



## *Get with the Guidelines-Heart Failure*

Application for Funding from the Michigan Department of Community Health

Hospital Name: \_\_\_\_\_

Hospital Contact Person: \_\_\_\_\_

Finance Department Contact Person: \_\_\_\_\_

Contact Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Are you a teaching hospital?  yes  no Hospital bed size: \_\_\_\_\_

Hospital Physician Champion: \_\_\_\_\_

Physician Champion e-mail address: \_\_\_\_\_

Person who will be responsible for data abstraction: \_\_\_\_\_

Contact Information for team members (i.e. Physician Champion, Project Coordinator, data abstractor, discharge planner, other staff)

Name	Title/Department	E-mail address/phone

Please answer the following information:

1. Does your hospital have written protocols for CHF?     Yes     No     Unknown
2. Does your hospital have written order sets for CHF?     Yes     No     Unknown
3. Are heart failure discharge instructions provided for all eligible patients?  
     Yes     No     Unknown
4. Check what your discharge instructions consistently include:
  - Discharge Medications
  - Activity level and dietary restrictions,
  - Signs and symptoms of worsening heart failure?
  - Instructions are not consistently done
5. Is LV function measured in all admitted HF patients?     Yes     No     Unknown
6. Does the hospital have the capability of measuring left ventricular ejection fraction by AHA, ACC standards?     Yes     No     Unknown
7. Check all that are prescribed at discharge for all eligible patients (with no contraindications):
  - Ace inhibitor and/or ARB
  - Beta blockers
9. Is smoking cessation counseling provided to all eligible patients (current or recent smokers)?  
     Yes     No     Unknown
10. Is the smoking cessation counseling documented in the chart and on the discharge instruction sheet?     Yes     No     Unknown
11. Does your hospital have the commitment and support of the medical staff, nursing staff, medical records, pharmacy, diagnostic testing, all involved departments and personnel for this project?  
 Yes     No     Unknown
12. Does your hospital have the capability to track readmissions of GWTG congestive heart failure patients over a 12 month period?     Yes     No     Unknown
13. Will you be able to enter data for 30 CHF patients within 90 days of the project starting?  
     Yes     No     Unknown  
    If no, how long do you estimate this would take? \_\_\_\_\_
14. Please give the number of CHF patient admissions in your hospitals in 2007. \_\_\_\_\_

If your institution were selected for this project, what do you hope to accomplish with this GWTG-CHF quality improvement program?

\_\_\_\_\_

\_\_\_\_\_  
Authorized Hospital Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Champion

\_\_\_\_\_  
Date

\_\_\_\_\_  
GWTG Hospital Coordinator

\_\_\_\_\_  
Date

**Please submit this application or express interest in applying no later than February 15, 2008.**

**Send electronically or fax to:  
Michigan Department of Community Health  
Cardiovascular Health, Nutrition and Physical Activity Section  
Attn: Jill Scott Gregus  
scottj1@michigan.gov  
Fax: (517) 335-9056  
Phone: (517) 335-9596**

Partners in this effort include:

