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Get With The Guidelines.
Heart Failure

PROGRAM MEASURES & DEFINITIONS

Updated 1/10/24: This document is updated annually, although the measures within the Get With The Guidelines® program may change more frequently. For the most current list of measures, log into your Get With The Guidelines user account or contact your American Heart Association Quality Consultant.

Introduction:

Get With The Guidelines®- Heart Failure is the American Heart Association's collaborative quality improvement program demonstrated to improve adherence to evidence-based care of patients hospitalized with heart failure. The registry facilitates opportunities to enter and monitor data on patients with heart failure. Metrics are tracked on hospitalization, secondary prevention strategies, discharge, and follow-up care. Additionally, teams can optimize their quality improvement activities utilizing the creative reporting capabilities of our newest platform. Super User accounts are available for health system quality staff to monitor the performance of all affiliated sites allowing for high level quality initiatives across systems. The American Heart Association supports the Get With The Guidelines platforms with a knowledgeable team of quality improvement consultants. An added value to our customers is ongoing virtual education featuring guideline-driven care, current hot topics, model-sharing, expert consultant panels and more!

Heart Failure Achievement Measures:

- **Evidence-based specific beta blockers:** Percent of HF patients who were prescribed evidence-based specific beta blockers (bisoprolol, carvedilol, metoprolol succinate CR/XL) at discharge. AHAHF2
- **Left Ventricular Function Assessed:** HF patients with documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge. AHAHF3
- **Post-discharge appointment for heart failure patients:** Percent of eligible heart failure patients for whom a follow-up appointment was scheduled and documented including location, date, and time for follow-up visits or home health visits. AHAHF4
- **Angiotensin receptor–neprilysin inhibitor (ARNi) at discharge:** Percentage of eligible patients with heart failure who are prescribed an ARNI at hospital discharge. AHAHF6
- **SGLT-2 inhibitor at discharge for patients with HFrEF:** Percent of patients with heart failure (HF) and reduced ejection fraction who are discharged on a SGLT-2 Inhibitor. AHAHF93
- **Mineralocorticoid receptor antagonist at discharge for patients with HFrEF (LVEF ≤40):** Percent of heart failure patients with left ventricular ejection fraction ≤40% or a qualitative assessment of moderate/severe dysfunction with no contraindications or documented intolerance who were prescribed mineralocorticoid receptor antagonists (MRA) or aldosterone antagonist at discharge. AHAHF110

Heart Failure Quality Measures:

- **ACEI/ARB or ARNi at discharge:** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) or angiotensin-receptor/neprilysin inhibitor (ARNI) contraindications who are prescribed an ACEI, ARB, or ARNI at hospital discharge. AHAHF1
- **Anticoagulation for atrial fibrillation or atrial flutter:** Percent of patients with chronic or recurrent atrial fibrillation or atrial flutter at high risk for thromboembolism, according to CHA2DS2–VASc risk stratification prescribed anticoagulation at discharge. AHAHF7
- **CRT-D or CRT-P placed or prescribed at discharge:** Percent of heart failure patients with left ventricular ejection fraction less than or equal to 35% with a QRS duration of 120 ms or above and left bundle branch block or QRS 150ms or above regardless of QRS morphology, with no contraindications, documented intolerance, or any other reason against who have CRT-D or CRT-P, had CRT-D or CRT-P placed, or were prescribed CRT-D or CRT-P at discharge. AHAHF8
- **DOAC at discharge for heart failure with non-valvular atrial fibrillation or atrial flutter patients:** Percent of eligible heart failure patients with non-valvular* atrial fibrillation or atrial flutter patients discharged on a direct-acting oral anticoagulant (DOAC). *Nonvalvular AF is AF in the absence of moderate-to-severe mitral stenosis or a mechanical heart valve. AHAHF109
- **DVT prophylaxis:** Percent of patients with heart failure and who are non-ambulatory who receive DVT prophylaxis by end of hospital day two. AHAHF9
- **Follow-up Visit Within 7 Days or Less:** Percent of eligible patients with a follow-up visit scheduled within 7 days or less from time of hospital discharge. AHAHF10
- **Hydralazine nitrate at discharge:** Black heart failure patients with left ventricular systolic dysfunction (LVSD) with no contraindications or documented intolerance who were prescribed a combination of hydralazine and isosorbide dinitrate at discharge. Note this treatment is recommended in addition to ACEI or ARB or ARNi and beta blocker therapy at discharge. AHAHF11
- **ICD counseling or ICD placed or prescribed at discharge:** Percent of heart failure patients with left ventricular ejection fraction less than or equal to 35% with no contraindications, documented intolerance, or any other reason against who had ICD counseling provided, who have ICD prior to hospitalization, had an ICD placed, or were prescribed an ICD at discharge. AHAHF12

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- **Influenza vaccination during flu season:** Percent of patients that received an influenza vaccination prior to discharge during flu season. AHAHF13
- **Lab monitoring follow up:** Percentage of patients age ≥18 years with a diagnosis of heart failure who were newly prescribed an aldosterone antagonist (MRA) at discharge or who had an aldosterone antagonist upon admission with a dose increase during discharge, who had potassium and renal function planned or ordered within one week post-discharge. AHAHF91
- **Pneumococcal Vaccination:** Percent of patients that received a pneumococcal vaccination prior to discharge. AHAHF14
- **Defect-free care for quadruple therapy medication for patients with HFrEF:** Percentage of patients who received "perfect care" based upon their eligibility for each of the four component medication measures. AHAHF106

Heart Failure Reporting Measures:

- **Referral to HF disease management, 60 minutes patient education, discharge packet for patients diagnosed with HF, or referral to outpatient cardiac rehabilitation program:** Percent of heart failure patients who were referred to heart failure disease management, received 60 minutes of patient education by a qualified educator, received an AHA heart failure interactive workbook, or were referred to an outpatient cardiac rehabilitation program. AHAHF15
- **60 Minutes of heart failure education:** Percent of heart failure patients who received 60 minutes of heart failure education by a qualified heart failure educator. AHAHF16
- **Activity level instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing activity level. AHAHF17
- **Advance directive executed:** Percent of patients who have documentation in the medical record that an advance directive was executed. AHAHF18
- **Advanced care plan:** Percent of heart failure patients who have an advanced care plan or surrogate decision-maker document in the medical record. AHAHF19
- **Angiotensin receptor neprilysin inhibitor (ARNi) at discharge for patients with HFpEF/HFmrEF:** Percentage of eligible patients with heart failure with preserved ejection fraction or mildly reduced ejection fraction who are prescribed an ARNI at hospital discharge. AHAHF101
- **ARBs at discharge for patients with HFpEF/HFmrEF:** Percent of heart failure patients with heart failure with preserved ejection fraction or mildly reduced ejection fraction who are prescribed an ARB at hospital discharge. AHAHF102
- **Beta blocker at discharge:** Percent of patients on beta blockers at discharge. AHAHF21
- **Blood pressure control at discharge (130/80 mmHg):** Percentage of heart failure patients with a last recorded systolic pressure < 130 mmHg and diastolic pressure < 80 mmHg blood pressure. AHAHF22
- **Blood pressure control at discharge (140/90 mmHg):** Percent of heart failure patients with a last recorded systolic pressure < 140 mmHg and diastolic pressure < 90 mmHg blood pressure. AHAHF23
- **Care transition record transmitted:** A care transition record is transmitted to a next level of care provider within seven days of discharge containing ALL of the following: reason for hospitalization, procedures performed during this hospitalization, treatment(s)/service(s) provided during this hospitalization, discharge medications, including dosage and indication for use, and follow-up treatment and services needed (e.g., post-discharge therapy, oxygen therapy, durable medical equipment). AHAHF24
- **Diabetes teaching:** Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes teaching at discharge. AHAHF25
- **Diabetes treatment:** Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes treatment in the form of gylcemic control (diet and/or anti-hyperglycemic medication) and/or follow-up appointment for diabetes management scheduled at discharge. AHAHF26
- **Diet instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing diet. AHAHF27
- **Follow-up instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing follow-up appointment. AHAHF29
- **Follow-up visit or contact within 48 Hours of discharge scheduled:** Percent of heart failure patients who had a follow-up visit or phone call scheduled to take place within 48 hours or less of hospital discharge. AHAHF30
- **Follow-up visit or contact within 72 hours of discharge scheduled:** Percent of heart failure patients who had a follow-up visit or phone call scheduled to take place within 72 hours or less of hospital discharge. AHAHF31
- **Heart failure disease management program referral:** Percent of heart failure patients referred to disease management program. AHAHF32
- **ICD placed or prescribed at discharge:** Heart failure patients with left ventricular ejection fraction less than or equal to 35% with no contraindications, documented intolerance, or any other reason against who have ICD, had ICD placed, or were prescribed ICD at discharge. AHAHF33
- **Ivabradine at discharge:** Percent of eligible heart failure patients who are prescribed ivabradine at hospital discharge. AHAHF34
- **Lipid-lowering medications at discharge:** Percent of HF patients with either CAD, PVD, CVA, or diabetes who were prescribed lipid-lowering medications at discharge. AHAHF35
- **Medication instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing discharge medications. AHAHF36

