Measure Comment Report for Cardiovascular Endorsement Maintenance 2010

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Ms. Carol O'Brien, Esq
Organization: Abbott Laboratories

Date - Time: Aug 19, 2011 - 05:59 PM

Comments
1050: Consider expansion of measure to align with complete lipid profile measure (NQF 75) now widely used for Medicare PQRS IVD measures and measures groups and with NCQA Heart Stroke Recognition measures.

Measure should recognize lipid **modifying** treatment and control vs. only lipid lowering therapies to align with NIH NCEP ATP III Treatment Guidelines that recognize the need to treat multiple lipid conditions beyond LDL-C control. NCEP Guidelines recommending treating high risk patients with low HDL-C and/or high triglycerides with combination therapies such as a fibdrate or nicotinic acid and also recognize treating non-HDL-C as a secondary target when triglycerides are >200 mg/dL.

Comments on the general draft report
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:40 PM

Comments
1049: With respect to measure 0964, we believe that this is a useful composite. However, we strongly encourage pairing prescription written with prescription filled to strengthen the value of the measure. We encourage the Steering Committee to work with the developer to expand the measure to include prescription filled.

We also support measure 0965 as an all-or-none composite measure. However, we urge the Steering Committee to work with the developer to strengthen the value of this measure by pairing prescription filled with follow through on treatment recommendations.

Comments on the general draft report
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:37 PM

Comments
1048: The value of both individual and composite measures has been demonstrated by CMS pilot studies, however, the current measure set however may require harmonization as a number of questions have been raised by the Steering Committee regarding measure harmonization and “best-in-class” measures. NQF should clarify if draft guidance on “best-in-class” has been used to assist this Committee as several measures in this project appear to be competing. For example, many of the CAD measures that include blood pressure monitoring, specify different age ranges for patients, and may cause confusion to physicians. Similarly, there appears to be considerable overlap between measures 0068 & 0074, which have a large percentage of members being eligible for both. This issue can pose potential problems in data collection and interpretation of results.

Comments on the general draft report
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:32 PM

Comments

1047: Among the measures that the Steering Committee has rejected, we encourage them to reconsider inclusion of 0282, Angina Without Procedure. This is of value to consumers and purchasers as it assesses overuse of invasive procedures such as PCIs.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:27 PM

Comments
1046: **General Comments**

- We appreciate that these competing measures contain differences with respect to data collection methods, applicable settings, and exclusion criteria; however, it's important that the Steering Committee continue to work with developers of measures #0068, #0067, #0075 to determine the feasibility of harmonizing specifications of these measures where appropriate.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:23 PM

Comments
1045: We encourage the Steering Committee to bypass this low-bar, low-impact measure that merely asks whether stroke risk has been assessed and doesn't consider appriate care and desired results. This is an excellent place to reduce the burden of collection and reporting.

1528: Beta Blocker at Discharge for ICD implant patients with a previous MI
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:21 PM

Comments
1044:

- #1528 Beta blocker at discharge for ICD implant patients with a previous MI (ACCF)
- #1529 Beta blocker at discharge for ICD implant patients with LVSD (ACCF)
- #0965 Patients with an ICD implant who receive prescriptions for all medications (ACE/ARB and beta blockers) for which they are eligible for at discharge (ACCF)
- Populations that are eligible for these measures should be captured under either AMI or Heart Failure measures. The need for such a niche measure is unclear.

1525: Chronic Anticoagulation Therapy
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:20 PM

Comments
1043: #1524: Assessment of thromboembolic risk (CHADS2) (ACCF/AHA/PCPI)

#1525: Chronic anticoagulation therapy (ACCF/AHA/PCPI)

- While CHADS2 criteria are included in the measure specifications for both measures, there are other clinical tools that may be used.
- Obtaining data to calculate these measures could be challenging for certain end users.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:20 PM

Comments
1042: #1524: Assessment of thromboembolic risk (CHADS2) (ACCF/AHA/PCPI)

#1525: Chronic anticoagulation therapy (ACCF/AHA/PCPI)

- While CHADS2 criteria are included in the measure specifications for both measures, there are other clinical tools that may be used.
- Obtaining data to calculate these measures could be challenging for certain end users.

0355: Bilateral Cardiac Catheterization Rate (IQI 25)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:19 PM

Comments
1041: We strongly support continued endorsement of this measure, but encourage the Steering Committee to reclassify it as a measure of appropriateness (overuse) rather than as an outcome measure.

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:18 PM

Comments
1040:

- This measure has a very narrow patient population focus, and it would be helpful for the developer to clarify the importance of having so many exclusions for this denominator.
- Have the measure developers considered including all LVSD patients with documented abnormalities that subsequently received ACE/ARB therapy at discharge?
- We support the Steering Committee's suggested modifications for this measure.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:17 PM

Comments
1039: We generally support this measure, which addresses crucial concerns about outcomes of care. However, we hope the Steering Committee will encourage CMS to reconsider the adjustment methodology. It is our understanding that use of hierarchical logistic regression overadjusts for risk, minimizing variation and shrinking differences among providers. Consumers and purchasers need to be able to discriminate among providers and providers themselves need to be able to

understand where they fall, performance-wise. We anticipate that more traditional logistic regression methods will enable better discrimination.

0355: Bilateral Cardiac Catheterization Rate (IQI 25)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:17 PM

Comments
1038:

- We seek clarification on the purpose of this measure and if this measure represents a good indicator of quality.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:16 PM

Comments
1037: We generally support this measure, which addresses crucial concerns about outcomes of care. However, we hope the Steering Committee will encourage CMS to reconsider the adjustment methodology. It is our understanding that use of hierarchical logistic regression overadjusts for risk, minimizing variation and shrinking differences among providers. Consumers and purchasers need to be able to discriminate among providers and providers themselves need to be able to understand where they fall, performance-wise. We anticipate that more traditional logistic regression methods will enable better discrimination.

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:16 PM

Comments
1036: We generally support this measure, which addresses crucial concerns about outcomes of care. However, we hope the Steering Committee will encourage CMS to reconsider the adjustment methodology. It is our understanding that use of hierarchical logistic regression overadjusts for risk, minimizing variation and shrinking differences among providers. Consumers and purchasers need to be able to discriminate among providers and providers themselves need to be able to understand where they fall, performance-wise. We anticipate that more traditional logistic regression methods will enable better discrimination.

0163: Primary PCI received within 90 minutes of Hospital Arrival
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:09 PM

Comments
1035:

- Although the developer notes that there is no increasing trend in the use of the exclusion reason, “system reason for delay,” which occurs in only 0.9% of cases, it raises the question as to the need for such an exclusion, as system delays would indicate an issue with quality.

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By

Name: Ms. Carol O'Brien, Esq
Organization: Abbott Laboratories
Date - Time: Aug 19, 2011 - 05:08 PM

Comments
1034: Abbott supports Maintenance Endorsement for IVD Lipid Control Measure 75. This measure is well established as PQRS measures 202-203 (Complete Lipid Profile- LDL-C Control) and will be included in the 2012 PQRS as individual measures, core measures and in measures groups for IVD, CVD Prevention and Elevated Blood Pressure.

This NCQA measure is also widely used to achieve NCQA Heart Stroke Recognition. Maintenance supports NQF criteria for reliability, validity, usability and high impact.

Treating all lipids, including LDL-C, supports NCEP ATP III Guidelines stating the need to treat lipid levels including non-HDL-C as a secondary target when triglycerides are 200 mg/dL.

The April 2008 ADA/ACC Consensus Statement on Lipoprotein Management in Patients with Cardiometabolic Risk states: "Even with adequate LDL cholesterol lowering, many patients on statin therapy have significant CVD residual risk. Many studies have demonstrated non-HDL cholesterol is a better predictor of CVD risk than is LDL cholesterol, and this may be especially true of statin-treated patients." (Brunzell, John D., et al. Lipoprotein Management in Patients with Cardiometabolic Risk/Consensus Statement from the American Diabetes Association and the American College of Cardiology Foundation; Diabetes Care, Volume 31, Number 4, April 2008: 811, 814.)

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:08 PM

Comments
1033:

- It would be helpful if the developer could cite the source of its definition for “moderate” and “severe” systolic dysfunction, and to the extent feasible, NQF should work with the Steering Committee and relevant measure developers to ensure that this definition is consistent across measures that include references to “moderate” and “severe” systolic dysfunction, to ensure objectivity of these definitions.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:05 PM

Comments
1032:

- Given the Steering Committee’s observation that there are currently a large number of excluded patients due to lack of assessment of LVSF, we think this issue could be addressed if the measure were modified to include: documentation of an LVSF assessment, documentation of the LVSF less than 40% or a narrative description of LVS function consistent with moderate or severe systolic dysfunction, followed by evidence of the appropriate course of dispensed therapy (e.g., ACEI or ARB), if an abnormal LVSF assessment is found.

0160: Beta-blocker prescribed at discharge for AMI
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:04 PM

Comments
1031: We encourage the Steering to Committee to bypas this measure because practice is topping out.

0135: Evaluation of Left ventricular systolic function (LVS)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:04 PM

Comments
1030:

- Data abstraction for this measure could be a challenge. Additionally, it could be difficult to determine in documentation whether left ventricular systolic (LVS) function was evaluated for all of the time periods specified by the measure. Documenting that an LVF assessment was planned at discharge is not a strong measure of a quality.
- Given that hospitals consistently achieve high-levels of performance with this measure, it would be important that the Steering Committee continue closely monitoring this measure to ensure that this measure does not result in any unintended consequences such as encouraging overuse of certain services or testing.

0133: PCI mortality (risk-adjusted)©
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:03 PM

Comments
1029:

- We have concerns over the inclusion of measures that include a post PCI mortality component. States which have a history of data collection on this issue have had to deal with the issue of "cherry-picking" of PCI candidates to generate better survival statistics. The measure as described, although risk adjusted, would not adequately distinguish between the urgent, rescue procedure and the elective planned procedure.

- Additionally, changes in the CathPCI data set are being planned, and it may be advisable to hold off on this measure until the changes are available for review.

0142: Aspirin prescribed at discharge for AMI
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:02 PM

Comments
1028: We encourage the Steering to Committee to bypas this measure because practice is topping out.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:02 PM

Comments
1027:

- The numerator/denominator statements for this measure reference ACE/ARB rather than Beta Blocker, and should be corrected.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:01 PM

Comments
1026:

- Obtaining data to calculate these measures could be challenging for certain end users.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 05:01 PM

Comments
1025: We encourage the Steering Committee to bypass this low-bar, low-impact measure as CMS is ending data collection with the understanding that practice has topped out.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:00 PM

Comments
1024:

- Although this measure is intended for an outpatient setting, in the numerator it states that "documentation must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed," which may involve documentation of an LVEF from an in-patient hospital setting. In-patient hospital data may not be readily available.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 05:00 PM

Comments
1023: The existence of racial disparities in health and health care is well established. Similar racial disparities in the health and health care of Medicare beneficiaries, in particular, have also been documented. These disparities extend to readmission to hospitals. Just this year, the *Journal of the American Medical Association* (JAMA) published an article showing that blacks have a higher likelihood of being readmitted to the hospital than do whites. In addition, the JAMA article concluded that hospitals serving a disproportionately large number of minorities have higher readmission rates. Proper accounting for these racial disparities is crucial.

