NATIONAL QUALITY FORUM

TO: Cardiovascular Endorsement Maintenance Steering Committee

FR: Reva Winkler, MD, MPH and Kathryn Streeter, MS

RE: Comments on Draft Report *National Voluntary Consensus Standards for Cardiovascular Disease: Endorsement Maintenance, 2010*

DA: September 6, 2011

The conference call on September 12, 2011 will continue the review of comments received during the recent NQF Member and Public Comment period.

Measures Not Recommended

A comment letter from ACCF/AHA/PCPI requested reconsideration of five measures not recommended. The summary of the Committee's evaluation are tabulated below. (The title is hyperlinked to the measure submission form).

STAFF NOTE: Measures without testing data for reliability and validity do not meet NQF's criteria for endorsement.

0065 Chronic stable coronary artery disease: symptom and activity assessment
Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period for whom there is documented results of an evaluation of level of activity AND an evaluation of presence or absence of anginal symptoms in the medical record. Numerator Statement: Patients for whom there are documented results of an evaluation of level of activity AND an evaluation of presence or absence of anginal symptoms* in the medical record. *Evaluation of level of activity and evaluation of presence or absence of anginal symptoms should include: •Documentation of Canadian Cardiovascular Society (CCS) Angina Class OR •Completion of a disease-specific questionnaire (eg, Seattle Angina Questionnaire or other validated questionnaire) to quantify angina and level of activity. Numerator Definition: Canadian Cardiovascular Society (CCS) Angina Classification Class 0: Asymptomatic Class 1: Angina with strenuous exercise Class 2: Angina with moderate exertion Class 3: Angina with mild exertion 1. Walking 1-2 level blocks at normal pace 2. Climbing 1 flight of stairs at normal pace Class 4: Angina at any level of physical exertion Denominator Statement: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period. Exclusions: None Adjustment/Stratification: No risk adjustment necessary Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process Data Source: Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data. This measure, in its previous specifications, is currently being used in the ACCF PINNACLE registry for the outpatient office setting. Measure Steward: AMA PCPI
STEERING COMMITTEE EVALUATION
1. Importance to Measure and Report: Y-8; N-13 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)*

0065 Chronic stable coronary artery disease: symptom and activity assessment
Rationale: • Measure introduced as a means to ensure there was documentation of the system burden and the activity that precipitated those symptoms. Not an outcomes measure. • Evidence lacking; no documentation of gap. • Testing data not provided.
Does the Measure Meet Criteria for Endorsement: No --Did not pass Importance to Measure and Report.
The developers submitted a letter to the Steering Committee disagreeing with the Committee's evaluation and requested a reconsideration of the measure evaluation citing the following: • "a notable gap in patient-centric measures that would focus attention on patient-reported outcomes, including their symptoms, function and health-related quality of life"; and • symptoms are an outcome and that there are racial disparities in symptom management and they want to lay a foundation for future measures of efficacy and appropriateness. The Steering Committee agreed that the measure, as specified, is a process measure that is not linked to an intermediate or ultimate outcome. Measure introduced as a means to ensure there was documentation of the patient burden and the activity that precipitated those symptoms and additionally noted: • There is no reliability or validity data that says the results distinguish quality at the physician level. • Evidence is lacking. What is the data/evidence that just doing an assessment is related to patient satisfaction, better outcomes, more or less angioplasty, or less MIs? • What is the gap? General perception that clinicians are not doing this well. PINNACLE data = 85.5%. • Testing data not provided. Steering Committee re-vote on Importance: Yes – 4, No -11
RECOMMENDATION: REMOVE ENDORSMENT

0077 Heart failure: Symptom and activity assessment
Description: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented Numerator Statement: Patient visits with quantitative results of an evaluation of both current level of activity and clinical symptoms documented* *Evaluation and quantitative results documented should include: • documentation of New York Heart Association (NYHA) Class OR • documentation of completion of a valid, reliable, disease-specific instrument (e.g., Kansas City Cardiomyopathy Questionnaire, Minnesota Living with Heart Failure Questionnaire, Chronic Heart Failure Questionnaire) Denominator Statement: All patient visits for those patients aged 18 years and older with a diagnosis of heart failure Exclusions: Documentation of medical reason(s) for not evaluating both current level of activity and clinical symptoms (eg, severe cognitive or functional impairment) Adjustment/Stratification: No risk adjustment necessary Level of Analysis: Type of Measure: Process Data Source: Electronic administrative data/claims, Electronic Clinical Data, Paper medical record/flow-sheet, Registry data Measure Steward: American Medical Association, 515 N State St., Chicago, IL 60654
STEERING COMMITTEE EVALUATION
1. Importance to Measure and Report: Y-8; N-10 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Process measure based on a clinical guideline recommendation supported by Level C evidence (expert consensus). • There is evidence to suggest that the variability in provider determination of NYHA class is considerable. • Use of psychometrically standardized questionnaires is more defensible; however, there is no evidence of a link between performing an assessment and outcome. • Unclear if there is a gap in documentation or a gap in clinically asking or assessing.

0077 Heart failure: Symptom and activity assessment

Steering Committee Recommendation for Endorsement: Not recommended.
Rationale: Does not meet the criterion for importance to measure.

- What is the evidence of realtionship to outcomes?
- Gap is likely a gap in documentation.

The developers submitted a letter to the Steering Committee disagreeing with the Committee's evaluation and requested a reconsideration of the measure evaluation citing the following:

- "a notable gap in patient-centric measures that would focus attention on patient-reported outcomes, including their symptoms, function and health-related quality of life"; and
- symptoms are an outcome and that there are racial disparities in symptom management and they want to lay a foundation for future measures of efficacy and appropriateness.

The Steering Committee agreed that the measure, as specified, is a process measure that is not linked to an intermediate or ultimate outcome. Measure introduced as a means to ensure there was documentation of the patient burden and the activity that precipitated those symptoms and additionally noted:

- There is no reliability or validity data that says the results distinguish quality at the physician level.
- Evidence is lacking. What is the data/evidence that just doing an assessment is related to patient satisfaction, better outcomes, more or less angioplasty, or less MIs?
- What is the gap? General perception that clinicians are not doing this well. PINNACLE data = 85.5%.

Steering Committee re-vote on Importance: Yes – 6, No -9

RECOMMENDATION: Not recommended

1486 Chronic stable coronary artery disease: blood pressure control

Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period with a blood pressure <140/90 mm Hg OR patients with a blood pressure =140/90 mm Hg and prescribed 2 or more antihypertensive medications during the most recent office visit
Numerator Statement: Patients with a blood pressure <140/90 mm Hg* OR
Patients with a blood pressure =140/90 mm Hg and prescribed** 2 or more anti-hypertensive medications during the most recent office visit
*BP value used for measure calculation:
•Must be specified in medical record if >1 value (systolic/diastolic) recorded, and
•Must be value upon which treatment decision was based, and
•May be obtained by measurement during office visit or review of a home blood pressure log, OR of a 24-hour ambulatory blood pressure monitor, but the value on which the treatment decision is being made and which might represent the average of more than 1 reading must be documented as such in the medical record
**Prescribed may include prescriptions given to the patient for two or more anti-hypertensive medications at most recent office visit OR patient already taking 2 or more anti-hypertensive medications as documented in current medication list. (Each anti-hypertensive component in a combination medication should be counted individually.)
Instructions:
All patients aged 18 years and older with a diagnosis of coronary artery disease must have a measurement of blood pressure recorded in order to satisfy the measure.
Report number of patients for 1st numerator component (outcome) AND
Report number of patients for 2nd numerator component (process) AND
Report total number of patients for all numerator components
Denominator Statement: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period
Exclusions: Documentation of medical reason(s) for not prescribing two or more antihypertensive medications (e.g., allergy, intolerant, postural hypotension, other medical reasons)
Documentation of patient reason(s) for not prescribing two or more anti-hypertensive medications (e.g., patient declined, other patient reasons)
Documentation of system reason(s) for not prescribing two or more antihypertensive medications (e.g., financial reasons, other reasons attributable to the healthcare delivery system)
Adjustment/Stratification: No risk adjustment necessary
Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process

1486 Chronic stable coronary artery disease: blood pressure control
Data Source: Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data Measure Steward: American Medical Association (AMA PCPI)
1. Importance to Measure and Report: Y-19; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Questions regarding scientific evidence supporting use of two drugs.
2. Scientific Acceptability of Measure Properties: C-2; P-4; M-11 N-4 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)* Rationale: • Errors in measure submission form were addressed: developers confirmed that the numerator includes patients with BP ≥140/90. • Testing has not been completed. No data were provided.
3. Usability: C-2; P-5; M-12; N-2 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)* Rationale: • Clear need for harmonization. • Developer stated the measure will be revised to reflect guidelines changes or updates as needed.
4. Feasibility: C-11; P-9; M-0; N-1 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions—no additional data source; 4d. Susceptibility to inaccuracies/unintended consequences identified; 4e. Data collection strategy can be implemented)* Rationale: • Measure includes exceptions that address end stage renal disease and elderly patients.
Does the Measure Meet Criteria for Endorsement: Y-8; N-12; A-0 Rationale: Testing not completed.
RECOMMENDATION: NOT RECOMMENDED FOR ENDORSEMENT

0013 Hypertension: Blood pressure management
Endorsed measure 0013 was originally Blood Pressure Measurement *Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged ≥ 18 years with diagnosed hypertension.(Retooled eMeasure)* Endorsed measure 0017 was originally Hypertension Plan of Care *Percentage of patient visits during which either systolic blood pressure ≥ 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg, with documented plan of care for hypertension. The revised submission replaces both measures.* Description: Percentage of patients aged 18 years and older with a diagnosis of hypertension with a blood pressure <140/90 mm Hg OR patients with a blood pressure ≥ 140/90 mm Hg and prescribed two or more anti-hypertensive medications during the most recent office visit within a 12-month period Numerator Statement: Patients with a blood pressure <140/90 mm Hg OR Patients with a blood pressure ≥ 140/90 mm Hg and prescribed two or more anti-hypertensive medications during the most recent office visit within a 12-month period Instructions: • Report number of patients for 1st numerator component (outcome) AND • Report number of patients for 2nd numerator component (process) AND • Report total number of patients for all numerator components Denominator Statement: All visits for patients aged 18 years and older with a diagnosis of hypertension Exclusions: • Documentation of medical reason(s) for not prescribing two or more anti-hypertensive medications (e.g., allergy, intolerant, postural hypotension) • Documentation of patient reason(s) for not prescribing two or more anti-hypertensive medications (e.g., patient declined)

0013 Hypertension: Blood pressure management

- Documentation of system reason(s) for not prescribing two or more anti-hypertensive medications (e.g., financial reasons)

Adjustment/Stratification: No risk adjustment necessary
Level of Analysis:
Type of Measure: Process
Data Source: Electronic administrative data/claims, Electronic Clinical Data, Paper medical record/flow-sheet, Registry data
Measure Steward: American Medical Association, 515 N State St., Chicago, IL 60654
This is an updated version of measure 0013 Blood pressure measurement combined with 0017 Plan of care.

STEERING COMMITTEE EVALUATION

1. Importance to Measure and Report: Y-19; N-1

(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)

Rationale:

- This is a new measure combining intermediate outcome and plan of care.
- More evidence is needed to support that two or more anti-hypertensive medications is considered a positive outcome without some additional definition of the measure related to the extent of control achieved (e.g., reduction in BP by a certain % from baseline after medications prescribed).
- Concern that credit could be given for undertreatment.

2. Scientific Acceptability of Measure Properties: C-3; P-5; M-7; N-5

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)

Rationale:

- No current performance data. Reliability and validity are not known. No testing data provided.
- Based on more than one BP measurement.
- BP values from home, office or 24-hour monitoring.
- Unintended consequence for the two medication threshold if patients should be on three.
- Concerns for patients that don't tolerate BP <140/90 versus undertreatment of patients who should be at target.

3. Usability: C-4; P-9; M-6; N-1

(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)

Rationale:

- Title seems misleading because it captures patients who are not under control.

4. Feasibility: C-9; P-6; M-5; N-0

(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions – no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified 4e. Data collection strategy can be implemented)

Rationale:

- Data are generated during care; collection easily implemented.

Does the Measure Meet Criteria for Endorsement?: Y-6; N-14; A-0

Rationale:

- Lack of evidence for two or more drugs component.
- Reliablity and validity not known- no testing data.
- Some patients may need three+ drugs—measure gives credit for patients that may be undertreated.
- New measure—no current performance data.

If applicable, Conditions/Questions for Developer:

1. What is the added value of this measure on top of previous ones?
2. Title seems misleading—it is not just BP control.

Developer Response:

1. Addresses other issues: blood pressure >140/90; includes ambulatory, home, and office monitoring.
2. Developer changed the title to "BP management".

