wegener's granulomatosis
- Mixed connective tissue disease (MCTD)
- Ankylosing Spondylitis (AS)
- Marie-Strumpell disease
- Reiter's syndrome (RS)

Do **not** accept:

- Osteoarthritis (OA, DJD)
- Arthritis

Ulcer disease

- Peptic ulcer (PUD)
- Duodenal ulcer
- Gastric ulcer
- Channel ulcer
- Postbulbar ulcer
- Marginal ulcer
- Stomal ulcer

Liver Disease

- Jaundice
- Hepatitis
- Cholestasis
- Hepatomegaly
- Portal hypertension
- History of variceal bleeding
- Ascites
- Portal-systemic encephalopathy
- Hepatic encephalopathy
- Hepatic fibrosis

- Cirrhosis
- Primary biliary cirrhosis (PBC)

Diabetes (mild to moderate)

- AODM - Adult onset DM
- IDDM - Insulin-dependent DM
- Juvenile diabetes
- Juvenile onset type diabetes
- Ketosis-prone diabetes
- MOD - Maturity onset diabetes
- MODM - Maturity onset diabetes mellitus
- MODY - Maturity onset diabetes of youth
- NIDDM - Non-insulin dependent diabetes mellitus
- Nonketosis-prone diabetes
- Type I DM, type 1 diabetes
- Type II DM, type 2 diabetes
- Diabetes – diet controlled, or controlled by oral hypoglycemics
- History of ketoacidosis, hyperosmolar coma

Do **NOT** accept (for either Type I or Type II):

- ◆ Diabetes with end-organ disease, such as
 - Diabetic retinopathy
 - Diabetic nephropathy
 - Arterionephrosclerosis
 - Azotemia
 - Chronic renal disorder
 - Chronic renal insufficiency
 - Renal insufficiency
 - Acute renal failure
 - Diabetic kidney disease
 - Diabetic nephropathy
 - Diffuse diabetic or nodular glomerulosclerosis
 - End stage renal disease (ESRD)
 - Kimmelstiel-Wilson lesion
 - Proteinuria, microalbuminuria, albuminuria (as a diagnosis)
 - Notation by provider that the patient has a positive urine test for proteinuria or microproteinuria, or albuminuria
 - Papillary necrosis
 - Renal dialysis
 - Diabetic neuropathy
- ◆ Secondary diabetes mellitus
- ◆ Borderline diabetes
- ◆ Impaired fasting glucose (IFG)
- ◆ Impaired glucose tolerance (IGT)
- ◆ Gestational diabetes mellitus (GDM)

Diabetes; End-organ Disease

- Diabetic retinopathy

Do **not** accept:

- ◆ Retinoschisis
- Diabetic nephropathy
 - Arterionephrosclerosis
 - Azotemia
 - Chronic renal disorder
 - Chronic renal insufficiency
 - Renal insufficiency
 - Acute renal failure

- Diabetic kidney disease
 - Diabetic nephropathy
 - Diffuse diabetic or nodular glomerulosclerosis
 - End stage renal disease (ESRD)
 - Kimmelstiel-Wilson lesion
 - Microalbuminuria (as a diagnosis)
 - Proteinuria, albuminuria (as a diagnosis)
 - Notation by provider that the patient has a positive urine test for proteinuria or microproteinuria, or albuminuria
 - Papillary necrosis
 - Renal dialysis
- Diabetic neuropathy
 - Neuropathic pain
 - Neuropathic symptoms

Cerebrovascular Disease (CVD)

- Cerebrovascular Disease
- Cerebral insufficiency
- Arteriovenous malformation (AVM)
- Transient ischemic attack (TIA)
- Cerebrovascular accident (CVA)
- Stroke
- Stroke in evolution
- Cerebral or brainstem infarction/hemorrhage
- Focal hemorrhage in brain
- Hemorrhagic stroke
- Thromboembolic stroke
- Atherothrombotic ischemic stroke
- Embolic or ischemic stroke
- Hemispheric infarct
- Intracerebral hemorrhage (ICH)
- Lacunar infarction
- Ruptured cerebral aneurysm
- Intracerebral/subarachnoid hemorrhage
- Hypertensive encephalopathy

Dementia

- Dementia
- Static dementia
- Progressive dementia
- Alzheimer's disease
- Multi-infarct dementia
- AIDS dementia
- Chronic cognitive deficit

Hemiplegia

- Permanent paralysis of one side (right or left) of the body

Do **not** accept:

- ◆ Temporary hemiplegia (e.g, occurs during a stroke or TIA but resolves or leaves residual weakness.
- ◆ Paraplegia

Moderate/severe renal disease

- End-stage renal disease (ESRD)
- Patient is on dialysis
- Chronic renal failure (CRF)
- Renal insufficiency
- Uremia
- Kidney transplant recipient
- Glomerulonephritis - acute (AGN)/chronic/membranous (MGN)/membranoproliferative (MPGN)
- Postinfectious glomerulonephritis (PIGN)
- Acute nephritic syndrome
- Rapidly progressive nephritic syndrome
- Rapidly progressive glomerulonephritis (RPGN)
- Crescentic glomerulonephritis
- Nephrotic syndrome (NS)
- Chronic nephritic/proteinuric syndrome
- Slowly progressive glomerular disease
- Nephritis – Acute/Chronic/tubulointerstitial
- Toxic nephropathy
- Pyelonephritis – acute/chronic
- Nephritis

Do **not** accept:

- ◆ Nephrectomy

Malignant Tumor

- Any primary malignant solid tumor, such as:
 - Hepatocellular carcinoma
 - Hepatoma
 - Adenocarcinoma of the prostate
 - Malignant tumors of the lung, breast, colon

Do **not** enter:

- ◆ Basal cell skin cancer
- ◆ Squamous cell skin cancer
- ◆ Metastatic tumors here. See "Metastatic tumor" below.

Leukemia

- Leukemia
- Acute/chronic myelogenous leukemia
- Acute/chronic lymphoblastic leukemia (ALL)
- Acute/chronic myeloid leukemia (AML)

- Acute/chronic myelocytic leukemia
- Acute/chronic lymphocytic leukemia
- Polycythemia vera

Lymphoma

- Lymphoma
- Lymphosarcoma
- Hodgkin's disease
- Non-Hodgkin's lymphoma (NHL)
- Myeloma
- Burkitt's Lymphoma
- Waldenstrom's macroglobulinemia
- Mycosis Fungoides

Metastatic tumor or definite/probable AIDs

- Secondary malignancy that appeared in parts of the body remote from the primary site
- Metastatic carcinoma of unknown primary origin (UPO)
- Metastatic solid tumors (e.g., breast, lung, colon)
- Acquired Immune Deficiency Syndrome (AIDS) – definite **or probable**
- AIDs related complex

CONTRAINDICATIONS

Inpatient documents: Refer to the Admission History and Physical and the Discharge Summary only.

Was the patient taking an ACE Inhibitor or angiotension receptor blocker at any time between 5/1/98 and 8/31/00?

Indicate whether the patient was prescribed or was taking any of the following medications during the study period.

ACE Inhibitors		Angiotension Receptor Agonists
Accupril	Lotensin	Atacand
Accuretic	Lotensin HCT	Avalide
Aceon	Lotrel	Avapro
Altace	Mavik	Candesartan
Benazepril Hydrochloride	Moexipril Hydrochloride	Cozaar
Benazepril Hydrochloride/ Amlodipine Besylate	Moexipril Hydrochloride/ Hydrochlorothiazide	Diovan
Benazepril Hydrochloride/ Hydrochlorothiazide	Monopril	Diovan HCT
Capoten	Monopril HCT	Eprosartan
Capozide	Perindopril	Hyzaar
Capozide 25/15	Prinivil	Irbesartan
Capozide 25/25	Prinzide	Irbesartan/ Hydrochlorothiazide
Capozide 50/15	Quinapril Hydrochloride	Losartan Potassium
Capozide 50/25	Ramipril	Losartan Potassium/ Hydrochlorothiazide
Captopril	Tarka	Micardis
Captopril-Hydrochlorothiazide	Teczem	Telmisartan
Enalapril Maleate	Trandolapril	Teveten
Enalapril Maleate/ Diltiazem Malate	Trandolapril/Verapamil Hydrochloride	Valsartan
Enalapril Maleate/ Hydrochlorothiazide	Uniretic	Valsartan/ Hydrochlorothiazide
Enalapril/ Felodipine	Univasc	
Fosinopril Sodium	Vaseretic	
Fosinopril Sodium/ Hydrochlorothiazide	Vaseretic 10-25	
Lexxel	Vaseretic 5-12.5	
Lisinopril	Vasotec	
Lisinopril/ Hydrochlorothiazide	Zestoretic	

When was a contraindication or intolerance to ACE Inhibitors noted by the provider between 5/1/98 and 8/31/00?

Enter the earliest date during the study period on which an allergy to ACE inhibitors is noted or **the provider notes** that the patient has a contradiction or intolerance to ACE inhibitors. The patient may or may not actually have been taking an ACE inhibitor at the time of the note.

Accept:

- Statement that ACE Inhibitor is contraindicated or not tolerated for reasons such as (specific reason does not need to be indicated),
 - Cough secondary to taking ACE inhibitors
 - Symptomatic hypotension
 - Hyperkalemia/elevated serum K+
 - Angioneurotic edema
 - Other contraindication/intolerance

Were any of the following noted by the provider to be the contraindication to ACE Inhibitors on the date entered in the previous question?

Indicate whether each of the listed signs/symptoms were noted as the contradiction to ACE Inhibitors on the specified date.

A cough secondary to ACE Inhibitors

The provider's note specifically states that ACE Inhibitors are contraindicated because the patient has a history of cough secondary to taking an ACE Inhibitor.

Symptomatic hypotension

Symptomatic hypotension is hypotension that results in symptoms such as:

- Faintness, light-headedness, dizziness
- Syncope

Accept:

- Symptomatic hypotension
- Orthostatic hypotension
- Hypotension

Do **not** accept:

- ◆ Transient episode of hypotension

Hyperkalemia

Notation of a history of or current elevated serum potassium (K+).

Angioneurotic edema

Angioneurotic edema: Large areas of swelling of subcutaneous tissues, mucous membranes, and occasionally an internal organ. The edema may be due to allergic sensitivity to drugs, food, or physical agents such as cold or wind, but in many cases the cause is unknown.

Accept:

- Angioneurotic edema

- Angioedema

Renal insufficiency

Renal insufficiency is the inability of the kidney to remove waste products from the blood at the normal rate.

Accept:

- Renal insufficiency
- Patient is receiving renal dialysis treatments
- Notation of a creatinine greater than 2

Is there evidence that the patient failed a previous trial of ACE Inhibitors at any time in the past?

Indicate whether there is a notation during the study period that the patient had an unsuccessful trial of an ACE Inhibitor (ACEI) or an angiotension receptor blocker.