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- **Mineralocorticoid receptor antagonist at discharge for patients with HFmrEF/HFpEF:** Percentage of heart failure patients with preserved left ventricular ejection fraction (≥45%) or a qualitative assessment of normal/mild dysfunction with no contraindications who were prescribed aldosterone antagonist at discharge. AHAHF20
- **Omega-3 fatty acid supplement use at discharge:** Heart failure patients without contraindication who are prescribed omega-3 fatty acid supplement at hospital discharge. AHAHF37
- **Outpatient cardiac rehab program referral:** Percent of heart failure patients referred to outpatient cardiac rehab program. AHAHF38
- **QRS duration documented:** Patients with a principle diagnosis of heart failure. AHAHF39
- **Referral to discharge packet for patients diagnosed with HF:** Percent of heart failure patients who received an AHA heart failure interactive workbook. AHAHF40
- **Smoking cessation:** Heart failure patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival. AHAHF41
- **Symptoms worsening instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing what to do if symptoms worsen. AHAHF42
- **Weight instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing weight monitoring. AHAHF43
- **Heath-related social needs assessment:** Percentage of patients with a diagnosis of heart failure discharged from your facility who had documentation of a standardized health-related social needs form or assessment completed during admission. Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes teaching at discharge. AHAHF85
- **SGLT-2 inhibitor at discharge for patients with HFpEF/ HFmrEF:** Percent of patients with heart failure (HF) and preserved ejection fraction or mildly reduced ejection fraction who are discharged on a SGLT-2 inhibitor. AHAHF94
- **SGLT-2 inhibitor at discharge for patients with HF (all patients):** Percent of patients with heart failure (HF) who are discharged on a SGLT-2 inhibitor. AHAHF95
- **Overall quadruple therapy medication for patients with HFrEF at discharge composite score:** Proportion of performance opportunities that were met among eligible opportunities for all four individual measures. AHAHF108

Heart Failure Descriptive Measures:

- **Age:** A histogram of patients grouped by age. AHAHF45
- **Beta blocker medication at discharge (all patients):** A histogram of all patients grouped by specific beta blocker medication prescribed at hospital discharge. AHAHF46
- **Beta blocker medication at discharge (eligible patients):** A histogram of eligible patients grouped by specific beta blocker medication prescribed at hospital discharge. AHAHF47
- **Diagnosis:** A histogram of patients grouped by diagnosis. AHAHF48
- **Discharge disposition:** A histogram of all patients grouped by discharge disposition. AHAHF49
- **Sex:** A histogram of patients grouped by sex. AHAHF50
- **In-hospital mortality:** A histogram of patients grouped by whether they expired in-hospital. AHAHF51
- **LOS:** A histogram of patient's length of stay, grouped by diagnosis. AHAHF52
- **Medical history:** A histogram of previously known medical history. AHAHF53
- **Race:** A histogram of patients grouped by race and Hispanic ethnicity. AHAHF54
- **Smoking cessation therapies prescribed:** A histogram of patients who received smoking cessation therapies grouped by smoking cessation therapies Prescribed. AHAHF55
- **Identified areas of unmet social needs:** Patients with heart failure who were assessed for health-related social needs grouped by unmet social needs identified. AHAHF86