At a minimum, this measure must be stratified to account for disparities in order for it to pass the test of scientific acceptability and remain endorsed under this maintenance review.

0076: Optimal Vascular Care
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 05:00 PM

Comments
1022:

- This measure requires a combination of claims and chart-based data, and not all end-users will have access to both data sources, particularly in those communities with limited electronic data infrastructure capabilities.
- We would request that the Steering Committee clarify what evidence supports the use of assessment of blood pressure at the end of the year versus blood pressure monitoring that might take place throughout the course of the year in the calculation of this measure. Documenting blood pressure two or three times per year may be more accurate in assessing improvements in a patient's blood pressure.
- It would be helpful if the Steering Committee could clarify the NQF's policy regarding the evaluation of composite measures, and specifically the evaluation process for each individual measure within the composite. It is important that individual measures encompassing the composite measure, be evaluated as standalone measures, using NQF's measure selection criteria--to ensure measure validity and reliability. Having individual measures endorsed within the composite allows users to choose a subset of these five measures to include in a composite as the users may not have access to the needed data for all measures.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older

Comment By	**On Behalf Of**
Name: Ms. Lisa M. Grabert, MPH	Name: Nancy Foster
Organization: American Hospital Association	Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:59 PM

Comments
1021: Disparities. **We urge the steering committee to have additional dialogue with the measure developer on stratification to properly account for the disparities underlying the HF readmission measure.** We recommend the steering committee re-examine this measure for scientific acceptability. We are concerned that the criteria included in section *2h: disparities* of the consensus development process has not been properly met. The NQF criteria in the maintenance report states:

If disparities in care have been identified, measure specifications, scoring and analysis allow for identification of disparities through stratification of results (e.g. by race, ethnicity, socioeconomic status, gender); or rationale/data justifies why stratification is not necessary or not feasible.

However, the measure developer states:

Disparities in race and socio-economic status have been reported at the patient level [for the heart failure readmission measure].

0135: Evaluation of Left ventricular systolic function (LVS)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:59 PM

Comments
1020: We encourage the Steering Committee to bypass this low-bar, low-impact measure, which merely captures evaluation of a function and does not include delivery of good care or obtaining a good result. This is a good place to reduce the burden of collection and reporting.

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:59 PM

Comments
1019: **#0075 IVD: Complete lipid profile and LDL control <100 (NCQA)**

 # 0074 Chronic stable coronary artery disease: Lipid control (PCPI)

- The NCQA measure includes a complete lipid profile while the PCPI measure does not require such a profile. It is unclear if it is better to require a complete lipid profile in the measure specification as both measures are seeking to measure LDL-control.
- We note that the patient population for this denominator is slightly different than the other blood pressure measures, and ask the Steering Committee to provide rationale as to the value of endorsing measures that are not applicable to broad patient populations.

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:58 PM

Comments
1018: **#0075 IVD: Complete lipid profile and LDL control <100 (NCQA)**

 # 0074 Chronic stable coronary artery disease: Lipid control (PCPI)

- The NCQA measure includes a complete lipid profile while the PCPI measure does not require such a profile. It is unclear if it is better to require a complete lipid profile in the measure specification as both measures are seeking to measure LDL-control.
- We note that the patient population for this denominator is slightly different than the other blood pressure measures, and ask the Steering Committee to provide rationale as to the value of endorsing measures that are not applicable to broad patient populations.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:58 PM

Comments
1017: Risk adjustment. **We urge the steering committee to have additional dialogue with the measure developer on the use of stratification to properly risk adjust the HF readmission measure.** We recommend the steering committee re-examine this measure for scientific acceptability. We are concerned that the criteria included in section *2e: risk adjustment/stratification* of the consensus development process has not properly been met. The NQF criteria in the maintenance report states:

It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.

However, the measure developer states:

The measure is not stratified.

The risk-adjustment methodology included in the HF readmission measure considers patients' diagnostic data (e.g., the severity of underlying medical conditions and co-morbidities) and demographic characteristics (e.g., age and gender). But, it does not consider patients' race or life circumstances, which can have just as great an impact on health outcomes. The risk-adjustment methodology must include recognition, which may be done by stratification, of such patient characteristics as race and limited English proficiency.

At a minimum, this measure must be stratified in order for it to pass the test of scientific acceptability and remain endorsed under this maintenance review.

0073: IVD: Blood Pressure Management

Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:57 PM

Comments
1016:

- We understand that NCQA's Committee on Performance Measurement intends to discuss home BP monitoring at an upcoming meeting, as there are concerns that the current measure specifications are not consistent with soon-to-be released guidelines from NIH's Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure that are expected in 2012. We support the alignment of this measure with the JNC's recommendations and hope that the measure developers can accomplish these changes in a timely manner.
- We concur with the Steering Committee's recommendation that this measure be harmonized with #0076 and include this measure's upper age limit of 75 years, and more broadly would like to encourage the Steering Committee to consider asking developers with similar measures to include in measure specifications, an upper age limit of 75 years to promote consistency across measures.
- Measure specifications pertaining to BP <140/90 need to be harmonized with diabetes measure that specify both BP control < 140/90 and BP <140/80. The existence of two different standards for BP control may be confusing to providers.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older

Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:56 PM

Comments
1015: **Appendix A:** List of Risk Adjustment Variables(for consideration as exclusions)

- Metastatic cancer or acute leukemia
- Cancer
- Diabetes of diabetic complications
- Protein-calorie malnutrition
- Disorders of fluid, electrolyte, acid-base
- Liver or biliary disease
- Peptic ulcer, hemorrhage, other specified gastrointestinal disorders
- Other gastrointestinal disorders
- Severe hematological disorders
- Iron deficiency or other anemias and blood disease
- Dementia or other specified brain disorders
- Drug/alcohol abuse/dependence/psychosis
- Major psychiatric disorders
- Depression
- Other psychiatric disorders
- Hemiplegia, paraplegia, paralysis, functional disability
- Stroke
- Chronic obstructive pulmonary disease
- Fibrosis of lung or other chronic lung disorders
- Asthma
- Pneumonia
- End stage renal disease or dialysis
- Renal failure
- Nephritis
- Other urinary tract disorders
- Decubitus ulcer or chronic skin ulcer

Comments on measures not recommended
Comment By
Name: Dr. Frederick A. Masoudi, MD, FACC
Organization: ACC/AHA Task Force on Performance Measures

Date - Time: Aug 19, 2011 - 04:56 PM

Comments
1014: The steering committee appropriately emphasized the need for more patient-centered outcomes measures in the report. However, two patient-level measures that were designed to meet this specific goal, namely 0065 and 0067 were not recommended for endorsement. Given the paucity of existing measures in this area, we would strongly encourage the group to reconsider their decision regarding these two measures.

0132: Aspirin at arrival for acute myocardial infarction (AMI)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:56 PM

Comments
1013: We encourage the Steering Committee to bypass this measure as CMS is ending data collection with the understanding that practice has topped out. This is a good place to reduce the burden of collection and reporting.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:55 PM

Comments
1012: The measure developer has included a list of risk-adjustment variables (Appendix A) that are applied to claims data. However, these variables are not being applied to ensure that cases that are not truly "re" admissions are left out of the measure's rate. Rather than use these variables in the risk-adjustment methodology, these variables should be considered candidates for additional exclusions. We urge the steering committee to ask the developer to provide evidence that these variables are not distorting the measure results. The developer should provide the following:

- Count of the frequency of these variables;
- Sensitivity analysis with and without the exclusions; and
- Variability of exclusions across hospital types (*i.e.* teaching and non-teaching).

At a minimum this data must be made publicly available in order for this measure to pass the test of scientific acceptability and remain endorsed under this maintenance review.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:54 PM

Comments
1011: <u>Exclusions</u>. **We urge the steering committee to request an analysis from the measure developer on a list of risk adjustment variables (Appendix A) that should be considered as candidates for measure exclusions.** We recommend the steering committee re-examine this measure for scientific acceptability. We are concerned that the criteria included in section *2d: exclusions justified* of the consensus development process has not been properly met. Currently, this measure only includes exclusions in five limited categories:

1. In-hospital death;
2. Without at least 30 days post-discharge enrollment in fee-for-service Medicare;
3. Transferred to another acute care facility;
4. Discharged against medical advice;
5. Admitted with heart failure within 30 days of discharge from an index admission.

The Affordable Care Act calls for this readmission measure to recognize planned cases and unrelated admissions; it does not. Therefore, it may be erroneously counting certain admissions and readmissions. Because this readmission measure is currently publicly reported and will be used to change reimbursement for hospitals in the near future, this omission must be rectified immediately. We urge the steering committee to take this into consideration and we ask the steering committee to query the measure developer on why this change has not been made to the measure.

Comments on the general draft report
Comment By
Name: Dr. Frederick A. Masoudi, MD, FACC
Organization: ACC/AHA Task Force on Performance Measures

Date - Time: Aug 19, 2011 - 04:54 PM

Comments
1010: The issue of composite measures is important--composites have a great deal of appeal for several reasons. While composite measures—specifically those utilizing an all-or-none scoring approach—are attractive because they provide an aggregate picture of performance, the construction of these measures can obscure important information**.** The score for an all-or-none composite for providers with an intermediate score across all measures or excellent performance for a select few and below-average performance relative to his or her peers would not be apparent in an all-or-none composite. In other words, one gets the same credit for having achieved none of 6 measures in a composite as they would for achieving 5 of the 6 measures in a composite. A summary score without additional information is not actionable by clinicians seeking to improve their performance and, ultimately, patient outcomes. While it may be that all-or-none composites may be optimal for a given circumstance, we support an empiric approach to determining the best composite rather than a reliance on a single appraoch.

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:54 PM

Comments
1009:

- It will be difficult for health plans to collect data on anti-platelet therapies, as these data would require extraction from another data source , such as a hospital or pharmacy, that may not be readily available to health plans.

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:53 PM

Comments
1007: We encourage the Steering Committee to work with the developer to revisit the excessive patient, system, and medical exclusions in this measure so that they all meet the following criteria: evidence-based, highly specific, and explicitly defined.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:53 PM

Comments
1008: We encourage the Steering Committee to work with the developer to revisit the excessive patient, system, and medical exclusions in this measure so that they all meet the following criteria: evidence-based, highly specific, and explicitly defined.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:53 PM

Comments
1006: We encourage the Steering Committee to work with the developer to revisit the excessive patient, system, and medical exclusions in this measure so that they all meet the following criteria: evidence-based, highly specific, and explicitly defined.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:53 PM

Comments
1005:

- While the exclusion of patients with CKD is appropriate, ACE inhibitors are not contraindicated for patients with CAD and hypertension, and therefore we ask the developer to provide rationale for this exclusion.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Ms. Lisa M. Grabert, MPH
Organization: American Hospital Association

On Behalf Of
Name: Nancy Foster
Organization: American Hospital Association

Date - Time: Aug 19, 2011 - 04:52 PM

Comments
1004: On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the National Quality Forum's (NQF) Cardiovascular Maintenance Review project. Reviewing measures that have previously been endorsed is one of the fundamental tenants of measure development and we commend the NQF for continually holding all developers to this high standard. Recognizing the current state of science and medicine and how advances alter our fundamental delivery of care is something that measures must be responsive to. Our detailed comments on the measures under review are included below.

0018: Controlling High Blood Pressure
Comment By
Name: Ms. Carmella Bocchino, MBA, RN
Organization: America's Health Insurance Plans

Date - Time: Aug 19, 2011 - 04:51 PM

Comments
1003:

- Please clarify the rationale behind the age range specified for this measure (e.g., 18 – 85 years), given that a similar measures state, "18 years and older."
- We encourage the developer to modify this measure if any of the 2012 JNC-8 2012 guidelines impact this measure as currently specified.
- Standards for adequate blood pressure control continue to vary based on populations and outcome being assessed. This may be a difficult measure to validate. The number of questions raised regarding this measure suggests that although hypertension remains a serious and prevalent risk factor, measures to assess its management remain difficult to clarify.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:49 PM

Comments
1002: We encourage the Steering Committee to bypass this low-bar, low-impact measure. It is a waste of resources to collect and report on mere completion of an assessment.

0076: Optimal Vascular Care
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:47 PM

Comments
1001: In addition to endorsing this measure for use at the level of group/practice, we encourage the Steering Committee to recommend endorsement for the individual clinician level. The rationale is that consumers often choose individuals to be a member of their care team and there is broad acceptance through existing NCQA clinicial-level measures for such composite elements as blood pressure control, LDL control, and daily aspirin use.

We also encourage the Steering Committee to consider reclassifying this as a combined process and outcome measure.

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:40 PM

Comments
1000: We encourage the Steering Committee to bypass this measure. We are concerned about the broad exclusions and encourage the Committee to work with NCQA to broaden its measure 0075 to cover additional areas of interest.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:35 PM

Comments
999: We support this measure and encourage the Steering Committee to make a strong recommendation to the measure developer to rapidly develop an all-or-none composite for its IVD process measures.

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:33 PM

Comments
998: We encourage the Steering Committee not to endorse this measure and rather to work with NCQA to refine its measure 0068, which is widely used. We encourage a strong recommendation to NCQA to broaden the application of 0068 in a timely manner to other data collection methods, settings, and patients.

Comments on the general draft report
Comment By
Name: Ms. Debra L. Ness, MS
Organization: National Partnership for Women & Families

Date - Time: Aug 19, 2011 - 04:30 PM

Comments
997: The National Partnership for Women & Families echos all comments submitted by the Pacific Business Group on Health with regard to these measures.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:29 PM

Comments
996: We encourage the Steering Committee to work with the measure developer to broaden the denominator by reducing exclusions, notably the overly broad patient and system reasons.

Comments on the general draft report
Comment By
Name: Dr. Carol Sakala, MSPH, PhD
Organization: Childbirth Connection

Date - Time: Aug 19, 2011 - 04:23 PM

Comments
995: Our organization appreciates the opportunity to comment on the Cardiovascular Endorsement Maintenance report. We appreciate the direction taken by the Steering Committee in:

• greater harmonization

• bypassing measures with high performance and little variation

• supporting outcome and all-or-none composite measures

• calling for new measures to address care coordination, functional status, patient-reported symptom control

• encouraging reduction in the number of measures through expanded denominators, measure consolidation, and all-or-none composites

We encourage the Steering Committee to

• bypass low-impact measures that merely require clinicians to make an assessment

• bypass measures similar to others that are now in wide use and reach out to developers to improve those measures to address gaps (e.g., rather than endorsing 0067, encourage NCQA to broaden 0068)

• call for new measures to address shared decision making and overuse

• bypass measures with topped-out care and little opportunity for improvement

• encourage further expansion of denominators

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
Comment By
Name: Mr. Del M. Conyers
Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:56 PM

Comments
993: Appropriate therapeutic medication management is critical for newly implanted ICD patients to ensure optimal outcome. Extensive research has demonstrated the efficacy of ACE inhibitor or ARB use in preventing adverse outcomes for patients with left ventricular systolic dysfunction. Moreover, research data provided by the measure stewards indicates a significant opportunity for improvement among providers. This measure meets the criteria for endorsement by NQF. This measure is important to measure and report as there is a large population risk; there is an identified responsible entity and process to maintain and update the measure; the data elements can be feasibly collection; and the intended use of the measure is both public reporting and quality improvement.

1529: Beta Blocker at Discharge for ICD implant patients with LVSD
Comment By
Name: Mr. Del M. Conyers

Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:56 PM

Comments

994: Appropriate therapeutic medication management is critical for newly implanted ICD patients to ensure optimal outcome. Extensive research has demonstrated the efficacy of ACE inhibitor or ARB use in preventing adverse outcomes for patients with left ventricular systolic dysfunction. Moreover, research data provided by the measure stewards indicates a significant opportunity for improvement among providers. This measure meets the criteria for endorsement by NQF. This measure is important to measure and report as there is a large population risk; there is an identified responsible entity and process to maintain and update the measure; the data elements can be feasibly collection; and the intended use of the measure is both public reporting and quality improvement.

1528: Beta Blocker at Discharge for ICD implant patients with a previous MI

Comment By

Name: Mr. Del M. Conyers

Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:56 PM

Comments

992: Appropriate therapeutic medication management is critical for newly implanted ICD patients to ensure optimal outcome. Extensive research has demonstrated the efficacy of ACE inhibitor or ARB use in preventing adverse outcomes for patients with left ventricular systolic dysfunction. Moreover, research data provided by the measure stewards indicates a significant opportunity for improvement among providers. This measure meets the criteria for endorsement by NQF. This measure is important to measure and report as there is a large population risk; there is an identified responsible entity and process to maintain and update the measure; the data elements can be feasibly collection; and the intended use of the measure is both public reporting and quality improvement.

1525: Chronic Anticoagulation Therapy

Comment By

Name: Mr. Del M. Conyers

Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:54 PM

Comments

991: This measure meets the criteria for endorsement by NQF. This measure is important to measure and report as hospital admissions for atrial fibrillation (AF) have increased 66% in the past decade. Additionally, approximately 60,000 strokes each year are preventable with appropriate risk stratification and anticoagulation with warfarin. There is a robust evidence base which suggests that clinical assessment and use of medication therapy are essential associated with optimal outcomes in AF patients. This measure has an identified responsible entity and process to maintain and update the measure; the data elements can be feasibly collection; and the intended use of the measure is both public reporting and quality improvement. Implementation of thise measure is intended to promote improved documentation to achieve more accurate assessment of physician performance and ensure receipt of appropriate anticoagulation therapy, which has demonstrated a reduction in stroke risk for patients with AF.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)

Comment By

Name: Mr. Del M. Conyers

Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:54 PM

Comments

990: This measure meets the criteria for endorsement by NQF. This measure is important to measure and report as hospital admissions for atrial fibrillation (AF) have increased 66% in the past decade. Additionally, approximately 60,000 strokes each year are preventable with appropriate risk stratification and anticoagulation with warfarin. There is a robust evidence base which suggests that clinical assessment and use of medication therapy are essential associated with optimal outcomes in AF patients. This measure has an identified responsible entity and process to maintain and update the measure; the data elements can be feasibly collection; and the intended use of the measure is both public reporting and quality improvement. Implementation of thise measure is intended to promote improved documentation to achieve more accurate assessment of physician performance and ensure receipt of appropriate anticoagulation therapy, which has demonstrated a reduction in stroke risk for patients with AF.

Comments on the general draft report

Comment By
Name: Mr. Del M. Conyers
Organization: Heart Rhythm Society

Date - Time: Aug 19, 2011 - 02:50 PM

Comments
989: As a National Quality Forum (NQF) member, the Heart Rhythm Society (HRS) is pleased to provide written comments on the draft report, *National Voluntary Consensus Standards:* Cardiovascular Endorsement Maintenance*2010: A Consensus Report*.

In reviewing the NQF-endorsed standards portfolio, it is evident thatthere is a paucity of national voluntary consensus standards that can be implemented to demonstrate the quality of heart rhythm care. HRS supports your overall efforts to expand the National Quality Forum (NQF) portfolio to include voluntary consensus standards that adequately address the quality of cardiovascular care, particularly, heart rhythm care.

The Heart Rhythm Society appreciates the opportunity to comment on this draft report. If you have questions regarding our comments or the Heart Rhythm Society's performance measure-related work, please contact Del M. Conyers, Director, Quality Improvement, at 202-464-3434 or dconyers@hrsonline.org.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Mr. David E. Domann, MS, RPh
Organization: Ortho-McNeill-Janssen Pharmaceutical, Inc.

Date - Time: Aug 19, 2011 - 12:36 PM

Comments
988: *This recommendation is being made to cover all quality measures in the "Cardiovascular Endorsement 2010" Process that are relevant to medication use. Additionally, we feel this recommendation should be applied across the entire NQF Endorsement or Re-Endorsement Process regarding quality measures that include medications in the specifications.*

As new medication options enter the market, timely inclusion of these new medications and/or drug classes in related quality measure specifications is needed to allow for their appropriate use without delay, where indicated by FDA. Additional alignment (or realignment) of clinical practice guideline-based and quality measure-based recommendations with FDA-approved indications for medications may be necessary to prevent unintended delays or disincentives for use of these new agents by healthcare providers, even though these new agents are FDA approved for the indications represented in the quality measures.

Comments on measures not recommended
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:20 PM

Comments
987: 0282 -- Angina without procedure

We ask the steering committee to reevaluate its decision to remove endorsement from this measure. This measure helps to assess overuse of invasive procedures (e.g., PCIs).

0077 -- Heart failure: Symptom and activity assessment (AMA)

We support the steering committee's decision to not recommend this measure for endorsement. The committee's reasons include: "there is no evidence of a link between performing an assessment and outcome." We whole heartedly agree with this point.

13 -- Hypertension: Blood pressure management

We agree that this measure should not be recommended. Whether or not the patient achieved blood pressure control should be measured and reported separately from whether the patient was prescribed medications. Additionally, there is standard standalone HEDIS measure for high blood pressure control for patients with hypertension (measure 0018) that is widely in use in the private sector. We are also concerned that this measure will mask outcomes and allow physicians a "pass" for just documenting the existence of a care plan even when the patient outcomes are poor.

0276 -- Hypertension admission rate (PQI 7)

We ask the steering committee to reevaluate its recommendation to remove endorsement from this measure as it could result in the loss of important information.

Comments on measures not recommended
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:19 PM

Comments
986: 1486 – Chronic stable coronary artery disease: blood pressure control

We support the steering committee's decisions to not recommend this measure for endorsement because testing for the measure has not been completed. Also problematic is that the measure combines an outcome (whether the patient's blood pressure is under control) and a process measure (whether the patient was prescribed antihypertensive medications), and essentially gives physicians a "pass" for simply having prescribed medications when a patient's blood pressure isn't under control. Additionally, the exclusions are too broad.

0065 -- Chronic stable coronary artery disease: symptom and activity assessment

We agree with steering committee's reasons to remove endorsement from this measure. The committee raises the important issue about the lack of evidence that "assessment alone is related to patient satisfaction, better outcomes, more or less angioplasty, or less MIs."

1525: Chronic Anticoagulation Therapy
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:18 PM

Comments
985: We are concerned about the broad medical and patient exclusions.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:17 PM

Comments
984: We do not agree with the steering committee's recommendation for endorsement. This check-the-box measure is inadequate to advance patient care. It only requires a clinician to "assess" a patient's stroke risk (i.e., risk of thromboembolic event). The committee notes that the measure has a strong link to outcomes. This is in direct contradiction to the steering committee comments on measure 0077 (also a measure focused purely on assessment), "there is no evidence of a link between performing an assessment and outcome."

Rather, the measure should report the patient's actual CHADS 2 score – this would allow tracking of a patient's stroke risk over time (e.g., did the patient get better or worse) as well as promote accountability.

The committee states this measure is meets the usability test because it improves physician documentation -- this is a basic competency of care and is insufficient to merit endorsement in this area.

0358: Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:17 PM

Comments

983: We support maintaining endorsement for this measure – a critical outcome measure for this area of care.

0355: Bilateral Cardiac Catheterization Rate (IQI 25)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:16 PM

Comments
982: We strongly support maintaining endorsement for this measure, which is one of a very few available indicators of overuse. The steering committee categorized this as an outcome measure when this is a measure of appropriateness.

0288: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:16 PM

Comments
981: We agree with NQF's decision to maintain endorsement of this hospital measure

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0277: Congestive Heart Failure Admission Rate (PQI 8)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:15 PM

Comments
980: We support maintaining endorsement for this measure – a critical outcome measure for this area of care.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:15 PM

Comments
979: We generally support this measure, which assess an important outcome of care. However, we ask CMS to reconsider the risk adjustment methodology applied to the measures (i.e., hierarchical logistic regression model - HLRM). For performanceinformation to be truly useful to consumers and purchasers, it must distinguish performance among providers. And as we have commented to CMS in the past, HLRM can wash away nearly all of the variation observed in the raw data because it it over-adjusts for risk. The result is that most providers (i.e., individual hospitals) being profiled will be labeled as "average." Regardless of which statistical test is used, the shrinkage in the distribution resulting from this HLRM will not allow for much differentiation of hospital performance, resulting in little or no information for consumers and purchasers (or for the hospitals themselves, for that matter).

In our conversations with other statisticians, we have found that which risk adjustment method is used is a matter of philosophy as there is no consensus about which is the "best." We therefore recommend that CMS also apply more traditional logistic regression approaches to their data to determine which approach is the best fit for helping patients understand which hospitals provide the best care.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:15 PM

Comments

978: We generally support this measures, which assess an important outcome of care. However, we ask CMS to reconsider the risk adjustment methodology applied to the measures (i.e., hierarchical logistic regression model - HLRM). For performanceinformation to be truly useful to consumers and purchasers, it must distinguish performance among providers. And as we have commented to CMS in the past, HLRM can wash away nearly all of the variation observed in the raw data because it it over-adjusts for risk. The result is that most providers (i.e., individual hospitals) being profiled will be labeled as "average." Regardless of which statistical test is used, the shrinkage in the distribution resulting from this HLRM will not allow for much differentiation of hospital performance, resulting in little or no information for consumers and purchasers (or for the hospitals themselves, for that matter).

In our conversations with other statisticians, we have found that which risk adjustment method is used is a matter of philosophy as there is no consensus about which is the "best." We therefore recommend that CMS also apply more traditional logistic regression approaches to their data to determine which approach is the best fit for helping patients understand which hospitals provide the best care.

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:14 PM

Comments
977: We generally support this measures, which assess an important outcome of care. However, we ask CMS to reconsider the risk adjustment methodology applied to the measures (i.e., hierarchical logistic regression model - HLRM). For performanceinformation to be truly useful to consumers and purchasers, it must distinguish performance among providers. And as we have commented to CMS in the past, HLRM can wash away nearly all of the variation observed in the raw data because it it over-adjusts for risk. The result is that most providers (i.e., individual hospitals) being profiled will be labeled as "average." Regardless of which statistical test is used, the shrinkage in the distribution resulting from this HLRM will not allow for much differentiation of hospital performance, resulting in little or no information for consumers and purchasers (or for the hospitals themselves, for that matter).

In our conversations with other statisticians, we have found that which risk adjustment method is used is a matter of philosophy as there is no consensus about which is the "best." We therefore recommend that CMS also apply more traditional logistic regression approaches to their data to determine which approach is the best fit for helping patients understand which hospitals provide the best care.

0164: Fibrinolytic Therapy received within 30 minutes of hospital arrival
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:13 PM

Comments
976: We support maintaining endorsement of this measure.

0163: Primary PCI received within 90 minutes of Hospital Arrival
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:13 PM

Comments
975: We support continued endorsement of this measure

0160: Beta-blocker prescribed at discharge for AMI
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:13 PM

Comments
974: We support placing this measure under “reserve status” since it is topped out.

0142: Aspirin prescribed at discharge for AMI
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:12 PM

Comments
973: We support placing this measure under “reserve status” since it is topped out.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:11 PM

Comments
972: We recommend placing this measure in reserve status asCMS is suspending data collection on this measure because it is “topped out.”

0135: Evaluation of Left ventricular systolic function (LVS)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:11 PM

Comments
971: As we have stated on other measures – this is a check–the-box measure that simply asks if the provider “evaluated” a patient’s left ventricular systolic (LVS) function. It will not support improvements in patient outcomes. The focus of the measure should instead focus on reporting the outcome of the evaluation. We do not agree with the committee’s decision to maintain endorsement and placement in reserve status – the measure should be removed altogether.

0132: Aspirin at arrival for acute myocardial infarction (AMI)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:10 PM

Comments
970: We encourage the steering committee to place this measure in reserve status because CMS is suspending data collection on this measure because it is topped out.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:10 PM

Comments
969: We are concerned of the broad exclusions (patient, system, and medical) in these measures. As noted throughout this document, exclusions should be *evidence-based, highly specific, and explicitly defined*.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:09 PM

Comments
968: We are concerned of the broad exclusions (patient, system, and medical) in these measures. As noted throughout this document, exclusions should be *evidence-based, highly specific, and explicitly defined*.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:08 PM

Comments
967: The steering committee should not recommend this measure for endorsement. It is a “check-the-box” measure that simply assesses whether the clinician completed an assessment. Such measures won’t improve patient care. Rather, the goal of the measure should report the patient’s health status so that the clinician and others can determine whether the patient is improving over time.

0076: Optimal Vascular Care
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:01 PM

Comments
966: We strongly support the committee’s recommendation to continue endorsement of this composite measure. It importantly includes among its components whether a patient achieved “tobacco-free status.” All too often, measures of tobacco use only include an “assessment” and “counseling,” which fail to report whether a patient quit smoking. The measure is an all-or-none composite – a patient-centered approach that captures whether the patient received all appropriate care.

Currently the measure is identified for use at the level of the “group/practice.” We urge the steering committee and the measure developer to specify this measure at the level of the individual physician. There are many good reasons for this. For example, consumers choose individual physicians to be a part of their care team. Additionally, existing NCQA measures that reflect many of the elements in the composite (e.g., blood pressure control, LDL control,daily aspirin use) are specified at the individual clinician level and are widely accepted.

The steering committee identifies this composite as an outcome measure. However, it is a combination of process and outcome measures and the steering committee should re-categorize the measure to reflect this.

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:00 PM

Comments
965: We support this intermediate outcome measure. Endorsing this measure is important even in light of Minnesota Community Measurement’s “Optimal Vascular Care” measure (0076). 0075 addresses individual physician performance, while Optimal Vascular Care measure only captures performance at the level of the group/practice.

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:00 PM

Comments
964: We do not support this measure. We are very concerned about the broad exclusions and believe that instead of endorsing measure 0074, the steering committee should obtain NCQA commitment to broaden its measure (0075 – IVD:

complete lipid profile and LDL control <100) to cover additional areas of interest – this will facilitate alignment with the private sector.

0073: IVD: Blood Pressure Management
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 12:00 PM

Comments
963: We support endorsing this measure of blood pressure control, a critical part of care for patients with IVD, AMI, CABG, or PCI.

0071: Acute Myocardial Infarction (AMI): Persistence of Beta-Blocker Treatment After a Heart Attack
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:59 AM

Comments
962: We support the steering committee's decision to continue endorsement of this measure given a significant gap in performance.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:59 AM

Comments
961: We support this measure but encourage the measure developer to commit to develop an all-or-nothing composite for its IVD process measures in the near term.

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:58 AM

Comments
960: We do not support this measure. As the steering committee notes, the measure overlaps with NCQA's measure of "use of aspirin or antithrombotics" (measure 0068), which is in wide use in the private sector. To promote alignment with the private sector, we recommend that instead of endorsing measure 0067, the appropriate action would be for the steering committee to obtain NCQA's commitment to broaden the application of its measure (0068) (e.g., to other data collection methods, settings, patients) within a short time frame.

We are also concerned with the measure's broad exclusions: patient reasons, system reasons, and medical reasons. Exclusions should always be *evidence-based, highly specific, and explicitly defined*. This ensures that the removal of a patient from calculations of a provider's performance is appropriate and, moreover, the exact reason for the removal will be clear in an audit. Having rigorous parameters will also result in more informative data.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:58 AM

Comments

959: The steering committee should require the measure developer to narrow the exclusions as they are too broad at this time (e.g., patient and system reasons).

0018: Controlling High Blood Pressure
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:57 AM

Comments
958: We support the steering committee's recommendation to maintain endorsement. This measure captures an important intermediate outcome.

Comments on the general draft report
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:56 AM

Comments
957:

0964 – Therapy with aspirin, P2Y12 inhibitor and statin (all medications) at discharge

This is a helpful composite. However, any measure of "prescription written" needs to be paired with a measure of "prescription filled." We ask the steering committee and measure developer to articulate how it will address this concern.

0965 -- Patients with an ICD implant who receive prescriptions for all medications (ACE/ARB and beta blockers) – for which they are eligible for at discharge).

We support this all-or-none composite. However, measures of medications prescribed should be paired with measures of prescription filled to capture follow-through with treatment recommendations

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Comments on the general draft report
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:55 AM

Comments
956: **Gaps in NQF's Cardiovascular Portfolio**

We support many of the areas that the steering committee identified for further measure development (e.g., functional status, patient-reported symptom control, patient comprehension of self-management, care coordination). We encourage the committee to also include shared-decision making and overuse.

We agree with approaches that the steering committee offered for reducing the number of cardiovascular measures:

- Expand denominator populations whenever appropriate
- Consolidate measures, for example a single BP control that can be applied to a variety of settings and stratified into populations of interest such as CAD and diabetes
- Use more all-or-none composites

The first two points will facilitate alignment and standardization, and the third point will facilitate patient-centeredness and more consumer-friendly information.

Comments on the general draft report
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:54 AM

Comments
955: In the spirit of promoting alignment among public and private sectors, we also encourage the steering committee to not endorse new measures where similar NQF-endorsed measures already exist and are broadly in use in the private sector. Instead, the goal should be to obtain commitment from the measure developers of the existing measures to broaden the scope of their measures to address any additional areas of interest. For example:

- The steering committee recommends endorsing measure 0067 (Chronic stable coronary artery disease: Antiplatelet therapy), which overlaps with NCQA's measure of "use of aspirin or antithrombotics" (measure 0068) – a measure that is widely accepted by in the private sector. To promote alignment with the private sector, we recommend not endorsing 0067 and instead obtaining NCQA's commitment to broaden the application of its measure within a short timeframe to include "new" areas covered by 0067 (e.g., other data collection methods, settings, patients).

Comments on the general draft report
Comment By
Name: Dr. David S. P. Hopkins, MS, PhD
Organization: Pacific Business Group on Health

Date - Time: Aug 19, 2011 - 11:52 AM

Comments
954:

- The Pacific Business Group on Health appreciates the opportunity to comment on the Cardiovascular Endorsement Maintenance, 2010, Consensus report.
- We applaud the steering committee's and NQF's efforts to bring greater harmonization and to lay aside measures with high performance and little variation such that there is no longer much opportunity for improvement.
- We support the steering committee's interest in outcome measures and advancing all-or-none composites, particularly for process of care measures.
- We encourage the steering committee to consistently avoid endorsing measures that simply require that providers "assess" or "evaluate" a patient's status. These measures lack a strong link to outcomes and won't generate significant improvements in patient care.

Comments on the general draft report
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 11:16 AM

Comments
953: Comments on Composite Measures:

CMS recommends that there be a mechanism for a composite methodology to be assessed in a manner that is not dependent upon the specific individual measures that comprise them, so that the methodology can be applied to measure sets without having to undergo review if a measure is removed or a new measure is added.

0289: Median Time to ECG
Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
952: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0290: Median Time to Transfer to Another Facility for Acute Coronary Intervention
Comment By
Name: Ms. Rabia Khan, MPH

On Behalf Of
Name: Dr. Michael Rapp

Organization: Centers for Medicare and Medicaid Services Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
950: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0288: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
951: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0164: Fibrinolytic Therapy received within 30 minutes of hospital arrival

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
948: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0163: Primary PCI received within 90 minutes of Hospital Arrival

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
949: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
946: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
947: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0142: Aspirin prescribed at discharge for AMI

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
944: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0160: Beta-blocker prescribed at discharge for AMI

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
945: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
942: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
943: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0135: Evaluation of Left ventricular systolic function (LVS)

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
940: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
941: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0286: Aspirin at Arrival

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
939: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

0132: Aspirin at arrival for acute myocardial infarction (AMI)

Comment By
Name: Ms. Rabia Khan, MPH
Organization: Centers for Medicare and Medicaid Services

On Behalf Of
Name: Dr. Michael Rapp
Organization: CMS

Date - Time: Aug 19, 2011 - 09:41 AM

Comments
938: CMS thanks NQF for considering the measure and supports the decision to recommend this measure for NQF endorsement.

Comments on measures not recommended

Comment By
Name: Dr. Nicole C. Quon, PhD
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

On Behalf Of
Name: John Smith, MD, PhD, Senior Vice President for Clinical Development and Medical Affairs
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

Date - Time: Aug 19, 2011 - 07:37 AM

Comments
937: Boehringer Ingelheim Pharmaceuticals, Inc. (BI) supports the recommendation to retire measure #0084 “Heart Failure (HF): Warfarin therapy patients with atrial fibrillation” from the NQF portfolio since the measure developer AMA-PCPI retired this measure in January 2011 [1].

REFERENCE

[1] American College of Cardiology Foundation (ACCF)/American Heart Association (AHA)/Physician Consortium for Performance Improvement (PCPI). Heart Failure Performance Measurement Set. ACCF/AHA Approved December 2010. PCPI Approved January 2011. http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/hfset-12-5.pdf. Accessed August 18, 2011.

1525: Chronic Anticoagulation Therapy

Comment By
Name: Dr. Nicole C. Quon, PhD
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

On Behalf Of
Name: John Smith, MD, PhD, Senior Vice President for Clinical Development and Medical Affairs
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

Date - Time: Aug 19, 2011 - 07:33 AM

Comments
936: Boehringer Ingelheim Pharmaceuticals, Inc. (BI) appreciates the opportunity to comment on measure #1525.BI supports the inclusion of FDA-approved anticoagulants in addition to warfarin, which better reflects up-to-date evidence for treating AF. BI also suggests revising the measure to include all AF patients “at risk” for thromboembolism identified in the ACC/AHA/ESC AF clinical guideline, which supports consideration of a more comprehensive set of risk factors beyond CHADS2. [1] For example, a patient “Age 65 to 74 y with diabetes mellitus or CAD” is recommended for oral anticoagulation with evidence level I [1, page e292]. Yet this patient would not be classified as “high risk” under CHADS2, so outcomes for this patient would not be captured in the proposed measure. By only specifying “high risk” patients, this measure may exclude part of the full AF population that might benefit from appropriate anticoagulation to prevent stroke. We encourage the measure developer to continue to refine this measure to align with the clinical guideline and consider additional risk factors that are not included in CHADS2. As stroke risk assessment serves as the foundation for anticoagulation therapy, a measure with limited risk assessment criteria has the potential to inhibit at-risk patients from receiving necessary therapies.

REFERENCE

[1] Fuster et. al. Circulation 2006;114:e257-e354.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)

Comment By
Name: Dr. Nicole C. Quon, PhD
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

On Behalf Of
Name: John Smith, MD, PhD, Senior Vice President for Clinical Development and Medical Affairs
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

Date - Time: Aug 19, 2011 - 07:32 AM

Comments
935: Boehringer Ingelheim Pharmaceuticals, Inc. (BI) appreciates the opportunity to comment on measure #1524.BI supports the development of measures to improve patient assessments and outcomes. The proposed measure would support evidence-based evaluation of thromboembolic risk and facilitate identification of patients who might benefit from stroke prevention interventions. The proposed measure relies on CHADS2, a commonly used risk stratification tool. However, the ACC/AHA/ESC AF clinical guideline also supports consideration of a more comprehensive set of risk factors.[1] We encourage the measure developer to continue to refine this measure to align with the clinical guideline and consider additional risk factors that are not included in CHADS2. As stroke risk assessment serves as the foundation for certain therapies, such as the prescription of anticoagulant drugs, a measure with limited risk assessment criteria has the potential to inhibit at-risk patients from receiving necessary therapies.

REFERENCE

[1] Fuster et. al. Circulation 2006;114:e257-e354.

Comments on the general draft report

Comment By
Name: Dr. Nicole C. Quon, PhD
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

On Behalf Of
Name: John Smith, MD, PhD, Senior Vice President for Clinical Development and Medical Affairs
Organization: Boehringer Ingelheim Pharmaceuticals, Inc.

Date - Time: Aug 19, 2011 - 07:29 AM

Comments
934: On behalf of Boehringer Ingelheim Pharmaceuticals, Inc. (BI), I am pleased to submit comments in response to the Cardiovascular Endorsement Maintenance 2010 project. BI agrees that the development, endorsement, and implementation of evidence-based performance measures are important for improving quality. We appreciate the opportunity to contribute to this project and look forward to continuing to work with NQF to improve care and outcomes for patients with cardiovascular disease.

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD

Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:14 PM

Comments
932: An ARB should be used when available for black patients as ACEI in black patients cause more angioedema

Racial differences in incidence of antihypertensive drug side effects may occur; African Americans and Asians have a 3- to 4-fold higher risk of angioedema(109,209,210) and have more cough attributed to ACEIs than whites. (211)

From: JNC pp 1226:

109. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive

patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981–2997.

209. Brown NJ, Ray WA, Snowden M, Griffin MR. Black Americans have an increased rate of angiotensin converting enzyme inhibitor-associated angioedema. Clin Pharmacol Ther 1996;60:8–13.

210. Lawrence J, Stockbridge N, Hung HMJ, Chi G. Joint statistical-clinical review: NDA resubmission dated 14 December 2001, including the results of the OCTAVE study. FDA, CDER, Div. Cardio-Renal Drug Products. NDA: 21–188 (omapatrilat for hypertension), June 2002. pp. 1–31. http:// www.fda.gov/ohrms/dockets/ac/02/briefing/3877B2_03_FDA-Medial Statistical.doc

211. Elliott WJ. Higher incidence of discontinuation of angiotensin converting enzyme inhibitors due to cough in black subjects. Clin Pharmacol Ther 1996;60:582–588.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:14 PM

Comments
933: An ARB should be used when available for black patients as ACEI in black patients cause more angioedema

Racial differences in incidence of antihypertensive drug side effects may occur; African Americans and Asians have a 3- to 4-fold higher risk of angioedema(109,209,210) and have more cough attributed to ACEIs than whites. (211)

From: JNC pp 1226:

109. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive

patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981–2997.

209. Brown NJ, Ray WA, Snowden M, Griffin MR. Black Americans have an increased rate of angiotensin converting enzyme inhibitor-associated angioedema. Clin Pharmacol Ther 1996;60:8–13.

210. Lawrence J, Stockbridge N, Hung HMJ, Chi G. Joint statistical-clinical review: NDA resubmission dated 14 December 2001, including the results of the OCTAVE study. FDA, CDER, Div. Cardio-Renal Drug Products. NDA: 21–188 (omapatrilat for hypertension), June 2002. pp. 1–31. http:// www.fda.gov/ohrms/dockets/ac/02/briefing/3877B2_03_FDA-Medial Statistical.doc

211. Elliott WJ. Higher incidence of discontinuation of angiotensin converting enzyme inhibitors due to cough in black subjects. Clin Pharmacol Ther 1996;60:582–588.

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:14 PM

Comments
930: An ARB should be used when available for black patients as ACEI in black patients cause more angioedema

Racial differences in incidence of antihypertensive drug side effects may occur; African Americans and Asians have a 3- to 4-fold higher risk of angioedema(109,209,210) and have more cough attributed to ACEIs than whites. (211)

From: JNC pp 1226:

109. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive

patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981–2997.

209. Brown NJ, Ray WA, Snowden M, Griffin MR. Black Americans have an increased rate of angiotensin converting enzyme inhibitor-associated angioedema. Clin Pharmacol Ther 1996;60:8–13.

210. Lawrence J, Stockbridge N, Hung HMJ, Chi G. Joint statistical-clinical review: NDA resubmission dated 14 December 2001, including the results of the OCTAVE study. FDA, CDER, Div. Cardio-Renal Drug Products. NDA: 21–188 (omapatrilat for hypertension), June 2002. pp. 1–31. http:// www.fda.gov/ohrms/dockets/ac/02/briefing/3877B2_03_FDA-Medial Statistical.doc

211. Elliott WJ. Higher incidence of discontinuation of angiotensin converting enzyme inhibitors due to cough in black subjects. Clin Pharmacol Ther 1996;60:582–588.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:14 PM

Comments
931: An ARB should be used when available for black patients as ACEI in black patients cause more angioedema

Racial differences in incidence of antihypertensive drug side effects may occur; African Americans and Asians have a 3- to 4-fold higher risk of angioedema(109,209,210) and have more cough attributed to ACEIs than whites. (211)

From: JNC pp 1226:

109. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive

patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981–2997.

209. Brown NJ, Ray WA, Snowden M, Griffin MR. Black Americans have an increased rate of angiotensin converting enzyme inhibitor-associated angioedema. Clin Pharmacol Ther 1996;60:8–13.

210. Lawrence J, Stockbridge N, Hung HMJ, Chi G. Joint statistical-clinical review: NDA resubmission dated 14 December 2001, including the results of the OCTAVE study. FDA, CDER, Div. Cardio-Renal Drug Products. NDA: 21–188 (omapatrilat for hypertension), June 2002. pp. 1–31. http:// www.fda.gov/ohrms/dockets/ac/02/briefing/3877B2_03_FDA-Medial Statistical.doc

211. Elliott WJ. Higher incidence of discontinuation of angiotensin converting enzyme inhibitors due to cough in black subjects. Clin Pharmacol Ther 1996;60:582–588.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:14 PM

Comments
929: An ARB should be used when available for black patients as ACEI in black patients cause more angioedema

Racial differences in incidence of antihypertensive drug side effects may occur; African Americans and Asians have a 3- to 4-fold higher risk of angioedema(109,209,210) and have more cough attributed to ACEIs than whites. (211)

From: JNC pp 1226:

109. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive

patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). JAMA. 2002;288:2981–2997.

209. Brown NJ, Ray WA, Snowden M, Griffin MR. Black Americans have an increased rate of angiotensin converting enzyme inhibitor-associated angioedema. Clin Pharmacol Ther 1996;60:8–13.

210. Lawrence J, Stockbridge N, Hung HMJ, Chi G. Joint statistical-clinical review: NDA resubmission dated 14 December 2001, including the results of the OCTAVE study. FDA, CDER, Div. Cardio-Renal Drug Products. NDA: 21–188 (omapatrilat for hypertension), June 2002. pp. 1–31. http:// www.fda.gov/ohrms/dockets/ac/02/briefing/3877B2_03_FDA-Medial Statistical.doc

211. Elliott WJ. Higher incidence of discontinuation of angiotensin converting enzyme inhibitors due to cough in black subjects. Clin Pharmacol Ther 1996;60:582–588.

1529: Beta Blocker at Discharge for ICD implant patients with LVSD
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:06 PM

Comments
928: suggest limiting to specific drugs that are FDA approved for use in LVSD: carvedilol, extended release metoprolol succinate.

The prescribing information for metoprolol succinate contains a boxed warning. Please consult the warning section of the prescribing information for metoprolol succinate further details and other important safety information. Prescribing information for metoprolol succinate may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800-236-9933.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:03 PM

Comments
927: Suggest limiting to specific drugs that are FDA approved for use in HF/LVSD: ARBs: candesartan (has a mortality claim) and valsartan.

The prescribing information for ATACAND (candesartan cilexetil) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for ATACAND may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800 -236-9933.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:03 PM

Comments
924: Suggest limiting to specific drugs that are FDA approved for use in HF/LVSD: ARBs: candesartan (has a mortality claim) and valsartan.

The prescribing information for ATACAND (candesartan cilexetil) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for ATACAND may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800 -236-9933.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:03 PM

Comments
925: Suggest limiting to specific drugs that are FDA approved for use in HF/LVSD: ARBs: candesartan (has a mortality claim) and valsartan.

The prescribing information for ATACAND (candesartan cilexetil) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for ATACAND may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800 -236-9933.

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:03 PM

Comments
926: Suggest limiting to specific drugs that are FDA approved for use in HF/LVSD: ARBs: candesartan (has a mortality claim) and valsartan.

The prescribing information for ATACAND (candesartan cilexetil) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for ATACAND may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800 -236-9933.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:00 PM

Comments
922: Given the measure states, “use of Aspirin or another antithrombotic,” please add BRILINTA (ticagrelor) **to the list of oral antiplatelet agents in section 2a.3, Table IVD-E.**

The prescribing information for BRILINTA (ticagrelor) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for BRILINTA may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800-236-9933.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 05:00 PM

Comments
923: Given the measure states, “use of Aspirin or another antithrombotic,” please add BRILINTA (ticagrelor) **to the list of oral antiplatelet agents in section 2a.3, Table IVD-E.**

The prescribing information for BRILINTA (ticagrelor) contains a boxed warning. Please consult the warning section of the prescribing information for further details and other important safety information. Prescribing information for BRILINTA may be obtained from www.astrazeneca-us.comor by calling the Information Center at AstraZeneca at 1-800-236-9933.

0076: Optimal Vascular Care
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 04:57 PM

Comments
920: Suggest adding LDL-C goal <70 mg/dL for those patients who are considered very high-risk: those with the presence of established CVD plus (1) multiple major risk factors (especially diabetes), (2) severe and poorly controlled risk factors (especially continued cigarette smoking), (3) multiple risk factors of the metabolic syndrome

(especially high triglycerides ≥200 mg/dL plus nonHDL-C ≥130 mg/dL with low HDL-C [<40 mg/dL]), and (4) patients with acute coronary syndromes. *[Grundy SM, Cleeman JI, Merz CN, et al for the Coordinating Committee of the National Cholesterol Education Program. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. Circulation. 2004;110(2):227-239.]*

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 04:57 PM

Comments
921: Suggest adding LDL-C goal <70 mg/dL for those patients who are considered very high-risk: those with the presence of established CVD plus (1) multiple major risk factors (especially diabetes), (2) severe and poorly controlled risk factors (especially continued cigarette smoking), (3) multiple risk factors of the metabolic syndrome

(especially high triglycerides ≥200 mg/dL plus nonHDL-C ≥130 mg/dL with low HDL-C [<40 mg/dL]), and (4) patients with acute coronary syndromes. *[Grundy SM, Cleeman JI, Merz CN, et al for the Coordinating Committee of the National Cholesterol Education Program. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. Circulation. 2004;110(2):227-239.]*

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Mrs. Kathy Gans-Brangs
Organization: AstraZeneca

Date - Time: Aug 18, 2011 - 04:57 PM

Comments
919: Suggest adding LDL-C goal <70 mg/dL for those patients who are considered very high-risk: those with the presence of established CVD plus (1) multiple major risk factors (especially diabetes), (2) severe and poorly controlled risk factors (especially continued cigarette smoking), (3) multiple risk factors of the metabolic syndrome

(especially high triglycerides ≥200 mg/dL plus nonHDL-C ≥130 mg/dL with low HDL-C [<40 mg/dL]), and (4) patients with acute coronary syndromes. *[Grundy SM, Cleeman JI, Merz CN, et al for the Coordinating Committee of the National Cholesterol Education Program. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. Circulation. 2004;110(2):227-239.]*

0277: Congestive Heart Failure Admission Rate (PQI 8)
Comment By
Name: Dr. Christopher Fee, MD
Organization: Society for Academic Emergency Medicine

Date - Time: Aug 18, 2011 - 02:22 PM

Comments
918: The Society for Academic Emergency Medicine (SAEM) has concerns about this measure as follows: **While ED admissions, per se, are not measured, pressure from medical center administration to reduce admissions of such patients will directly impact ED throughput (and other NQF endorsed measures regarding ED length of stay). This is mentioned in the Steering Committee's review but no resolution is suggested. If adopted, one of the**

unintended consequences will be an increased burden on ED observation units to manage this complex patient population. On the other hand, it will place pressure on hospitals to support outpatient CHF clinics where EDs can send patients for next day follow-up.

Comments on the general draft report
Comment By
Name: Dr. Christopher Fee, MD
Organization: Society for Academic Emergency Medicine

Date - Time: Aug 18, 2011 - 02:20 PM

Comments
917: The Society for Academic Emergency Medicine (SAEM) has reviewed this draft report and agrees with endorsement with one exception: **0277 CHF admission (PQI 8) (AHRQ). While ED admissions, per se, are not measured, pressure from medical center administration to reduce admissions of such patients will directly impact ED throughput (and other NQF endorsed measures regarding ED length of stay). This is mentioned in the Steering Committee's review but no resolution is suggested. If adopted, one of the unintended consequences will be an increased burden on ED observation units to manage this complex patient population. On the other hand, it will place pressure on hospitals to support outpatient CHF clinics where EDs can send patients for next day follow-up.**

Comments on the general draft report
Comment By
Name: Dr. Christopher Fee, MD
Organization: Society for Academic Emergency Medicine

Date - Time: Aug 18, 2011 - 02:13 PM

Comments
916: While ED admissions per se are not measured, several have expressed concern about the push-back on admitting such patients (which would then directly effect another measure, that of ED LOS). This is also mentioned in the steering committee's review but no resolution is suggested. If adopted, one of the unintended consequences will be an increased burden on ED Observation units to manage this complex patient population. On the other hand, it will place pressure on hospitals to support outpatient CHF clinics where EDs can send patients for next day follow-up.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 02:07 PM

Comments
915: NAHQ members have asked for clarification in the specifications about EF's done in prior visits or documented in the Electronic Health Record. A provider by acknowledge these procedures, but not provide billing codes for a visit done in the office/outpatient setting. Please address how this would be included / excluded in the measure.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 02:01 PM

Comments
914: Please provide clairification if this measure is hospital based inpatient or outpatient/ambulator care.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)

Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 02:00 PM

Comments
913: This measure is important to measure, however the identification of the denominator population to identify atrial fibrillation do not fit well into current ICD9 coding. ICD9 coding can reflect a transient episode or chronic episode. NAHQ recommends further evaluation of the measure and denominator population prior to inclusion.

0133: PCI mortality (risk-adjusted)©
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:59 PM

Comments
912: NAHQ expresses concerns about the use of registry data in publicly reported measures. These data bases represent significant burden colletions and expense to hospitals. NAHQ recommends measures that are open sources and able to be reproduced by any vendor or organization.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:58 PM

Comments
911: NAHQ members do not suport this measure as written. All cause readmission loses its meaning to clinicians and providers as this does not provide information that could lead to performance improvement.

0290: Median Time to Transfer to Another Facility for Acute Coronary Intervention
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:56 PM

Comments
910: NAHQ members are concerned about possible unintended consequence that can occur when targets are set to transfer a patient prior to stability or proper evaluation. This may not be in the best interest of the patient.

0289: Median Time to ECG
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:54 PM

Comments
909: Experience in collection of this measure demonstrates that not having a single clock (pre-arrival to arrival) makes this measure problematic and inaccurate if the EKG is performed prior to hospital arrival. Additionally, the measure developer of this measure often excludes acute AMI because the location of the MI is on the row below the Acute AMI on an EKG tracing. This should be resolved.

The inclusions of admission to a critical access hospital does not meet CAH billing requirements. If a patient is treated in the ED of a CAH hospital and then admitted as an inpatient there, there are two different bills according to CMS requirements, however, physically the patient never leaves the same facility. This should be clarified in the outpatient manual .

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:52 PM

Comments
908: NAHQ requests clarification of the role ofprasugrel and ticagrelor in the inclusion criteria of this measure.