Accept:

- Failed prior trial of ACE Inhibitor or an angiotension receptor blocker
- Patient unable to take ACE Inhibitors or an angiotension receptor blocker

Was the patient taking a beta blocker at any time between 5/1/98 and 8/31/00?

Indicate whether the patient was prescribed or was taking any of the following medications during the study period.

Beta Blockers

Acebutolol Hydrochloride	Levitol
Atenolol	Lopressor
Atenolol-Chlorthalidone	Lopressor HCT
Beta Blockers	Metoprolol Succinate
Betapace	Metoprolol Tartrate
Betapace AF	Metoprolol Tartrate/ Hydrochlorothiazide
Betaxolol Hydrochloride	Nadolol
Bisoprolol Fumarate	Nadolol/Bendroflumethiazide
Bisoprolol Fumarate/Hydrochlorothiazide	Normodyne
Blocadren	Penbutolol Sulfate
Brevibloc	Pindolol
Carteolol Hydrochloride Oral	Propranolol Hydrochloride
Cartrol	Sectral
Carvedilol	Senormin
Coreg	Sotalol Hydrochloride
Corgard	Tenoretic
Corzide	Tenoretic 100
Corzide 40/5	Tenoretic 50
Corzide 80/5	Tenormin
Esmolol Hydrochloride	Timolide 10-25
Hydrochlorothiazide-Propranolol	Timolol Maleate
Inderal	Timolol Maleate/ Hydrochlorothiazide
Inderal LA	Toprol XL
Inderide	Trandate

Inderide LA
Kerlone
Labetolol Hydrochloride

Visken
Zebeta
Ziac

When was a contraindication or intolerance to beta blockers noted by the provider between 5/1/98 and 8/31/00?

Enter the earliest date during the study period on which an allergy to beta blockers is noted or **the provider notes** that the patient has a contradiction or intolerance to beta blockers.

Accept:

- Statement that beta blockers are contraindicated or not tolerated for reasons such as (specific reason does not need to be indicated),
 - Asthma or Chronic Obstructive Pulmonary Disease (COPD)
 - Shortness of breath (SOB) at rest
 - Heart block (ECH or provider note)
 - Heart rate less than 60 or systolic blood pressure less than 100
 - Other contraindication or intolerance

Were any of the following noted by the provider to be the contraindication to beta blockers on the date entered in the previous question?

Indicate whether each of the listed signs/symptoms were noted as the contradiction to beta-blockers on the specified date.

Asthma or COPD

Asthma

- Hyperresponsiveness of the airways to a variety of inhaled stimuli
- Occupational asthma
- Allergic Asthma
- Chronic obstructive asthma
- Extrinsic/intrinsic Asthma
- Allergic asthma
- Idiosyncratic asthma
- Occupational asthma
- Bronchial asthma
- Bronchial induced asthma
- Bronchospasm in a patient with a history of asthma
- Reactive airway disease (RAD)
- Reversible hyper-reactive lung disease
- Reversible airway disease
- Reversible obstructive airway disease
- Chronic obstructive asthma

Chronic Obstructive Pulmonary Disease (COPD)

- Chronic bronchitis
- Simple obstructive lung disease
- COLD - chronic obstructive lung disease
- COPD
- Obstructive airways disease
- Emphysema

Shortness of breath (SOB) at rest

Enter the date on which the provider noted that beta blockers were contraindicated due to shortness of breath at rest.

Do **not** accept:

- Shortness of breath on exertion only.

Heart block (ECG or provider note)

Enter the date on which the provider noted that beta blockers were contraindicated due to heart block or that heart block was noted on an ECG interpretation.

Accept:

- Second-degree heart block
- Third-degree heart block

A heart rate less than 60 or a systolic blood pressure less than 100

Enter the date on which the provider noted that beta blockers were contraindicated due to a heart rate of less than 60 or a systolic blood pressure less than 100.

Is there evidence that the patient failed a previous trial of beta blockers at any time in the past?

Indicate whether there is a notation during the study period that the patient had an unsuccessful trial of a beta blocker.

Accept:

- Failed prior trial of a beta blocker
- Patient unable to take beta blockers

Was a contraindication or an intolerance to anticoagulation therapy documented by the provider?

Indicate whether the provider noted that the patient had a contraindication to, an allergy to, intolerance to or that the patient refused to initiate anticoagulant therapy at any time during the study period.

The reason that anticoagulation therapy is contraindicated does not have to be mentioned but may include:

- Alcoholism
- Allergy/hypersensitivity/intolerance/contraindication to warfarin (Coumadin)
- Bleeding diathesis (e.g. dysfunctional platelets, von Willebrand's disease, thrombocytopenia, clotting factor deficiency, hemophilia)
- Bleeding within the past 4 weeks (including gastrointestinal bleeding, melena, epistaxis, any bleeding requiring transfusion; excluding menses and occult hemoglobin in stools)
- Known intracranial neoplasm, mass or other intracerebral pathology (e.g. aneurysm, abscess)
- Notation of frequent falls in the medical record
- Pregnancy
- Previous hemorrhagic stroke at any time or non-hemorrhagic stroke within 1 month
- Suspect aortic dissection
- Unsupervised dementia/psychosis

Do **not** accept:

- ◆ One of the above mentioned conditions in the absence of a statement that the condition is a contraindication to antiplatelet therapy

Was a contraindication or intolerance to of antiplatelet therapy documented by the provider?

Indicate whether the provider noted that the patient had a contraindication to, an allergy to, intolerance to or that the patient refused to initiate antiplatelet therapy at any time during the study period.