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Completion Rates and Missing Elements:

- **HF achievement award qualified:** Percent of patients who have the minimum necessary data elements complete to be included in GWTG Achievement Measures for award calculation. AHAHF56
- **HF quality award qualified:** Percent of patients who have the minimum necessary data elements complete to be included in GWTG Quality Measures for award calculation. AHAHF57
- **Record completion rate:** Percent of patient records that are saved as complete. AHAHF58
- **Missing HF achievement award qualified:** Histogram of missing data for key elements needed for appropriate inclusion in GWTG Achievement Measures. AHAHF59
- **Missing HF quality award qualified:** Histogram of missing data for key elements needed for appropriate inclusion in GWTG Quality Measures. AHAHF60

Composites and Defect Free:

- **Overall diabetes cardiovascular initiative composite score:** Proportion of performance opportunities that were met among eligible opportunities for all four individual achievement measures.
- **HF defect-free:** Percentage of patients who received "perfect care" baed upon their eligibility for each of the four component heart failure measures.

Heart Failure Discharge Instruction Group Measures:

- **Activity level instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing activity level. AHAHF17
- **Diet instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing diet. AHAHF27
- **Follow-up instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing follow-up appointment. AHAHF29
- **Medication instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing discharge medications. AHAHF36
- **Symptoms worsening instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing what to do if symptoms worsen. AHAHF42
- **Weight instruction:** Heart failure patients discharged home with a copy of written instructions or educational materials given to patient or caregiver at discharge or during the hospital stay, addressing weight monitoring. AHAHF43

Risk-Adjusted Mortality Measure:

- **Risk-adjusted mortality ratio:** A ratio comparing the actual in-hospital mortality rate to the risk-adjusted expected mortality rate. A ratio equal to 1 is interpreted as no difference between the hospital's mortality rate and the expected rate. A ratio greater than 1 indicates that the hospital's mortality rate is higher than the expected rate. A ratio of less than 1 indicates that the hospital's mortality rate is lower than the expected rate. AHAHF44

Target: Heart Failure℠:

Target: Heart Failure draws from the American Heart Association's vast collection of content-rich resources for patients and healthcare professionals, including educational tools, prevention programs, treatment guidelines, quality initiatives and outcome-based programs.

- **ACEI/ARB or ARNI at discharge:** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) or angiotensin-receptor/neprilysin inhibitor (ARNI) contraindications who are prescribed an ACEI, ARB, or ARNI at hospital discharge. AHAHF1
- **Evidence-based specific beta blockers:** Percent of HF patients who were prescribed evidence-based specific beta blockers (bisoprolol, carvedilol, metoprolol succinate CR/XL) at discharge. AHAHF2
- **Follow-up visit within seven days or less:** Percent of eligible patients with a follow-up visit scheduled within 7 days or less from time of hospital discharge. AHAHF10
- **Referral to HF disease management, 60 minutes patient education, discharge packet for patients diagnosed with HF, or referral to outpatient cardiac rehabilitation program:** Percent of heart failure patients who were referred to heart failure disease management, received 60 minutes of patient education by a qualified educator, received an AHA heart failure interactive workbook, or were referred to an outpatient cardiac rehabilitation program. AHAHF15

- **Mineralocorticoid receptor antagonist at discharge for patients with HFrEF (LVEF ≤40):** Percent of heart failure patients with left ventricular ejection fraction ≤ 40% or a qualitative assessment of moderate/severe dysfunction with no contraindications or documented intolerance who were prescribed mineralocorticoid receptor antagonists (MRA) or Aldosterone Antagonist at discharge. AHAHF110
- **Defect-free care for quadruple therapy medication for patients with HFrEF:** Percentage of patients who received "perfect care" based upon their eligibility for each of the four component medication measures. AHAHF106 (Target: HF Optimal ONLY)

Target Type 2 Diabetes:

- **Diabetes treatment:** Percent of diabetic patients or newly-diagnosed diabetics receiving diabetes treatment in the form of gylcemic control (diet and/or anti-hyperglycemic medication) and/or follow-up appointment for diabetes management scheduled at discharge. AHAHF26
- **ACEI/ARBs or ARNI at discharge for patients with diabetes:** Percent of heart failure patients with diabetes and left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) or angiotensin-receptor/neprilysin inhibitor (ARNI) contraindications who are prescribed an ACEI, ARB, or ARNI at hospital discharge. AHAHF77
- **Evidence-based specific beta blockers for patients with diabetes:** Percent of heart failure patients with diabetes who were prescribed an evidence-based specific beta blocker (bisoprolol, carvedilol, metoprolol succinate CR/XL) at discharge. AHAHF78
- **Measure LV function (patients with diabetes):** Percent of patients with heart failure and diabetes who have documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge. AHAHF79
- **Post discharge appointment for heart failure patients with diabetes:** Percent of eligible patients with heart failure and diabetes for whom a follow-up appointment was scheduled and documented including location, date, and time for follow-up visits, or location and date for home-health visits. AHAHF80
- **Lipid-lowering medications at discharge for patients with diabetes:** Percent of heart failure patients with diabetes who were prescribed lipid-lowering medications at discharge.. AHAHF81
- **Smoking cessation for patients with diabetes:** Percent of heart failure patients with diabetes and a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival. AHAHF82
- **Anti-hyperglycemic with proven CVD benefit at discharge:** Percent of patients with heart failure (HF) and diabetes who are discharged on an anti-hyperglycemic medication with proven cardiovascular disease (CVD) benefit at discharge (SGLT-2 inhibitor). AHAHF84
- **Overall diabetes cardiovascular initiative composite score:** Proportion of performance opportunities that were met among eligible opportunities for all eight individual achievement measures.

30-Day Follow Up:

- **30-DAY ACEI/ARB/ARNI :** Percent of heart failure patients with left ventricular systolic dysfunction (LVSD)* and without both angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB), or ACEI and angiotensin receptor neprilysin inhibitor (ARNI) contraindications who are on an ACEI, ARB, or ARNI 30 days post discharge. AHAHF61
- **30-Day evidence-based specific beeta-blocker for LVSD :** Percent of heart failure patients on an evidence-based specific beta-blocker (Bisoprolol, Carvedilol, Metoprolol Succinate CF/XL) 30 days post discharge. AHAHF63
- **30-Day referral to cardiac rehabilitation or disease management:** Percent of Heart Failure patients who are referred to an outpatient cardiac rehabilitation or disease management program within 30 days of discharge. AHAHF64
- **30-Day participation in cardiac rehabilitation or disease management program:** Percent of Heart Failure patients who participated in an outpatient cardiac rehabilitation or disease management program within 30 days of discharge. AHAHF65
- **30-Day re-hospitalization:** Percent of heart failure patients (unadjusted) with one or more re-hospitalization in the first 30 days post discharge. AHAHF66
- **30-Day follow up no completed:** Patients without a completed 30-day follow up form, grouped by days since discharge. AHAHF67
- **30-Day defect-free care for quadruple therapy medication for patients with HFREF:** Percentage of patients who received "perfect care" based upon their eligibility for each of the 4 component 30 day medication measures. AHAHF107
- **30-Day mineralocorticoid receptor antagonist for patients with HFREF (LVEF ≤ 40) :** Percent of heart failure patients with left ventricular ejection fraction <=40% or a qualitative assessment of moderate/severe dysfunction with no contraindications or documented intolerance who were prescribed Mineralocorticoid Receptor Antagonists (MRA) or Aldosterone Antagonists 30 days post discharge. AHAHF111