RECOMMENDATION: Not recommended

0070 Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)

Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy
Numerator Statement: Patients who were prescribed* beta-blocker therapy**
*Prescribed may include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list
**Beta-blocker therapy:
•For patients with prior MI, no recommendations or evidence cited in current chronic stable angina guidelines for preferential use of specific agents
•For patients with prior LVEF <40%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate
Denominator Statement: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have prior MI or a current or prior LVEF <40%
Exclusions: Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerant, bradycardia, AV block without permanent pacemaker, arrhythmia, hypotension, asthma, other medical reasons)
Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons)
Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system
Adjustment/Stratification: no risk adjustment necessary
Level of Analysis: Clinicians: Individual; Clinicians: Group
Type of Measure: Process
Data Source: Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data This measure, in its previous specifications, is currently being used in the ACCF PINNACLE registry for the outpatient office setting. Retooled eMeasure
Measure Steward: American Medical Association | 515 N. State St. | Chicago | Illinois | 60654

STEERING COMMITTEE EVALUATION:

1. Importance to Measure and Report: Y-17; N-0

(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)

Rationale:

- Cohort studies have demonstrated significant gaps in care regarding the measure.
- The measure takes into account specific beta blockers mentioned in the guidelines for patients with left ventricular systolic dysfuntion. However, data are lacking on beta blocker therapy with normal left ventricular function, more than three years after a myocardial infarction.

2. Scientific Acceptability of Measure Properties: C-4; P-9; M-2; N-0

(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)

Rationale:

- Measure can be modified to reflect any changes in the guideline recommendations.
- Exclusions include system reasons for not prescribing the beta blocker therapy. Examples provided: insurance, medication availability, and the availability of local cardiac rehabilitation programs.

3. Usability: C-9; P-10; M-2; N-0

(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)

Rationale:

- The measure is already in use but is not in any public reporting initiative.
- Useful measure if it can be revised as needed to be consistent with guidelines.

4. Feasibility: C-9; P-8; M-2; N-0

(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions – no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified 4e. Data collection strategy can be implemented)

Rationale:

- Data are generated as part of the care process and are sometimes available from the EHR.
- Sixty-four percent of the submissions were rejected due to an inaccurate diagnoses code. This was an implementaiton issue, that has been addressed.

0070 Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
Does the Measure Meet Criteria for Endorsement? Y-17; N-4; A-0 Rationale: The measure reports performance that has a strong positive impact on lowering mortality among patients with chronic CAD and LVEF <40%. It is in use and feasibility has been documented. Abstraction of the paper record is prone to error, however.
If applicable, Conditions/Questions for Developer: What is the evidence for beta blocker use beyond 3 years? Response: The newly released AHA guidelines for the prevention of cardiovascular disease in women do note that "Beta-blockers should be used for up to 12 mo (Class I; Level of Evidence A) or up to 3 y (Class I; Level of Evidence B) in all women after MI or ACS with normal left ventricular function unless contraindicated." As a result of this change to the evidence base, the Work Group will be consulted and any necessary modifications will be made to the measure.
Evaluation of competing and related measures: • 0071 AMI: persistence of beta blocker therapy (NCQA) • 0072 CAD: beta-blocker treatment after a heart attack (NCQA) – retired by developer in favor of 0071 • 0160 Beta blocker prescribed at discharge [for AMI] (CMS) The Committee agreed that a measure of adherence to beta blockers after AMI is superior to measuring a single point in time and selected measure, 0071, as "best-in–class" for outpatient measures of beta blocker use. Measure 0160 is recommended for reserve endorsement.
RECOMMENDATION: REMOVE ENDORSEMENT

Competing measures

A commenter asked whether the draft guidance on best-in-class was 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 and 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."

Several commenters identified several pairs of competing measures:

Anti-platelet therapy:

- **0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy (AMA PCPI)**
- **0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic (NCQA)**

Comment: "As the Steering Committee notes, the measure overlaps with NCQA's measure of use of aspirin or anti-thrombotics (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."

Comment: "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."

Lipid control:

- **0075 IVD: Complete lipid profile and LDL control 100 (NCQA)**
- **0074 Chronic stable coronary artery disease: Lipid control (PCPI)**

Comment: "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."

Comment: "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."

STAFF NOTE: NQF's guidance on competing measures and "best-in-class" was used by the Steering Committee.

At the September 2, 2011 conference call the Committee decided to revisit the competing measures questions. Committee members noted that "it is not fair to ask providers for different measures." The measure evaluations are summarized below. The updated guidance on competing measures can be found here beginning on page 18.

Side-by-sides of the measure evaluations:

- **0068: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic (NCQA)**
- **0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy (AMA PCPI)**

0068 Ischemic vascular disease (IVD): use of aspirin or another antithrombotic	0067 Chronic stable coronary artery disease: antiplatelet therapy
Description: The percentage of patients 18 years and older with ischemic vascular disease who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had the following during the measurement year. -Use of aspirin or another antithrombotic Numerator Statement: Use of aspirin or another antithrombotic. Electronic specification: Documentation of use of aspirin or another antithrombotic during the measurement year. Refer to TTable IVD-D to identify the code for prescribed oral anti-platelet therapy. Refer to Table IVD-E to identify medications for oral anti-platelet therapy. Medical Record Specification: Documentation of use of aspirin or another antithrombotic during the measurement year. At a minimum, documentation in the	Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who were prescribed aspirin or clopidogrel. Numerator Statement: Patients who were prescribed aspirin or clopidogrel* within a 12-month period. *Prescribed may include prescription given to the patient for aspirin or clopidogrel at one or more visits in the measurement period OR patient already taking aspirin or clopidogrel as documented in current medication list. Denominator Statement: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period. Exclusions: Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (e.g., allergy, intolerant, receiving other thienopyridine therapy, bleeding coagulation disorders, receiving warfarin therapy, other medical reasons). Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (e.g., patient declined, other patient reasons). Documentation of system reason(s) for not prescribing aspirin or

0068 Ischemic vascular disease (IVD): use of aspirin or another antithrombotic	0067 Chronic stable coronary artery disease: antiplatelet therapy
medical record must include a note indicating the date on which aspirin or another antithrombotic was prescribed or documentation of prescription from another treating physician. Denominator Statement: Patients 18 years or older as of December 31 of the measurement year discharged alive for AMI, CABG, or PCI on or between January 1 and November 1 of the year prior to the measurement year or who had a diagnosis of IVD during both the measurement year and the year prior to the measurement year. Exclusions: None Adjustment/Stratification: No risk adjustment necessary Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process Data Source: Paper medical record/flowsheet; Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record NA ; retooled eMeasure Measure Steward: NCQA	clopidogrel (e.g., lack of drug availability, other reasons attributable to the healthcare system). Adjustment/Stratification: No risk adjustment necessary Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process Data Source: Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data. This measure, in its previous specifications, is currently being used in the ACCF PINNACLE registry for the outpatient office setting. Retooled eMeasure Measure Steward: AMA
1. Importance to Measure and Report: Y-21; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Performance gap demonstrated. The 25th percentile has not broken 90%. • Cost-effective.	1. Importance to Measure and Report: Y-21; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: 1 a. • Secondary prevention of coronary artery disease is a high impact aspect of healhcare. • Quality gap has been established. • This measured process leads to improved health outcomes.
2. Scientific Acceptability of Measure Properties: C-2; P-14; M-4; N-1 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)* Rationale: • Clearly specified with no significant exclusions. • Sufficient supplemental reliability and validity documentation was provided. • According to the measure developer, exclusions for clinical reasons thought to have been less than 5% aren't listed as an exclusion.	2. Scientific Acceptability of Measure Properties: C-16; P-5; M-0; N-0 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)* Rationale: • Well-specified measure. • Important to monitor the "other" exclusion option to prevent increasing percentages over time that may be misleading.
3. Usability: C-12; P-7; M-0; N-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)* Rationale: • Overlap with other measures using aspirin or other antithrombotics.	3. Usability: C-16; P-5; M-0; N-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)* Rationale: • Meaningful and easily understandable to providers and consumers. • Not used yet in public reporting initatives. AHA Get With The Guidelines uses this metric. • Harmonization will need to be addressed.
4. Feasibility: C-13; P-7; M-1; N-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions—no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified; 4e. Data collection strategy can be implemented)*	4. Feasibility: C-19; P-2; M-0; N-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions—no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified; 4e. Data collection strategy can be implemented)*

0068 Ischemic vascular disease (IVD): use of aspirin or another antithrombotic	0067 Chronic stable coronary artery disease: antiplatelet therapy
Rationale: • Data will be generated as a byproduct of the care process during healthcare delivery as well as electronically. • Important to note this measure has been retooled for meaningful use.	Rationale: • Data elements are readily available and retreiveable. • Exlcusions are available with routine evaluation of the data that exist. • Retooled eMeasure.
Does the Measure Meet Criteria for Endorsement: Y-20; N-1; A-0 Rationale: • Important, effective care process. • Gap in care— further opportunity for improvement.	Does the Measure Meet Criteria for Endorsement: Y-21; N-0; A-0 Rationale: • High impact aspect of healthcare. • Aspirin as part of a secondary prevention plan is a very important and proven intervention. • Easy to understand and use this metric.
If Applicable, Conditions/Questions for Developer: • Possible unintended consequences due to lack of exclusions Developer response: o While some exclusions may be coded and included in administrative data and are relatively easily accessible for chart review, a recent paper by Kmetik et al., indicates that MOST exclusions are relative. Many of the relative contraindications appear to be either minor in nature, or can be overcome by use of different medications. In terms of exceptions (patients removed from the denominator by the clinician at the time of service) , the same research showed that the rates of physician added exceptions were quite low, inconsistent in rate, and many had to come from extensive manual chart review even from an EMR. o Codes (like CPT-II codes) that might be used to indicate exceptions are not widely used, and at the present time cannot be easily audited for accuracy. o In addition, the measure allows for physician discretion in prescribing alternative oral anti-platelet therapies when aspirin is contraindicated. o The performance goal is not 100%. Kmetik KS, O'Toole MF, Bossley H, Brutico CA, Fischer G, Grund SL, Gulotta BM, Hennessey M, Kahn S, Murphy KM, Pacheco T, Pawlson LG, Schaeffer J, Schwamberger PA, Scholle SH, Wozniak G. Exceptions to outpatient quality measures for coronary artery disease in electronic health records. Ann Intern Med. 2011 Feb 15;154(4):227-34. • Harmonization with 0076 and 0067: Developer response: NCQA is open to harmonizing this and other measures with other developers' measures and while in some other areas, PCPI and NCQA measures have been harmonized, no direct harmonization has been performed for CV measures at this time. NQF is preparing cross walks for both competing measures' evaluation and harmonization. NCQA and AMA PCPI-ACC_AHA have initiated discussions regarding harmonizing elements within this measure where there is potential for harmonization. Harmonization efforts will continue in areas of exclusions and whether it is possible (and/or alternative strategies) to	If Applicable, Conditions/Questions for Developer: Harmonization with measures 0076 and 0068: Developer Response: Upon original development of the measure set in 2003 and as part of the 2009 update, patients with chronic stable coronary artery disease were identified as the denominator for the measure set to be consistent with ACC/AHA clinical practice guidelines for patients with chronic stable angina which served as the primary evidence base to support measure development. The specific ICD-9 codes selected for CAD encompass all of the relevant codes in the 410-414 series, as well as procedure codes for patients who have undergone coronary bypass surgery or percutaneous coronary intervention. The 410-414 series of codes have been previously identified by other sources, including the American Heart Association as part of their yearly statistical reports, as representative of patients with coronary heart disease.The measure is limited to the only antiplatelet agents (ie, aspirin and clopidogrel) recommended by the guideline, as follows: Aspirin should be started at 75 to 162 mg per day and continued indefinitely in all patients unless contraindicated (Class I Recommendation, Level A Evidence). Clopidogrel [is recommended] when aspirin is absolutely contraindicated (Class IIa Recommendation; Level of Evidence B).This represents an update to the previous version of the measure that allowed for aspirin, clopidogrel or a combination of aspirin and extended release dipyridamole and is consistent with changes to the evidence. The Work Group also included denominator exceptions for the measure so that physicians can exclude patients for whom aspirin or clopidogrel is not appropriate. If the patient has been prescribed another type of antithrombotic for valid reasons, the medical reason exception might apply.

0068 Ischemic vascular disease (IVD): use of aspirin or another antithrombotic	0067 Chronic stable coronary artery disease: antiplatelet therapy
harmonize denominator conditions (IVD vs. CAD) and the potential risks and benefits to populations being measured. There remain significant differences in the respective measures related to complexity, feasibility, standardization, and medication prescribing. As previously noted, the process for harmonization for most specifications must be carried out in a careful and deliberate manner since changes in specifications can affect both trendability of results as well as affect completeness, accuracy and reliability of data collection.	
Evaluation of Competing and Related Measures • 0076 Optimal vascular care • 0068 IVD: use of aspirin or antithrombotics (NCQA) • 0067 CAD: antiplatlet therapy (PCPI) Several Committee members suggested that the composite measure 0076 would be sufficient to address the use of anti-thrombotics along with other important aspects of care. The Committee was divided and did not reach consensus on whether to recommend the composite only. In comparing measures 0068 and 0067, some Committee members questioned whether these are really competing measures since they have different data collection methods, applicable settings, exclusions and cover different patients. Additionally: • IVD is a broader denominator that includes coronary artery disease (CAD), cerebrovascular disease (CVD) and peripheral vascular disease (PAD). • The evidence for aspirin use is very strong for CAD and CVD, less so for PAD though the guidelines do recommend aspirin in PAD. • 0067 allows for exclusions, such as warfarin use. Vote to recommend for endorsement: Yes – 11, No -4	Evaluation of Competing and Related Measures • 0076 Optimal vascular care • 0068 IVD: use of aspirin or antithrombotics (NCQA) • 0067 CAD: antiplatlet therapy (PCPI) Several Committee members suggested that the composite measure 0076 would be sufficient to address the use of anti-thrombotics along with other important aspects of care. The Committee was divided and did not reach consensus on whether to recommend the composite only. In comparing measures 0068 and 0067, some Committee members questioned whether these are really competing measures since they have different data collection methods, applicable settings, exclusions and cover different patients. • IVD is a broader denominator that includes coronary artery disease (CAD), cerebrovascular disease (CVD) and peripheral vascular disease (PAD). • The evidence for aspirin use is very strong for CAD and CVD, less so for PAD though the guidelines do recommend aspirin in PAD. • 0067 allows for exclusions, such as warfarin use. Vote to recommend for endorsement: Yes – 12, No -3
RECOMMENDATION: MAINTAIN ENDORSEMENT	RECOMMENDATION: MAINTAIN ENDORSEMENT