The reason that antiplatelet therapy is contraindicated does not have to be mentioned but may include:

- Contraindications to antiplatelet therapy
- Hypersensitivity or allergy to salicylates (rare)
- Clinically active hepatic disease
- Bleeding tendency
- Anticoagulant therapy
- Bleeding within the past 4 weeks (including gastrointestinal bleeding, melena, epistaxis, any bleeding requiring transfusion; excluding menses and occult hemoglobin in stools)

Do **not** accept:

- ◆ One of the above mentioned conditions in the absence of a statement that the condition is a contraindication to antiplatelet therapy
- ◆ Occult blood in the stool
- ◆ Bleeding related to menses

See antiplatelet medication list below.

Aspirins		Combinations
Acuprin 81	Easprin	Arthritis Pain Formula
Arthritis Foundation Aspirin	Ecotrin	Ascriptin
Arthritis Pain	Ecotrin Low Strength Adult	Ascriptin Maximum Strength
ASA	Ecotrin Maximum Strength	Aspidrox
Ascriptin Enteric	Empirin	Aspirin Buffered
Aspergum Cherry	Entaprin	Aspir-Mox
Aspergum Original	Entercote	Aspir-Mox IB
Aspirin	Extra Strength Bayer	Magnaprin
Aspirin Enteric Coated	Genacote	
Aspirin Litecoat	Gennin-FC	Other Antiplatelet Drugs
Aspirin Lo-Dose	Genprin	Clopidogrel
Aspirin Low Strength	Halfprin	Plavix
Aspirin Tri-Buffered	Litecoat Aspirin	Dipyridamole
Aspirin, Extended Release	Low Dose ASA	Persantine
Aspirin-Antacid	Med Aspirin	Persantine IV
Aspir-Low	Minitabs	Aggrenox
Aspirtab	Norwich Aspirin	Ticlid
Aspir-trin	Ridiprin	Ticlopidine Hydrochloride
Bayer Aspirin	Sloprin	
Bayer Low Strength	St. Joseph Aspirin	
Bayer Plus	St. Joseph Aspirin Adult Chewable	
Buffered Aspirin	Stanback Analgesic	
Bufferin	Therapy Bayer	

Bufferin Arthritis Strength	Tri-Buffered Aspirin
Bufferin Extra Strength	Uni-Buff
Buffex	Uni-Tren
Coated Aspirin	Valomag
CTD Aspirin	Zorprin

EXAMS

For each inpatient and outpatient echocardiogram, radionuclide ventriculography, cardiac catheterization and contrast ventriculography on or prior to 8/31/00, enter the date of the test, the value of the LVEF measurement, and, if no LVEF is noted, the left ventricular systolic function status. Check "No LVEF or function" if neither is available. Enter the date of the test or check "date unavailable" if date of test is unknown. (Prior date OK).

Date of test

- A date during or prior to the study period is permitted here.
- Enter the **date of the test** as noted on the test report or by the provider. If the report isn't available and cannot be calculated select "Date Unavailable."
- Inpatient documents: Refer to the Admission H&P and the Discharge Summary only.

Type of test

Echocardiogram

Accept:

- Echocardiogram (nonstress)
- Echocardiogram performed in conjunction with an exercise or pharmacological stress test.

Radionuclide Ventriculography

Nuclear Medicine involves the administration of radioactive materials (radionuclides) to obtain specific diagnostic information. These radionuclides transmit a pattern of rays that represent the organ size, shape and function and are detected by a specialized camera.

Accept:

- Radionuclide cardiac angiography
- Radionuclide Cineangiography
- Radionuclide Ventriculogram
- Radionuclide myocardial infarct detection study
- Cardiac blood pooling imaging
- Gated Wall Motion study
- First Pass nuclear study
- Nuclear heart scan
- Nuclear ventriculography
- MUGA or SPECT
- Position emission tomograph (PET)

Contrast Ventriculography

Visualization of the ventricles of the heart on x-ray using a radiologic contrast medium. It is usually performed in conjunction with a cardiac angiogram. If a cardiac angiogram was performed, look for results of an LVEF or statement regarding left ventricular systolic function.

Accept:

- Contrast ventriculography
- Ventriculography
- Cardiac catheterization
 - With ventriculography
 - On which an LVEF was noted
 - On which left ventricular function was noted
- Coronary angiogram/angiography
 - With ventriculography
 - On which an LVEF was noted
 - On which left ventricular function was noted

LVEF percentage

Left ventricular ejection fraction (LVEF) is usually expressed as a percentage (e.g., 50%), but may be expressed as 50 or 0.50.

Enter the numerical value of the LVEF. For example, if an LVEF is 50%, or 0.50 or 50, enter "50". If a range is given, enter the higher value.

Accept:

- LVEF, Left Ventricular Ejection Fraction, Ejection Fraction, or EF

Left ventricular systolic function

Indicate which of the listed responses, if any, describe left ventricular systolic function on the exam results. If the results are described using other terminology, select "Other finding" and write the notations about left ventricular function in the "Abstractor Notes." If there is no comments on left ventricular systolic function, check the "No LVEF or left ventricular function" checkbox.

Note: "Decreased, not otherwise specified" means that the notation indicated that left ventricular function was decreased, but did not specify how much it was decreased. So you would select this response if the notation stated, for example:

- Left ventricular function decreased.
- Decreased LV function

Abstractor Notes:

Types of results to be entered include comments on:

- Hypokinesia, akinesia, and/or dyskinesia, including extent and location
- Wall-motion abnormalities or paradoxical wall motion, including extent and location
- Specific areas of the heart, such as specific walls or segments (e.g., posterior, inferior, posterolateral), the septum, the apex, other portions of the left ventricle.
- Left ventricular dysfunction
- Size of left ventricle/ventricular dilation
- Ejection fraction when described rather than noting a value/percentage (e.g., reduced, abnormal)

Do **not** include in the Abstractor Notes comments on:

- ◆ The right ventricle
- ◆ The right or left atria
- ◆ Aortic root
- ◆ Pericardium (e.g., pericardial effusion)
- ◆ Valves: aortic, mitral, tricuspid, pulmonic
- ◆ Presence/absence of clots

NOTE: If you have entered any value for LVED in the LVEF test table above, questions "B," "C," and "D" may be skipped. Check the "No LVEF value noted by provider" checkbox for question "B" and the "No Data" checkboxes for questions "C" and "D" and question "E".

Enter the date and result of each LVEF value (or check LVEF Value Unavailable) noted by the provider on or prior to 8/31/00 other than the results entered in the table above (i.e., other than noted as a result of a specific test). Enter the date the value was determined or check "Date Unavailable" if the date determined is unknown. (Prior date OK).

Date LVEF determined

The purpose of this question is to collect LVEF values that are noted by the provider that are not in the context of a test result (e.g., "patient's LVEF during last hospitalization was 35%", "history of LVEF < 40%").

Accept:

- A date during or prior to the study period is permitted here.
- Enter the date the LVEF was determined. If the date determined isn't available and cannot be calculated select "Date Unavailable."
- Inpatient documents: Refer to the Admission History and Physical and the Discharge Summary only.

LVEF value

Enter the value, if known, or check "LVEF Value Unavailable" if the numerical value is not noted.

Left ventricular ejection fraction (LVEF) is usually expressed as a percentage (e.g., 50%), but may be expressed as 50 or 0.50.

Enter the numerical value of the LVEF. For example, if an LVEF is 50%, or 0.50 or 50, enter "50". If a range is given, enter the higher value.

Accept:

- LVEF, Left Ventricular Ejection Fraction, Ejection Fraction, or EF

NOTE: If you have entered any value for LVED in question "B" above, questions "C," and "D" may be skipped. Check the "No Data" checkboxes for questions "C" and "D" and proceed to question "E".

When was left ventricular systolic dysfunction first noted by the provider (i.e., not noted a test result)?

This may be noted as a history or a diagnosis or a comment in the progress note. For inpatient stays, refer to the Admission History and Physical and the Discharge Summary only.

Accept:

- Dilated cardiomyopathy
- Diffuse hypokinesia
- Global hypokinesia
- Moderate or severe left ventricular systolic dysfunction
- Mild left ventricular systolic dysfunction

When was diastolic dysfunction first noted by the provider (i.e., not noted a test result)?

This may be noted as a history or a diagnosis or a comment in the progress note. For inpatient documents, refer to the Admission History and Physical and the Discharge Summary only.

Accept:

- Hypertrophic cardiomyopathy
- Idiopathic hypertrophic subaortic stenosis (IHSS)
- Diastolic dysfunction

Was a coronary angiogram performed between 5/1/98 and 8/31/00?

A coronary angiogram is the study of the arterial blood vessels of the heart by injection of contrast media through a catheter (thin flexible tube) that has been positioned into the aorta or the heart. A rapid succession of X-rays is taken to view blood flow through the coronary arteries.

For inpatient documents, refer to the Admission History and Physical and the Discharge Summary only.

Accept:

- Heart catheterization
- Cardiac catheterization
- Coronary angiogram
- Coronary angiography
- Coronary arteriography
- Coronary dye test

Was a coronary angiogram recommended or refused between 5/1/98 and 8/31/00?

Enter the earliest date on which the patient refused a coronary angiogram. For inpatient stays, refer to the Admission History and Physical and the Discharge Summary only.

Accept refusal of:

- Heart catheterization
- Cardiac catheterization
- Coronary angiogram
- Coronary angiography
- Coronary arteriography
- Coronary dye test

When was there a notation that the patient was not a candidate for revascularization?

Enter the earliest date during the study period when the provider **specifically notes** that there is a contraindication to revascularization (e.g., PTCA, CABG). The reason does not have to be noted and may be a notation such as, "Patient not suitable candidate for revascularization." Also accept a notation that the patient is not a candidate for cardiac catheterization due to the patient's medical condition.

For inpatient documents, refer to the Admission History and Physical and the Discharge Summary only.

Examples of reasons include:

- Terminal illness;
- Intracranial pathology contraindicating systemic anticoagulants (e.g. stroke within 1 month);
- Advanced dementia;
- Bedbound (e.g. severe impairment in ability to perform basic activities of daily living);
- Anaphylaxis to contrast material;
- Progressive renal insufficiency;
- Digitalis intoxication;
- Severe anemia (HCT < 30) or active gastrointestinal bleeding;
- Ejection fraction less than 25% or left ventricular end-diastolic dimension > 7.5 cm.;
- Active infection, sepsis or fever which may be due to infection;
- Coronary anatomy documented in the medical record not to favor revascularization- often evidenced by a prior coronary angiogram which revealed multivessel coronary disease but did not result in revascularization;
- In unstable patients, lack of a cardiac catheterization laboratory or a cardiac surgical team in the hospital;
- Two or more prior CABG operations; and
- Stress radionuclide or echocardiogram which reveals only small areas of reversible radionuclide defects or echocardiographic wall motion abnormalities, that is only small areas of ischemia.

Were any of the following documented between 5/1/98 and 8/31/00?

Indicate whether there was a notation during the study period that noted the following. For inpatient documents, refer to the Admission History and Physical and the Discharge Summary only.