0076: Optimal Vascular Care
Comment By
Name: Jan Orton, MS, RN, CPHQ
Organization: National Association of Healthcare Quaoity

Date - Time: Aug 18, 2011 - 01:51 PM

Comments
907: This outcomes measure reflects best optimal care. However, as a measurement at a clinical / provider level, there is no apparent exclusion for patients who despite excellent clinical care and provider education, choose to not follow provider best practice recommendations (choose to not fill the statin, choose to continue to smoke, etc). Providers who reviewed this measure are concerned about the potential public reporting and perceived poor care that may be implied without a measurement of patient choice / refusal without a corresponding process measure that reflects the provider side of these best practice. Additionally, this measure may have geographical &/or economic/poverty variation that also may appear negative for a provider / clinic.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:33 PM

Comments
906: It is unclear if this measure is for hospital based inpatient or outpatient / ambulatory care. Please clarify. If this is a clinic based measurement, this measure would be labor intensive to collect.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:32 PM

Comments
905: This measure is important to measure, however the identification of the denominator population to identify atrial fibrillation do not fit well into current ICD9 coding. ICD9 coding can reflect a transient episode or chronic episode. Intermountain recommends further evaluation of the measure and denominator population prior to inclusion.

0133: PCI mortality (risk-adjusted)©
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:31 PM

Comments
904: This registry proposed measure requires a significant burden collection and expense to hospitals and is not available to hospitals without significant registry and labor expense. Intermountain believes the methodology for this measure should be open sourced.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:30 PM

Comments

903: Intermountain believes that All cause readmission loses its meaning to clinicians and providers as this does not provide information that could lead to performance improvement. Readmission for a trauma when a spouse is driving is an outcome that has no relationship to the care provided during the AMI episode of care.

0290: Median Time to Transfer to Another Facility for Acute Coronary Intervention
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:29 PM

Comments
902: Intermountain believes this measure could have unintended consequences by attempting to meet a target time when a patient may not be stable for transport.

0289: Median Time to ECG
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:27 PM

Comments
901: 1. Experience in collection of this measure demonstrates that not having a single clock (pre-arrival to arrival) makes this measure problematic and inaccurate if the EKG is performed prior to hospital arrival.

2. The inclusions of admission to a critical access hospital does not meet CAH billing requirements. If a patient is treated in the ED of a CAH hospital and then admitted as an inpatient there, there are two different bills according to CMS requirements, however, physically the patient never leaves the same facility. This should be clarified in the outpatient manual .

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:26 PM

Comments
900: Intermountain requests clarification of the role ofprasugrel and ticagrelor and why they would / would not be included.

0076: Optimal Vascular Care
Comment By
Name: Ms. Jan A. Orton, MS, RN, CPHQ
Organization: Intermountain Healthcare

Date - Time: Aug 18, 2011 - 12:25 PM

Comments
899: This outcomes measure reflects best optimal care. However, as a measurement at a clinical / provider level, there is no apparent exclusion for patients who despite excellent clinical care and provider education, choose to not follow provider best practice recommendations (choose to not fill the statin, choose to continue to smoke, etc). Providers who reviewed this measure are concerned about the potential public reporting and perceived poor care that may be implied without a measurement of patient choice / refusal without a corresponding process measure that reflects the provider side of these best practice. Additionally, this measure may have geographical &/or economic/poverty variation that also may appear negative for a provider / clinic.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Bart W. Galle, Jr., PhD
Organization: Heart Failure Society of America

Date - Time: Aug 12, 2011 - 03:23 PM

Comments
898:
The Quality of Care Committee of the Heart Failure Society of America has reviewed and supports this measure.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Bart W. Galle, Jr., PhD
Organization: Heart Failure Society of America

Date - Time: Aug 12, 2011 - 03:23 PM

Comments
897: The Quality of Care Committee of the Heart Failure Society of America has reviewed and supports this measure.

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients
Comment By
Name: Bart W. Galle, Jr., PhD
Organization: Heart Failure Society of America

Date - Time: Aug 12, 2011 - 03:22 PM

Comments
896:
The Quality of Care Committee of the Heart Failure Society of America has reviewed and supports this measure.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Bart W. Galle, Jr., PhD
Organization: Heart Failure Society of America

Date - Time: Aug 12, 2011 - 03:21 PM

Comments
895: The Quality of Care Committee of the Heart Failure Society of America has reviewed and supports this measure.

Comments on the general draft report
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:59 PM

Comments
894: 0965: This measure is too specific to be generalized to the population.

0135: Evaluation of Left ventricular systolic function (LVS)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:58 PM

Comments
893: This measure is only attainable if there is an integrated medical record. Until medical records are integrated the hospital does not know what occurred before admission and after discharge. Measure 0079 is unnecessary if NQF is going to use this measure with an integrated medical record.

0018: Controlling High Blood Pressure
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:57 PM

Comments
892: This measure depends on patient compliance.

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:56 PM

Comments
891: All-cause mortality does not correlate well with Heart Failure mortality.

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:56 PM

Comments
890: All-cause mortality does not correlate well with Heart Failure mortality.

0277: Congestive Heart Failure Admission Rate (PQI 8)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:55 PM

Comments
889: This measure is both reasonable and attainable.

0358: Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:55 PM

Comments
888: This should not be measured as an all-cause mortality rate.

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:54 PM

Comments
887: This measure is both reasonable and attainable.

0083: Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:53 PM

Comments
886: As in measure 0081, prescription of a beta-blocker is occurring at the time of hospital discharge, however to collect the data for individual clinicians would be very labor intensive. Measuring this at both levels may lead to duplication of

medications and increase medication errors. Preventing over prescribing would largely depend on patients accurately reporting their medications to hospital and physicians office personnel. Having the same EMR for inpatient and hospital owned physician practices would greatly facilitate monitoring of this measure.

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:53 PM

Comments
885: Prescription of ACE inhibitor or ARB therapy is occurring at the time of hospital discharge, however to collect the data for individual clinicians would be very labor intensive. Measuring this at both levels may lead to duplication of medications and increase medication errors. Preventing over prescribing would largely depend on patients accurately reporting their medications to hospital and physicians office personnel.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:52 PM

Comments
884: This measure is both reasonable and attainable.

1529: Beta Blocker at Discharge for ICD implant patients with LVSD
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:51 PM

Comments
883: This measure is too specific to be generalized to the population.

1528: Beta Blocker at Discharge for ICD implant patients with a previous MI
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:51 PM

Comments
882: Medications are typically altered at the time of implant. Medication adjustment may be required after the patient has a device implanted so this measure in certain circumstances may not serve the patient well. Most ICD’s are Pacers.

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:50 PM

Comments
881: This measure is both reasonable and attainable.

1525: Chronic Anticoagulation Therapy
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:50 PM

Comments
880: This measure is both reasonable and attainable.

1524: Assessment of Thromboembolic Risk Factors (CHADS2)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:50 PM

Comments
879: This measure is both reasonable and attainable.

0142: Aspirin prescribed at discharge for AMI
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:49 PM

Comments
878: This measure is both reasonable and attainable.

0160: Beta-blocker prescribed at discharge for AMI
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:49 PM

Comments
877: This measure is both reasonable and attainable.

0133: PCI mortality (risk-adjusted)©
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:48 PM

Comments
876: Please specify if this is an all-cause mortality. Patients who do not arrive at an interventional facility within 60 minutes of first medical contact should be excluded from this measure.

0355: Bilateral Cardiac Catheterization Rate (IQI 25)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:47 PM

Comments
875: This measure should be monitored through medical staff professional practice evaluation.

0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:46 PM

Comments
874: An all-cause mortality rate does not correlate well with AMI mortality.

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:46 PM

Comments
873: This measure is both reasonable and attainable.

0164: Fibrinolytic Therapy received within 30 minutes of hospital arrival
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:45 PM

Comments
872: If a non-interventional facility can transfer a patient within 60 minutes to a facility that does cardiac intervention it is better to do so, then give the fibrinolysis. Once a patient is at an interventional facility, we question whether 30 minutes is achievable. 60 minutes would be more achievable for this measure.

0163: Primary PCI received within 90 minutes of Hospital Arrival
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:44 PM

Comments
871: This measure is both reasonable and attainable.

0132: Aspirin at arrival for acute myocardial infarction (AMI)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:44 PM

Comments
870: This measure is both reasonable and attainable.

0290: Median Time to Transfer to Another Facility for Acute Coronary Intervention
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:44 PM

Comments
869: This measure is both reasonable and attainable.

0288: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:43 PM

Comments
868: Fibrinolysis within 30 minutes is unreasonable as the physician needs time to find out if there are contraindications and decide if fibrinolysis is reasonable for the patient being treated. The time on this measure should be 60 or 90 minutes to provide for time to determine proper treatment. This is a better measure for non-interventional facilities that must transfer the patient and should exclude patients who cannot be transferred within 90 minutes because of remote location.

0286: Aspirin at Arrival
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:42 PM

Comments
867: This data can be collected by the facility, however if it is intended the facility ensure compliance then that would be extremely difficult as this is not within the facility's control.

0289: Median Time to ECG
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:42 PM

Comments
866: This measure is both reasonable and attainable.

0071: Acute Myocardial Infarction (AMI): Persistence of Beta-Blocker Treatment After a Heart Attack
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:41 PM

Comments
865: The facility can evaluate whether the patient has the resources to comply with medication recommendations and when available refer them to low-cost resources when they do not. The patient though is responsible for compliance. The facility and physicians can only control whether or not the beta-blocker treatment is prescribed.

0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:40 PM

Comments
864: Diabetics cannot take particular medications due to renal issues. In the excluded populations, diabetics are not listed. They physician will do what is best for the patient.

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:40 PM

Comments
863: This measure is both reasonable and attainable.

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:39 PM

Comments
862: It is reasonable that patients would have had a lipid profile when seen by the facility. When seen by private practioners it may be less likely that a patient would have an LDL screening. Currently, there is only limited

infrastructure to know what hospital owned physicians prescribe and no infrastructure to know what private physicians are doing in their practices. The goal is to build the infrastructure for hospital owned physician practices.

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:39 PM

Comments
861: We suggest the wording of this measure be changed to "anti-platelet therapy" rather than defining that it must be aspirin or clopidogrel prescribed. It is a good measure for a hospital facility because the facility and its staff can control what is prescribed, unlike being able to control compliance as is measured in some of the other measures.

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:38 PM

Comments
860: This measure is both reasonable and attainable.

0073: IVD: Blood Pressure Management
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:37 PM

Comments
859: Patients would have a controlled blood pressure upon discharge from the hospital facility, but tracking and follow-up would be difficult without a medical home. Also, it is difficult to treat these conditions with medications alone. All patients are not compliant when follow-up care is recommended. It can be difficult for patients with no insurance to gain access to prescription medications. Diet and exercise are also a key to success. For this measure, it may be reasonable to also hold insurance carriers accountable for making proper medications available and affordable for patients to remain in compliance.

0076: Optimal Vascular Care
Comment By
Name: Krystal D. Graham, MHA
Organization: Palmetto Health

Date - Time: Aug 11, 2011 - 02:36 PM

Comments
858: This measure would be difficult to achieve as every patient does not have a medical home. This makes monitoring and ensuring compliance with recommendations difficult. The medical records at our facility currently are not integrated with those of physician practices.

0076: Optimal Vascular Care
Comment By
Name: Vanessa Reddy
Organization:

On Behalf Of
Name: Dr. Susan M. Begelman, M.D., F.A.C.C.
Organization: Genentech Inc.

Date - Time: Aug 10, 2011 - 05:25 PM

Comments
857: Add HDL as a modifiable risk factor of CAD, since HDL is established and recognized as a significant cardiovascular risk factor that is modifiable through pharmacotherapy, diet and/or exercise

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0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By

On Behalf Of

Name: Vanessa Reddy
Organization:

Date - Time: Aug 10, 2011 - 05:13 PM

Name: Dr. Susan M. Begelman, M.D., F.A.C.C.
Organization: Genentech Inc

Comments
856: Consider changing term "lipid-lowering" to "lipid-**modifying**," since some dyslipidemia treatments lower atherogenic as well as raise beneficial types of lipoprotein-cholesterol levels (e.g., HDL-C)

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Barbara Riegel, DNSc
Organization: University of Pennsylvania

Date - Time: Aug 02, 2011 - 10:43 AM

Comments
855: The measures you have chosen (LVEF assessment, BB for LVSD, ACE or ARB for LVSD) are great. But, I was distressed to see that symptom and activity assessment was not judged to be important. Functional outcomes such as this are the primary correlate of health-related quality of life (HRQL). HRQL is now recognized as the key patient-centered outcome. Thus, to measure only the indicators of provider care without acknowledging the patient's perspective seems ill-advised. I strongly encourage you to reconsider this stance.

Barbara Riegel, DNSc, RN, FAAN, Professor, University of Pennsylvania

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1529: Beta Blocker at Discharge for ICD implant patients with LVSD
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 03:12 PM

Comments
854: Of course this makes sense.

However, similar to #1522, it's hard to imagine why a patient with CHF and LVSD was not already treated with a beta-blocker prior to receiving an ICD (unless it was for secondary prevention). Patients (with the exception of those who have experienced life-threatening arrhythmias) who have not received optimal doses of RAAS blockade and beta-blockers should be treated with these drugs for 3 months before being evaluated for an ICD. A substantial proportion will no longer meet the LV function criteria for ICD implantation after receiving 3 months of optimal medical therapy, and these usually have a good prognosis.

One more comment. I don't see any measure related to CRT. This is a very effective intervention for heart failure patients with demonstrable dyssynchrony. Multiple trials have shown improvement in outcomes (hospitalizations and survival). Indeed, well-functioning CRT devices have a similar survival benefit as do ICDs used for primary prevention and have the added advantage of improving quality of life and reducing symptoms.

1522: ACE/ARB Therapy at Discharge for ICD implant patients with LVSD
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 03:01 PM

Comments
853: Presumably most of these patients will have low EFs and should be on an ACE inhibitor or (in my view) and aldosterone blocker (since ARBs have not improved cardiac function or reduced sudden death to the extent that aldosterone blockers have,

However, a more relevant question is why a patient receiving an ICD was not already on an ACEI/ARB/aldosterone blocker. If they weren't, probably should not have gotten an ICD until they were appropriatedly treated (unless it was for secondary prevention).

0358: Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:56 PM

Comments
852: This is an obvious thing to measure. To what extent it reflects quality of care vs the population served is difficult to determine. I didn't see mention of risk adjustment, which would be essential. It also has the potential to discourage centers specializing in the care of patients with advanced heart faliure from accepting transfers of patients who are "high risk".

0330: Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization for patients 18 and older
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:48 PM

Comments
851: Personally, I have real concerns about readmission rates as quality measures. One reason is our data from the VA system showed over a 5 year period in patients who were hospitalizaed for heart failure that there was a progressive rise in readmission rates associated with a progressive decline in mortality rates. (Heidenreich JACC 2010;56:362-68). A likely reason for this may be that systems which have programs in place to see patients early post-discharge and/or employ various forms of remote monitoring, home visits, and contact with trained NPs will recognize clinical deterioration earlier and admit the patient.

This measure has the potential to discourage timely readmissions.

0277: Congestive Heart Failure Admission Rate (PQI 8)
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:39 PM

Comments
850: This is useful data, but I am not certain how it can be interpreted as a "quality measure", since it is not clear "who" is being assessed. Epidemiologically, this can be very useful. It also can potentially be used as a measure of availability of health care serives and population health.

However, it's not clear how valid it would be as a measure of performance of practioners or even hospitals.

Having looked at heart failure data from multiple international regions and countries, the one conclusion that is likely to emerge from such a measure is that the U.S. offers very poor health care to heart failure patients and individuals at risk for developing heart failure.

0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:28 PM

Comments
849: Agree with a mortality measure, but have 2 concerns. First, the validity of risk-standardization adjustment and second, whether it should be "all cause" mortality vs cardiovascular mortality. Given the advanced age of many heart failure patients, an increasing proportion of whom are in palliative care programs, many deaths cannot be considered a result of substandard care.

0162: ACEI or ARB for left ventricular systolic dysfunction - Heart Failure (HF) Patients

Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:22 PM

Comments
848: See comment for #0081

0137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:22 PM

Comments
847: See comment for 0081

0135: Evaluation of Left ventricular systolic function (LVS)
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:20 PM

Comments
846: See comments on #0079

0081: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:19 PM

Comments
845: I agree with this measure, as do our (HFSA) guidelines and those of other organizations.

However, the data for ACE inhibitors is stronger and more consistent than that for ARBs. I would suggest that the measure should read:

"Patients with heart failure with left ventricular dysfunction or asymptomatic left ventricular systolic dysunction should be treated with an ACE inhibitor. In those that do not tolerate and ACE inhibitor because of angioedema or cough, an ARB should be employed."

Note, data from multiple trials (RALES, EPHESUS, EMPHASIS) has indicted that aldosterone blockers (spironolactone and eplerenone) improves outcomes and reverses LV remodeling at least as well as ACE inhibitors or ARBs and may reduce mortality and prevent hospitalizations to a greater extent. We (the VA system) are promulgating use of aldosterone antagonists for patients with LV systolic dysfunction who remain symptomatic or continue to experience decompensation as an add on therapy to ACE inhibitors or ARBs.

0079: Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)
Comment By
Name: Barry M. Massie
Organization: Heart Failure Society of America

Date - Time: Jul 30, 2011 - 02:05 PM

Comments
844: This is an important measure. However, I don't understand why it is limited to "outpatient setting". Patients with heart failure need to have an evaluation of cardiac function. This would include patients admitted for heart failure or found to have heart failure when admitted for another condition.

To be optimal, this evaluation should include assessments beyond measurement of the EF. This includes evaluation of cardiac structure (valve abnormalities, chamber size, hypertrophy), and other findings that may be causal or of important prognostic value). Assessment of diastolic function is also important when EF is not reduced, since a rapidly rising

proportion of patients with clinical heart failure (>50% from recent registries) have normal EF and these measurements help validate the diagnosis of heart failure..

0289: Median Time to ECG
Comment By
Name: Dr. Michael P. Phelan, MD, FACEP
Organization: Cleveland Clinic

Date - Time: Jul 23, 2011 - 10:57 AM

Comments
843: Because of the narrowness of the defintion of this measure regarding just transferred patients this measure typically excludes tertiary referral ceneters from collecting and measureing their own time to ecg. The burden falls on transferring hospitals to collect and improve time to ecg but fails to capture the time to ecg for patients with stemi and chest pain in the larger hosptials where patients are transferred into. It might make sense to reformulate the defintion to include all patients presenting to any hospital with an MI not just those patienbts transferred to PCI centers.

0076: Optimal Vascular Care
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 05:01 PM

Comments
802: Dear NQF,

#0076 Optimal Vascular Disease care, a composite measure, is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In the interest of measure parsimony, and in the interest of promoting forward progress on clinical outcomes, #0076 should supercede individual item stand-alone measures that are currently included in the NQF portfolio.

Gail Amundson, Caterpillar representative

Measure Submitter Response
Thank you for your comments and support.
We agree that additional separate, duplicative measures do not need to be collected. Measure # 0076 offers the benefit of a composite, in that achieving the all-or-none increases the chance for reduction of the risk of long term complications, more so than improvement of a single component alone and additional benefit in that the components that are collected as part of the composite can be measured and used for quality improvement efforts to move the needle towards achieving increased optimal care rates.
In Minnesota, we have been fortunate to witness improved care for Minnesotans with chronic conditions and believe that transparency and focus on measuring and improving goals has played a part in this transformation. Currently 40% of ischemic vascular disease patients in Minnesota are achieving all targets for the components of the composite (optimal care). For example, in Minnesota, compliance with one part of the component, daily aspirin use, is fairly high, but there is still room for improvement in blood pressure and LDL control. Focusing on these two components would improve the percentage of patients achieving all components of the composite.

0075: IVD: Complete Lipid Profile and LDL Control <100
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:58 PM

Comments
801: Dear NQF,

This element is included in endorsed measure #0076 Optimal Vascular Disease care. The composite Optimal Vascular Disease measure is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In lieu of the fact that there is an endorsed composite measure this single service measure should be considered for retirement.

Gail Amundson, Caterpillar representative

0074: Chronic Stable Coronary Artery Disease: Lipid Control
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:58 PM

Comments
800: Dear NQF,

This element is included in endorsed measure #0076 Optimal Vascular Disease care. The composite Optimal Vascular Disease measure is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In lieu of the fact that there is an endorsed composite measure this single service measure should be considered for retirement.

Gail Amundson, Caterpillar representative

0073: IVD: Blood Pressure Management
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:57 PM

Comments
799: Dear NQF,

This element is included in endorsed measure #0076 Optimal Vascular Disease care. The composite Optimal Vascular Disease measure is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In lieu of the fact that there is an endorsed composite measure this single service measure should be considered for retirement.

Gail Amundson, Caterpillar representative

0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:57 PM

Comments
798: Dear NQF,

This element of CAD care is included in endorsed measure #0076 Optimal Vascular Disease care. The composite Optimal Vascular Disease measure is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In lieu of the fact that there is an endorsed composite measure this single service measure should be considered for retirement.

Gail Amundson, Caterpillar representative

0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:53 PM

Comments
797: Dear NQF,

This element of CAD care is included in endorsed measure #0076 Optimal CAD care. The composite Optimal CAD measure is superior for providing information to clinicians, stimulating practice redesign, and is more intuitive for patients.

In lieu of the fact that there is an endorsed composite measure this single service measure should be considered for retirement.

Gail Amundson, Caterpillar representative

0013: Hypertension: Blood Pressure Control
Comment By
Name: Dr. Gail M. Amundson, MD, FACP
Organization: Caterpillar Inc.

Date - Time: Jul 05, 2011 - 04:48 PM

Comments
796: Dear NQF,

One important purpose of measurement is to determine how well clinical practice is stacking up compared to evidence-based recommendations. This measure is weak because of the positive numerator credit for certain patients not meeting goal.

Gail Amundson, Caterpillar Representative