- **0075 IVD: Complete lipid profile and LDL control 100 (NCQA)**
- **0074 Chronic stable coronary artery disease: Lipid control (PCPI)**

0075 IVD: Complete lipid profile and LDL control <100	0074 Chronic stable coronary artery disease: lipid control
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year	Endorsed measure 0074 was originally CAD: drug therapy for lowering LDL-cholesterol *Percentage of patients with CAD who were prescribed a lipid – lowering therapy (based on current ACC/AHA guidelines)*. Original version is a retooled eMeasure. Description: Percentage of patients aged 18 years and older with

0075 IVD: Complete lipid profile and LDL control <100	0074 Chronic stable coronary artery disease: lipid control
and the year prior to measurement year, who had each of the following during the measurement year. • Complete lipid profile • LDL-C control <100 mg/dL Numerator Statement: A complete lipid profile performed during the measurement year. A LDL-C control result of <100mg/dL using the most recent LDL-C screening test during the measurement year. Denominator Statement: Patients 18 years of age an older as of December 31 of the measurement year who were discharged alive for AMI, CABG, or PCI on or between January 1 and November 1 of the year prior to the measurement year or who had a diagnosis of IVD during both the measurement year and the year prior to the measurement year. Exclusions: None Adjustment/Stratification: no risk adjustment necessary NA NA Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Outcome Data Source: Paper medical record/flowsheet; Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Lab data NA; retooled eMeasure Measure Steward: NCQA	a diagnosis of coronary artery disease seen within a 12-month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result ≥100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin. Numerator Statement: Patients who have a LDL-C result <100 mg/dL OR Patients who have a LDL-C result ≥100 mg/dL and have a documented plan of care1 to achieve LDL-C <100 mg/dL, including at a minimum the prescription of a statin within a 12-month period. Definitions: *Documented plan of care may also include: documentation of discussion of lifestyle modifications (diet, exercise); scheduled re-assessment of LDL-C. *Prescribed may include prescription given to the patient for a statin at one or more visits in the measurement period OR patient already taking a statin as documented in current medication list. Numerator Instructions: The first numerator option can be reported for patients who have a documented LDL-C < 100 mg/dL at any time during the measurement period. Denominator Statement: All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period. Exclusions: Documentation of medical reason(s) for not prescribing a statin (e.g., allergy, intolerance to statin medication(s), other medical reasons). Documentation of patient reason(s) for not prescribing a statin (e.g., patient declined, other patient reasons). Documentation of system reason(s) for not prescribing a statin (e.g., financial reasons, other system reasons). Adjustment/Stratification: No risk adjustment necessary Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process Data Source: Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Registry data. This measure, in its previous specifications, is currently being used in the ACCF PINNACLE registry for the outpatient office setting. Measure Steward: AMA
1. Importance to Measure and Report: Y-19; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Evidence-based, intermediate outcome.	1. Importance to Measure and Report: Y-20; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Considerable evidence in terms of opportunity for improvement and impact. • Performance gaps demonstrated across insured populations and across provider. • A measure based on clinical guidelines.
2. Scientific Acceptability of Measure Properties: C-15; P-6; M-0; N-0 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g.*	2. Scientific Acceptability of Measure Properties: C-9; P-8; M-4; N-0 *(2a. Precise specifications; 2b. Reliability testing; 2c. Validity testing; 2d. Exclusions justified; 2e. Risk adjustment/stratification; 2f. Meaningful differences; 2g. Comparability; 2h. Disparities)*

