NATIONAL QUALITY FORUM

CONFERENCE CALL OF CARDIOVASCULAR ENDORSEMENT MAINTENANCE STEERING COMMITTEE

May 11, 2011

***Committee Members Present*:** Raymond Gibbons, MD (chair); Mary George, MD, MSPH (vice-chair); Carol Allred, RN; Rochelle Ayala, MD, FACP; Dianne Jewell, PT, DPT, PhD, CCS; Bruce Koplan, MD, MPH; Thomas Kottke, MD, MSPH; George Philippides, MD, FACC; Jon Rasmussen, PharmD; Devorah Rich, PhD; Andrea Russo, MD; Roger Snow, MD, MPH; Kathleen Szumanski, MSN, RN, NE-BC

***NQF Staff Present*:** Karen Pace, PhD, RN (Senior Director, Performance Measures); Heidi Bossley, MSN, MBA (Managing Director of Consensus Development Process); Reva Winkler, MD, MPH (Project Senior Advisor); Ashley Morsell, MPH (Project Manager); Kathryn Streeter, MS (Project Manager); Tenee Davenport (Project Analyst)

***Others Present*:** Laura Blum (Heart Rhythm Society); Robert Bonow, MD (ACC/PCPI); Jensen Chiu, (ACC); Del Conyers (Heart Rhythm Society); Joanne Cuny; Joanne Debuhr; Mark Estes (ACC); John Halperin (ACC); Kris Leber (OFMQ); Kristyne McGuinn (ACC); Bob Rehm (NCQA); Melanie Shahriary (ACC); Anne Snowden (MNCM); John Spertus, MD, MPH (ACC/PCPI); Samantha Tierny, MPH (PCPI); Karen Kmetik, PhD (PCPI)

MEETING PURPOSE

The purpose of the conference call was to follow up on issues remaining from the Cardiovascular Endorsement Maintenance 2010 project, including deferred measures, related and competing measures, and possible inactive endorsement. The Steering Committee also considered a letter from ACCF/AHA/PCPI, dated May 3, 2011, requesting reconsideration of several measures previously discussed and providing feedback to the initial discussion on competing measures. The Committee voted on the various measures after the call using a Survey Monkey tool.

MEASURES PREVIOUSLY DISCUSSED

The Committee deferred final evaluation of measure 0073, awaiting responses from the measure developer.

0073 IVD: Blood pressure management
Description: The percentage of patients 18 years of age and older who were discharged alive with 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 BP reported as under control <140/90 Numerator Statement: The numerator is the number of patients in the denominator whose most recent blood pressure is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and the diastolic BP must meet the desired threshold of <140/90 mm Hg Denominator Statement: Patients 18 years or 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: All patients with ESRD, who are pregnant or who had an admission to a non-acute inpatient setting during the measurement year

0073 IVD: Blood pressure management

Adjustment/Stratification: No risk adjustment necessary NA
Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Intermediate Outcome
Data Source: Paper medical record/flow-sheet; Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record
Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, DC 20005

Does the Measure Meet Criteria for Endorsement: Deferred (Based on measure as submitted: Y -8; No-12)
Rationale:
The Steering Committee deferred final evaluation of this measure citing several concerns:

- Remove 140/80 —lack of evidence for this target (140/90 only is in retooled EHR specifications).
- Exclusions for elderly patients or patient's intolerance of lower BP.
- Home monitoring BP not included.
- Specifications for exclusiosn of ESRD not clear.

After reviewing the measure developer's responses, does the measure meet NQF's criteria for endorsement?
As currently specified (BP <140/90, no age limits): Yes-3; No-9

ONLY IF the measure is harmonized with 0076 as to age (18-75 years): Yes-12; No-1

1. Importance to Measure and Report: Y-21; N-0
(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)
Rationale: Extensive evidence of benefit for achieving blood pressure control in patients with ischemic vascular disease.

2. Scientific Acceptability of Measure Properties: C-0; P-16; 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)
Rationale:

- What is the evidence for BP target of <140/80?
- Evidence base for elderly population and benefit of taking their systolic to less than 140 is lacking.
- Home blood pressure measurements are not being accepted, and the absence of that is considered a real problem.
- Measure submission included evidence supporting importance of excluding end stage renal disease patients from this measure; however, they are not listed as exclusion in the measure specifications.

3. Usability: C-4; P-15; M-1; N-0
(3a. Meaningful/useful for public reporting and quality improvement; 3b. Harmonized; 3c. Distinctive or additive value to existing measures)
Rationale:

- Measuring blood pressure only once in the year after a procedure is thought to be not very meaningful in patients who have fluctuated.
- Gap demonstrated with the 10th percentile being 28 and the 90th being 62.
- Step-wise process for identifying patients in medical records; this submission is a hybrid specification and a physician-level measure.

4. Feasibility: C-5; P-13; 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:

- Burden for public reporting purposes to have it as a hybrid measure if only 50 percent of physicians' offices use electronic health records.

Measure developer response:

- Removed the 140/80 specification.
- Clarified the end stage renal disease exclusion.
- Willing to harmonize with measure 0076 that has an upper age limit of 75 years.
- Explains the challenges of using home blood pressure monitoring data.

Steering Committee discussion: The Committee generally agreed that the developer responded to the Committee's concerns, particularly if the measure is harmonized with measure 0076 for age. The Committee will re-vote on whether the revised measure meets the criteria for endorsement.

ACCF/AHA/PCPI requested reconsideration of the following three measures:

- 0013 Hypertension: Blood pressure control
- 0065 Chronic stable coronary artery disease: Symptom and activity assessment
- 0077 Heart failure: Symptom and activity assessment

0013 Hypertension: Blood pressure control
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 2 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 2 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 2 or more anti-hypertensive medications (e.g., allergy, intolerant, postural hypotension) Documentation of patient reason(s) for not prescribing 2 or more anti-hypertensive medications (e.g., patient declined) Documentation of system reason(s) for not prescribing 2 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
Steering Committee Recommendation for Endorsement: Y-6; N-14; A-0 Rationale: • New measure—no performance data. • Reliability and validity not known. • Some patient may need 3+ drugs—measure gives credit for patients that may be undertreated. Reconsideration: Does the measure meet NQF's criteria for endorsement? Yes-6; No-9
If applicable, Conditions/Questions for Developer: What is the added value of this measure on top of previous ones? Developer Response: Addresses other issues: blood pressure > 140-90; includes ambulatory, home, and office monitoring.
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 2 or more anti-hypertensive medications are 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 percentage from baseline after medications prescribed). • Some patients may need 3 drugs—measure gives credit for patients that may be under treated.

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:

- New measure: no current performance data. Reliability and validity are not known.
- Based on more than one BP measurement.
- BP values from office, home, or 24-hour monitoring.
- Concerns for patients that don't tolerate BP < 140/90 versus under treatment of patients who should be at target.
- Unintended consequence for the 2 medication threshold if patients should be on 3.

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:

- New measure combining previous measures of BP measurement and plan of care.
- Title seems somewhat misleading. Developer changing title to "management".

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.

ACCF/AHA/PCPI requested reconsideration of this measure because they disagree with the Committee's concerns that two drugs may not be sufficient for controlling blood pressure and "a measure also needs to avoid adverse consequences and be feasible to collect."

Steering Committee discussion: The Committee and developer again discussed the balance between under treatment versus adverse consequences at length. Committee members asked about the data/evidence for two drugs compared to three or more drugs.

Staff note: The Committee also evaluated measure 0018 Controlling high blood pressure (NCQA)—Percentage of patients with last BP <140/90 mm Hg [ages 18-85 years] and determined that it meets the criteria for endorsement.

The Committee will re-vote on whether measure 0013 meets the 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 are 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 (e.g., 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

0065 Chronic stable coronary artery disease: Symptom and activity assessment
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: American Medical Association, 515 N. State St., Chicago, IL 60654
Does the Measure Meet Criteria for Endorsement: Did not pass Importance to Measure and Report. Rationale:
If applicable, Conditions/Questions for Developer:
1. Importance to Measure and Report: Y-8; N-13 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale: • Measure introduced as a means to ensure there was documentation of the patient burden and the activity that precipitated those symptoms. • The measure is performing the assessment, not whether it is acted on. Not an outcomes measure. • There is no reliability or validity data that says the results distinguish quality at the physician level. • Evidence 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. Reconsideration: Does the measure meet NQF's criteria for Importance to Measure and Report (impact; gap; evidence/relationship to outcomes)? Yes-4; No-11

ACCF/AHA/PCPI requested reconsideration of measure 0065 because "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." They also noted that symptoms are an outcome, there are racial disparities in symptom management, and they want to lay a foundation for future measures of efficacy and appropriateness.