An allergy to radiologic contrast medium.

Accept:

- Allergy to radiologic contrast medium
- Allergy to radiologic dye

The patient's CAD was inoperable

Accept:

- The status of the patient's coronary artery disease (CAD) is such that surgery is not a treatment option.

Provider notation that the patient had a life-threatening disease

Accept:

- Any notation by the provider that the patient has a life-threatening illness
- Notation of limited life-expectancy.

LABORATORY TESTS

General guidelines:

Hierarchy for determining date entry

- Date on lab report indicated when the specimen was obtained.
- Date on which results were reported as indicated on the lab report.
- Date indicated by the provider that the test was performed.

Was the patient taking Coumadin or warfarin at any time between 5/1/1998 and 8/31/00?

Indicate whether there was any indication (e.g., prescription, current medication, etc.) that the patient was taking either coumadin or warfarin during the study period.

Enter the 5 most recent dates prior to and including 4/30/99 on which an outpatient INR was obtained and enter the results. Enter only the admission INR noted on the Admission H&P and the most recent INR noted on the discharge summary of each hospitalization.

If more than one INR result is noted on a single date, enter the value that closest to 2.5.

Do not enter INR tests for which the result is unknown.

Accept:

- INR or Coagulation study

Enter the 5 most recent dates between 5/1/1999 and <<ENDABS>> on which an outpatient INR was obtained and enter the results. Enter only the admission INR noted on the Admission H&P and the most recent INR noted on the discharge summary of each hospitalization.

If more than one INR result is noted on a single date, enter the value that closest to 2.5.

Do not enter INR tests for which the result is unknown.

Accept:

- INR or Coagulation study

Enter the date and value of LDL cholesterol measurements. Include all outpatient LDL tests, the admission LDL test noted on the inpatient Admission H&P and the most recent LDL test noted on the Discharge Summary of each hospitalization.

Enter the date and the numerical result of LDL cholesterol measurements.

- Enter all outpatient LDL tests. This includes tests done in the Emergency Room when the patient was not admitted.
- Enter the LDL taken on admission (including the Emergency Room test) as noted on the Admission H&P and the most recent test noted on the Discharge Summary. Do not enter more than one admission test
 - Do not duplicate entries. If the LDL test noted on the Discharge Summary is the test that was noted on admission, enter it only once.

- If you are unable to determine whether the 2 inpatient tests are duplicates and the values of both tests are the same, enter the test and that value only once.
- If a test was performed but the results were not noted or available, select "Results not available."

For each test, select the units of measurement and indicate whether the test was fasting.

- Fasting - when the patient has been fasting for at least 12 hours.
- Post-prandial (after meal) {PPG} blood glucose.
 - Note:** If PP is the abbreviation used, be certain that it is referring to post-prandial (after meal) and NOT pre-prandial (before meal)
- If there was no notation regarding fasting or not fasting, select "No data."

Enter the dates of all outpatient blood tests for digoxin levels, the admission digoxin level noted on the admission H&P and the most recent digoxin level noted on the Discharge Summary of each hospitalization

- Enter all outpatient digoxin levels. This includes tests done in the Emergency Room when the patient was not admitted.
- Enter the digoxin level taken on admission (including the Emergency Room test) as noted on the Admission H&P and the most recent test noted on the Discharge Summary. Do not enter more than one admission test
 - Do not duplicate entries. If the digoxin level noted on the Discharge Summary is the test that was noted on admission, enter it only once.
 - If you are unable to determine whether the 2 inpatient tests are duplicates and the values of both tests are the same, enter the test and that value only once.
- If the date obtained is unavailable, enter the date of the results.
- Enter the date whether performed, whether or not the results were noted or available.

Enter the date and result of each outpatient serum potassium and each serum creatinine, the admission serum potassium and serum creatinine noted on the inpatient Admission H&P and only the most recent serum potassium and most recent serum creatinine noted on the Discharge Summary of each hospitalization.

- Enter the date and numerical result of each outpatient serum potassium (K+) and serum creatinine test. This includes tests done in the Emergency Room when the patient was not admitted.
- Enter the admission serum potassium and serum creatinine taken on admission (including Emergency Room tests) as noted on the Admission H&P and the most recent test noted on the Discharge Summary. Do not enter more than one admission test.
 - Do not duplicate entries. If the test noted on the Discharge Summary is the test that was noted on admission, enter it only once.
 - If you are unable to determine whether the 2 inpatient tests are duplicates and the values of both tests are the same, enter the test and that value only once.
- If a test was performed but the results were not noted or available, select "Results not available."
- If a potassium test and a creatinine test were both taken on the same date, enter the date once for the potassium test and once for the creatinine test and enter the result of both tests.

For Potassium, accept:

- Serum K+
- Serum Potassium
- K+
- Electrolytes, lytes
- SMAC-7, SMA-7
- Chem panel, Chem-7

- Metabolic panel
- Cr
- Creat
- Serum Cr
- Serum creatinine
- Creatinine level
- SMAC-7, SMA-7
- Chem panel, Chem-7
- Metabolic panel

HOSPITAL/LONG TERM CARE FACILITY

Enter each date on which the patient was discharged from the hospital with a diagnosis of heart failure. For each date indicate whether the admission diagnosis was also for heart failure

Enter each discharge date on which the patient had a discharge diagnosis of heart failure and indicate whether one of the admission diagnoses for that hospitalization was heart failure. Heart failure may be the only discharge or admission diagnosis or one of several diagnoses. Heart failure does not need to be the primary admission or the primary discharge diagnosis.