0075 IVD: Complete lipid profile and LDL control <100	0074 Chronic stable coronary artery disease: lipid control
Comparability; 2h. Disparities) Rationale: • Reliability testing is in process and currently not available. • Clarifications needed in the specifications for the target population's age: 18 years and older or 18 years to 75 years.	Rationale: Concerns regarding patient preference type or patient refusal type of exclusion; however, in general, exceptions are used rarely.
3. Usability: C-20; P-0; M-0; N-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)* Rationale: • Already in use as part of HEDIS measures and will need to be harmonized with other lipid measures. • Data is generated as a byproduct of care processes during delivery and is available as electronic data.	3. Usability: C-6; P-11; M-4; N-0 *(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)* Rationale: • Deomonstrated through multiple quality improvement programs. • Not in use for public reporting at this time, but will be in the future. • Additive values need to be addressed, and measure will need to be harmonized with other lipid measures.
4. Feasibility: C-20; P-1; M-0; N-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions—no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified; 4e. Data collection strategy can be implemented)* Rationale: • Measure has been retooled for EHR meaningful use.	4. Feasibility: C-8; P-11; M-1; N-0 *(4a. Clinical data generated during care process; 4b. Electronic sources; 4c. Exclusions—no additional data source; 4d. Susceptibility to inaccuracies/ unintended consequences identified; 4e. Data collection strategy can be implemented)* Rationale: • Data can be extracted electronically.
Does the Measure Meet Criteria for Endorsement: Y-21; N-0; A-0 Rationale: • LDL <100 in IVD is an accepted standard backed by evidence. • There is a gap in performance. • The measurement is being done, it is feasible, and improvement would likely lead to health benefits.	Does the Measure Meet Criteria for Endorsement: Y-17; N-4; A-0 Rationale: • Opportunity for improvement. • Evidence-based, outcome measure.
If Applicable, Conditions/Questions for Developer: • What about intolerance to statins? Response: While some exclusions to statins are coded and included in administrative data and are relatively easily accessible for chart review, a recent paper by Kmetik et al., indicates that MOST exclusions are relative so that the majority of patients who have "contraindications" to statins are actually ON statins. Many of the relative contraindications (muscle cramping, GI disturbance, etc.) appear to be either minor in nature, or can be overcome by use of different medications. In terms of exceptions (patients removed from the denominator by the clinician at the time of service), the same research showed that the rates of physician added exceptions were quite low, inconsistent in rate, and many had to come from extensive manual chart review even from an EMR. In addition this measure is focused on the reducing	If Applicable, Conditions/Questions for Developer: • How are patients who have not had an LDL test performed counted in the measure? • Response: All patients aged 18 years and older with a diagnosis of coronary artery disease must have an LDL-C recorded in order to satisfy the measure. The measure specifications will be clarified that patients who have not had an LDL test performed would not meet the measure.

0075 IVD: Complete lipid profile and LDL control <100	0074 Chronic stable coronary artery disease: lipid control
cholesterol, but is not prescriptive about the use of a statin. There are other mechanisms by which cholesterol reduction can be achieved (i.e., modifications in diet, exercise, etc.)	
Evaluation of Competing and Related Measures • 0076 Optimal vascular care • 0075 IVD- complete lipid profile and LDL control <100 (NCQA) • 0074 Chronic stable coronary artery disease: lipid control (PCPI) Several Committee members suggested that the composite measure 0076 would be sufficient to address the use of anti-thrombotics along with other important aspects of care. The Committee was divided and did not reach consensus on whether to recommend the composite only. In comparing measures 0075 and 0074, , some Committee members questioned whether these are really competing measures since they have different data collection methods, applicable settings, exclusions and cover different patients. Vote to recommend for endorsement: Yes – 9, No -6	Evaluation of Competing and Related Measures • 0076 Optimal vascular care • 0075 IVD- complete lipid profile and LDL control <100 (NCQA) • 0074 Chronic stable coronary artery disease: lipid control (PCPI) Several Committee members suggested that the composite measure 0076 would be sufficient to address the use of anti-thrombotics along with other important aspects of care. The Committee was divided and did not reach consensus on whether to recommend the composite only. In comparing measures 0075 and 0074, some Committee members questioned whether these are really competing measures since they have different data collection methods, applicable settings, exclusions and cover different patients. Vote to recommend for endorsement: Yes – 14, No -1
RECOMMENDATION: MAINTAIN ENDORSEMENT	RECOMMENDATION: MAINTAIN ENDORSEMENT

ACTION ITEM: After reviewing the comments, the side-by-side evaluations and the competing measure guidance, Committee should choose between the competing measures or provide a compelling rationale for endorsing two similar measures.