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Advanced Certification in Heart Failure:

- **Care transition record transmitted:** Care transition record transmitted to a next level of care provider within 7 days of discharge containing ALL of the following: Reason for hospitalization, Procedure performed during this hospitalization, Treatment(s)/Service(s) provided during this hospitalization, Discharge medications, including dosage and indication for use, Follow-up treatment(s) and service(s) needed. ACHF-03
- **Discussion of advance directives/advance care planning:** Patients who have documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider. ACHF-04
- **Advance directive executed:** Patients who have documentation in the medical record that an advance directive was executed. ACHF-05
- **Post-discharge evaluation for heart failure patients:** Patients who have a documented re-evaluation conducted via phone call or home visit within 72 hours after discharge. ACHF-06
- **Beta blocker therapy (i.e., bisoprolol, carvedilol, or sustained-release metoprolol succinate) Prescribed for LVSD at discharge:** Beta blocker therapy (i.e., bisoprolol, carvedilol, or sustained-release metoprolol succinate) is prescribed for heart failure patients with LVSD at discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) ≤40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction. ACHF-01
- **Post-discharge appointment for heart failure patients:** Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within seven days post-discharge and documented including location, date, and time. ACHF-02

Comprehensive Cardiac Certification:

- **Aldosterone antagonist prescribed at discharge:** Patients with a diagnosis of heart failure with a left ventricular ejection fraction (LVSD) ≤35% who were prescribed an aldosterone antagonist at discharge. CCPIP-02

Rural Recognition Measures:

- **HF Composite Score:** Proportion of performance opportunities that were met among eligible opportunities for the 6 individual component measures. AHAHF113
- **Evidence-Based Specific Beta Blockers:** Percent of HF patients who were prescribed evidence-based specific beta blockers (bisoprolol, carvedilol, metoprolol succinate CR/XL) at discharge. AHAHF2
- **Left Ventricular Function Assessed:** HF patients with documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge. AHAHF3
- **Post Discharge Appointment for Heart Failure Patients:** Percent of eligible heart failure patients for whom a follow-up appointment was scheduled and documented including location, date, and time for follow-up visits or home health visits. AHAHF4
- **Angiotensin Receptor Neprilysin inhibitor (ARNi) at Discharge:** Percentage of eligible patients with heart failure who are prescribed an ARNi at hospital discharge. AHAHF6
- **SGLT-2 inhibitor at Discharge for Patients with HFrEF:** Percent of patients with heart failure (HF) and reduced ejection fraction who are discharged on a SGLT-2 inhibitor. AHAHF93
- **MRA at Discharge for Patients with HFrEF:** Percent of heart failure patients with left ventricular ejection fraction ≤40% or a qualitative assessment of moderate/severe dysfunction with no contraindications or documented intolerance who were prescribed mineralocorticoid receptor antagonists (MRA) or aldosterone antagonist at discharge. AHAHF110

How Quality Achievement Awards Are Determined:

Quality achievement measures provide the basis for evaluating and improving treatment of HF patients. Formulating those measures begins with a detailed review of HF guidelines. When evidence for a process or aspect of care is so strong that failure to act on it reduces the likelihood of an optimal patient outcome, an achievement measure may be developed regarding that process or aspect of care. Achievement measure data are continually collected, and results are monitored over time to determine when new initiatives or revised processes should be incorporated. As such, achievement measures help speed the translation of strong clinical evidence into practice. For participating hospitals to earn recognition for their achievement in the program, they must adhere to achievement measures. Quality measures apply to processes and aspects of care that are strongly supported by science. Application of quality measures may not, however, be as universally-indicated as achievement measures. The Get With The Guidelines team follows a strict set of criteria in creating achievement and quality