The measure developer presented lengthy arguments in favor of this measure reiterating the points outlined in the letter.

Steering Committee discussion:

- PINNACLE data shows 85.5% compliance—these are the highly motivated providers.
- Several Committee members pointed out that this measures the process of an assessment only and is not tied to any action and it does not include the results of the assessment.

The Committee will re-vote on the Importance criterion for measure 0065.

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:

0077 Heart failure: Symptom and activity assessment
• 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 (e.g., 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 Recommendation for Endorsement: Did not meet Importance to Measure and Report criteria Rationale: Does not meet the criterion for importance to measure. Concerns with 1c: outcome or evidence.
If applicable, Conditions/Questions for Developer:
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 a score on the measure and outcomes. • Unclear if there is a gap in documentation or a gap in clinically asking or assessing. • Testing results not included with submission Reconsideration: Does the measure meet NQF's criteria for Importance to Measure and Report (impact; gap; evidence/relationship to outcomes)? Yes-6; No-9

ACCF/AHA/PCPI requested reconsideration of measure 0077 for the same reasons as measure 0065.

The Steering Committee did not specifically discuss this measure separate from measure 0065. The Committee will re-vote on the Importance criterion for measure 0077.

RELATED AND COMPETING MEASURES

The Committee continued the discussion of competing measures by reviewing the pros and cons outlined by staff in the briefing memo as well as the comments from ACCF/AHA/PCPI. NQF staff also advised the Committee that NQF's ultimate goals would be to endorse a composite measure and individual components that are all specified for electronic health records (EHRs) and to develop recommendations that move the portfolio in that direction. The Committee understood that it will first vote on whether to recommend the composite (0076) only or the composite and individual measures. If the Committee supports the composite only, the following discussion is unnecessary.

Steering Committee's recommendation for endorsement of 0076: Optimal vascular care (composite) ONLY: Yes-10; No-9.

If the Committee decides to recommend the individual measures as well as the composite, then issues about two competing measures remain:

- 0068 Ischemic vascular disease (IVD): Use of aspirin or anti-thrombotic AND/OR
- 0067 Chronic stable coronary artery disease: Anti-platelet therapy

0068 Ischemic vascular disease (IVD): Use of aspirin or antithrombotic

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
Numerator Statement: Use of aspirin or another antithrombotic
Electronic specification:
Documentation of use of aspirin or another antithrombotic during the measurement year. Refer to table 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 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 NA None
Level of Analysis: Clinicians: Individual; Clinicians: Group Type of Measure: Process
Data Source: Paper medical record/flow-sheet; Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record
Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, DC 20005

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.

If the Committee recommends both individual measures and composite: Yes-11; No-4

If applicable, Conditions/Questions for Developer:
Title and description do not match numerator—developer clarified the description as above.

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.

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.
- Title and description do not match numerator.
- According to the measure developer, exclusions for clinical reasons thought to have been less than 5% aren't listed as an exclusion.

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 anti-thrombotics.

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)
Rationale:

- Data will be generated as a byproduct of the care process during health care delivery as well as electronically.

0068 Ischemic vascular disease (IVD): Use of aspirin or antithrombotic
• Important to note this measure has been retooled for meaningful use.

0067 Chronic stable coronary artery disease: Antiplatelet therapy
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 clopidogrel (e.g., lack of drug availability, 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. Measure Steward: American Medical Association, 515 N. State St., Chicago, IL 60654
Does the Measure Meet Criteria for Endorsement: Y-21; N-0; A-0 Rationale: • High-impact aspect of health care. • Aspirin as part of a secondary prevention plan is a very important and proven intervention. • Easy to understand and use this metric. If the Committee recommends both individual measures and composite: Yes-12; No-3
If applicable, Conditions/Questions for Developer:
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 healh care. • Quality gap has been extablished. • This measured process leads to improved health outcomes.
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-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-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)* Rationale:

0067 Chronic stable coronary artery disease: Antiplatelet therapy
• Data elements are readily available and retrievable. • Exclusions are available with routine evaluation of the data that exisits. • Retooled eMeasure.