Was this patient a resident of a long-term care facility during the study period?

Indicate whether the patient was a resident of a long-term care facility at any time during the study period. The admission and discharge dates do not have to be during the study period; however, the patient must be a resident at some time during the study period.

Enter all dates on which the patient was admitted to a long-term care facility.

Enter each date on which the patient was admitted to a long-term care facility.

Enter all dates on which the patient was discharged from a long-term care facility.

Enter each date on which the patient was discharged from a long-term care facility.

COUNSELING

GENERAL GUIDELINES:

Counseling consists of an encounter in which counseling; education, advice, teaching or instruction is received by the patient from the provider in the form of a discussion and/or written material. The notation often refers to a discussion, review of information, or encouragement with regard to the patient's management of the condition.

Do **not** enter:

- ◆ Counseling that took place prior to the initial diagnosis of diabetes

In order to qualify as counseling, the notation must include **at least one** of the following 4 characteristics:

1. Involvement of the patient in the management of the disease (i.e., something that the patient will do, is able to do due to instruction, not something the provider will do).
*Note: If the statement implies that the activity is a goal **set by the patient** (e.g., patient has a goal to lose 5 pounds by the next visit), this should be entered in the following question as goal setting instead of counseling.*

Accept:

- We talked about the importance of appropriate foods and diet.
- Can state what foods to avoid for low-salt diet

Do **not** accept:

- ◆ Will start ACE Inhibitors. (This is a provider action)
- ◆ Patient continues to have many dietary issues (this is an assessment, instruction may or may not have been given).

2. A statement by the provider about what the patient will do or should do in the future in the management of the disease. This does **not** include what the patient has been doing up until the time of the notation.

*Note: If the statement implies that the activity is a goal **set by the patient** (e.g., patient has a goal to lose 5 pounds by the next visit), this should be entered in the following question as goal setting instead of counseling.*

Accept:

- Advised to do daily weights
- Encouraged to walk 5-6 days/week
- Will exercise more
- Patient is reluctant to or is resistant to doing recommended risk management (e.g., resistant to beginning an exercise program).

Do **not** accept:

- ◆ She is on a low salt diet
- ◆ Has started walking

3. Written material about the disease, medication, risk factors, complications, etc. is given to or discussed with the patient.

4. A checklist completed by provider or patient that indicates what type of counseling or advice was given to the patient or addressed at the visit (i.e., implies a discussion took place).

Do **not** accept for counseling:

- ◆ Notations regarding return appointments, RTC, etc.
- ◆ Instructions to call or see provider or if a certain symptom or event occurs (e.g., "If swelling gets worse she is to call the clinic").
- ◆ Descriptions of activities that have occurred entirely in the past.
- ◆ The provider's plan (i.e., what the provider will do) such as; "will double her dose in 2 weeks if she doesn't respond."

- ◆ Checklist completed by provider or patient that indicates what the patient had been doing prior to the visit (e.g., "adhering to diet").

Enter all dates on which the patient received outpatient counseling regarding heart failure medication use.

The note must imply or state that medication use (of a medication on the Heart Failure medication list) was discussed or reviewed. Counseling may be regarding side effects, compliance, special instructions on timing of doses (e.g., dose increases or timing if there is a weight change) how to take/administer the medication, etc.

Do **not** accept:

- ◆ A medication order or plan.
- ◆ List of current medication.
- ◆ Statements that the provider is simply making adjustments in the prescribed dose (may or may not be communicating this to patient).
- ◆ Statements that the patient was told simply what drug to take or to continue taking the same drugs - what dose; what frequency (e.g., "advised to increase diuretic to 10mg"). There must be information other than or in addition to what the prescription is (such as a side effects, importance of taking regularly, etc.).
- ◆ Counseling regarding a medication that does not appear on the heart failure medication list.

Enter all dates on which the patient received outpatient counseling regarding a low-salt diet.

Accept:

- Counseling, discussion, review regarding
 - Low-salt diet, importance of diet
 - Meal planning or food preparation methods for low-salt diet
 - Food management for low-salt diet
- Visit with dietitian/nutritionist regarding low-salt diet
- Examples: "reviewed importance of reducing sodium intake"

Do NOT accept:

- ◆ Dietary therapy for a condition other than a low-salt diet.
- ◆ Dietary counseling for a diet other than low-salt or an unspecified diet
- ◆ An order or just a description of the diet (i.e., patient on low-salt diet)
- ◆ Referral to dietitian or order to schedule appointment with dietitian.
- ◆ Statements that do not specifically indicate that diet was discussed such as, "pt follows no specific diet."

LOW SALT DIET:

- Low sodium (NA) diet
- NAS – no added salt
- 2Gm (or other amount) Na diet

Enter all dates on which the patient received outpatient counseling regarding exercise.

Look for any documentation that the patient received instruction on the importance of exercise/activity or advice regarding specific activities.

Accept:

- Counseling, discussion or review regarding exercise, activity levels, importance of exercise
- Advice on specific level or type of exercise

- Order, referral, recommendation to enter exercise program
- Examples: "talked about how much to walk/day, "encouraged to walk 5-6 days/week," "advised to increase exercise"

Do **not** accept:

- ◆ Documentation of patient's reported physical activity (e.g., walking 1/2 mile per day) without evidence that counseling took place.

Enter all dates on which the patient received outpatient counseling regarding monitoring their weight.

Look for any documentation that the patient received instruction on the importance of or approach to the monitoring of weight.