Steering Committee discussion of measures 0068 and 0067:

- 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 and less so for PAD, although the guidelines do recommend aspirin in PAD.
- Measure 0067 allows for exclusions, such as warfarin use.

0075 IVD: Complete lipid profile and LDL control <100 (NCQA) AND/OR
0074 Chronic stable coronary artery disease: Lipid control (PCPI)

0075 IVD: Complete lipid profile and LDL control <100
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 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 31st 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/flow-sheet; Electronic administrative data/claims; Electronic clinical data; Electronic Health/Medical Record; Lab data Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, DC 20005
Does the Measure Meet Criteria for Endorsement: Y-21; N-0; A-0 Rationale: • LDL less than 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. If the Committee recommends both individual measures and composite: Yes-9; No-6
If applicable, Conditions/Questions for Developer: • Clarify age inclusion. Response: The submission has been corrected in the description to read 18 years of age and older. • 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.
1. Importance to Measure and Report: Y-19; N-0 *(1a. Impact; 1b. Performance gap; 1c. Outcome or Evidence)* Rationale:

0075 IVD: Complete lipid profile and LDL control <100

- Evidence-based, intermediate outcome.

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. 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.

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.

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.

0074 Chronic stable coronary artery disease: Lipid control

Description: Percentage of patients aged 18 years and older with 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 <100 mg/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 careto 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: American Medical Association, 515 N. State St., Chicago, IL 60654

Does the Measure Meet Criteria for Endorsement: Y-17; N-4; A-0
Rationale:

- Opportunity for improvement.
- Evidence-based.

If the Committee recommends both individual measures and composite: Yes-14; No-1

If applicable, Conditions/Questions for Developer:

0074 Chronic stable coronary artery disease: Lipid control
• 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.
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 process measure based on clinical guidelines.
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)* Rationale: • Concerns regarding patient preference type or patient refusal type of exclusion; however, in general, exceptions are used rarely.
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: • Demonstrated 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-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.

Steering Committee discussion of measures 0075 and 0074:

- Similar issues of IVD and CAD populations.
- Measure 0074 is applicable to skilled nursing facilities.

General Discussion on Competing Measures

Committee members found it very difficult to compare similar measures. Each measure is tailored to a specific data collection method, includes variations in applicability for setting, and handles exclusions differently. Given these differences, some Committee members wondered whether these measures are really competing measures. NQF staff advised the Committee that it may recommend multiple measures with explicit rationale of the need for multiple measures. The Committee will vote on a recommendation for each of the individual measures.

Phase 2 Competing Measures

Each of three pairs of competing measure from Phase 2 consist of one measure under review (1525, 0081, 0083) and a similar measure from Active Health (0624, 0610, 0615) that are based on administrative/claims data. The Committee has determined that measures 0081 and 0083 meet the criteria for endorsement. The Committee believed that measure 1525 would meet the criteria for endorsement only if it were revised to include other Food and Drug Administration-approved drugs (i.e., dabigatran) as well as warfarin. The measure developers have responded with the attached redline changes to the measure that include the revisions requested by the Committee.

On Monday, May 9, 2011, the Consensus Standards Approval Committee (CSAC) determined that the guidance on competing measures should more explicitly state that multiple measures are acceptable if they use different data platforms, particularly administrative/claims data. Committee members agreed that the measurement enterprise is in transition toward a uniform data system but currently requires measures for multiple data sources until EHRs are more widely used. The Committee will vote on recommendation for endorsement for measures 1525, 0081, and 0083.

The committee voted and unanimously recommended (Yes-15; No-0) the following for endorsement:

- 1525 Chronic anticoagulation therapy [for a-fib or a-flutter] (PCPI)
- 0081 Heart failure: ACEI/ARB therapy (PCPI)
- 0083 Heart failure: Beta blocker therapy (PCPI)

NEXT STEPS

1. NQF staff will quickly prepare a summary of the call to circulate to the Committee with the link to the Survey Monkey ballot. The recording of the call will also be available.
2. Another conference call will be scheduled to discuss inactive endorsement and any other remaining issues.