Accept:

- Counseling, discussion or review regarding monitoring of weight/weight control
- Patient given a schedule for weighing
- Instructions on weight-monitoring

Do **not** accept:

- ◆ Recording of patient's weight at the visit

When was the patient first noted to be a CURRENT smoker on or after 5/1/1998?

Smoking status applies to cigarette smoking only. If there is no reference as to what the patient smokes (e.g., cigarettes, cigars), assume cigarette smoking.

NOTE: Unlike the smoking question on the New Diagnosis tab, you may use any source of information here that indicates that the patient was a smoker during the study period.

- Accept:
 - Smoker
 - Current number of packs per day (PPD) or per year
 - Current smoker, Smoker (+)
 - Currently in a smoking cessation program
 - Trying to quit
 - Advised to quit smoking

Do **not** accept:

- ◆ Marijuana smoking in the absence of cigarette smoking
- ◆ Cigar or pipe smoking or tobacco chewing in the absence of cigarette smoking

Enter all dates on which the patient received outpatient counseling regarding smoking cessation.

Accept:

- Documentation of smoking cessation counseling at a provider visit including nutritionists, MSWs, psychologists
- Notation reflecting patient education on smoking cessation (e.g., video instruction, pamphlets, counseling) or referral to a smoking cessation group.
 - Smoking Cessation Workshop (Nicotine Anonymous)
 - Hypnotherapy to stop smoking
 - Acupuncture for smoking cessation
 - Given brochure, information regarding smoking cessation
- Prescription for NRT (Nicotine Replacement Therapy) with evidence that Smoking cessation discussion took place.

- Patient not willing or unable to quit smoking
- Discussion about quitting (e.g., agrees to try quitting).

Do **not** accept:

- ◆ Patient is trying to quit smoking as a history item (in the absence of any implication that a discussion took place about quitting)
- ◆ Smoking status or amount that patient smokes

Enter all dates on which there was outpatient heart failure-related counseling other than the types of counseling in the questions above (e.g., unspecified, general, other risk factors).

Accept:

- Counseling, discussion or review of heart failure risk factors
- Notation of "heart failure management counseling"
- Signs and symptoms of heart failure exacerbation reviewed or discussed
- Cardiac rehab education.
- Attendance at or referral to group counseling, class or patient educator related heart failure management

Enter all dates on which an action plan was noted that indicated the patient was to either change the dose of the diuretic medication or to call the physician or case manager if the patient gained a specified number of pounds/kilograms?

Enter the first date on which there is evidence that the patient was told to do either of the following if he/she gained a specified number of pounds or kilograms:

- Change the dose of their diuretic medication
- Contact the physician or case manager (office/clinic)

Do not accept:

- Any plan of action other than those listed above.
- A plan of action that does not specify the number of pounds or kilograms
- Notation that the diuretic is to be increased without reference to the weight gain.

Examples

- Patient to double the dose of diuretic if there is a weight gain of more than 5 pounds in 5 days.
- Will monitor weight and call if it increases by more than 2 pounds in one day

Enter all dates on which goal setting or an action plan for heart failure was noted in the outpatient setting other than the action plan for weight gain.

Goal setting or action plans must have at least one of the following 2 characteristics:

1. Specific goals that patient or provider that will take place in the future to manage the disease. The goal is specific if it has one of the following:

- A **numerical** component
- Indicates the **method** to be used in achieving the goal
- Is a specific one-time event

Accept:

Quantified numerically:

- Will reduce weight by 1 pound every 2 weeks
- Will increase exercise to 3x per week.
- Will cut cigarette smoking down to _ pack per day.
- Will monitor weight daily

Method specified:

- Will try to lose weight by eating dessert only once per week.
Specific one-time event
- Patient will join Weight Watcher's program

Do **not** accept:

- ◆ Will try to lose weight (not specific in number of pounds or in method)
- ◆ Has started walking
- ◆ Has been exercising 3x/week
- ◆ Patient has written weekly goals

2. **Specific** plans or actions the patient will take if certain symptoms or a specific situation occurs or recurs.

- If his weight gain is more than 2 pounds in a day, he will double his diuretic dose."

Do **not** accept for goal-setting or action plan:

- ◆ Notation such as, "patient to call or return to clinic in..."
- ◆ Instructions to call or see provider or if a certain symptom or event occurs (e.g., "If swelling gets worse she is to call the clinic").
- ◆ Will try to keep his diastolic below 90 (a provider goal, not the patient's).
- ◆ Statements that are counseling rather than a plan of action such as:
 - Has been advised to check blood sugar anytime she feels unwell.
 - Reviewed importance of taking medications as prescribed
 - Discussed preventative measures
- ◆ Statements such as "Pt to be given note to be off work until..."

When was there outpatient counseling for a cholesterol reduction diet?

CHOLESTEROL LOWERING DIET

- Lipid lowering diet
- American Heart Association (AHA) diet
- Low saturated fat, low cholesterol diet (Step II Diet)
- Limiting total daily fat intake to no more than 30% of total calories
- Any mention of counseling to lower fat in diet

Accept:

- Counseling, discussion, review regarding
 - Cholesterol lowering diet, importance of diet
 - Meal planning or food preparation methods for cholesterol lowering diet
 - Food management for cholesterol lowering diet
- Visit with dietitian/nutritionist is considered to be diet counseling
- Examples: "reviewed importance of low fat/cholesterol lowering diet"

Do NOT accept:

- ◆ Dietary therapy for a condition other than a cholesterol lowering diet.
- ◆ An order or just a description of the diet
- ◆ Referral to dietitian or order to schedule appointment with dietitian.
- ◆ Statements that do not specifically indicate that diet was discussed such as, "pt follows no specific diet,"