NATIONAL QUALITY FORUM

Memo

TO: Cardiovascular Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: July 1, 2014

Purpose of the Call

The Cardiovascular Standing Committee will meet via conference call on Monday, July 7th, 2014 from 2-4pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period that ended on June 25, 2014.
- The Committee will decide whether reconsideration of any measures or other courses of action is warranted.
- The Committee will vote again on measures that did not reach consensus during the initial evaluation.
- The Committee will review proposed responses to the post-evaluation comments.

Due to time constraints on the call, we would like for the Committee member who served as the lead discussant for each measure to be prepared to summarize the rationale for the Committee's decision on the measure and to summarize any new information that was included in the comments.

Due to time constraints, during this call we will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation action items and comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: (877) 298-1950 (*NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?513704
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?513704

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an

ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from February 10, 2014 to February 28, 2014 for the 18 measures under review. Please note: one of the 18 measures under review was withdrawn prior to the in-person Standing Committee meeting. A total of 3 pre-evaluation comments were received, the majority of which pertained to recommendations of harmonization of drug lists in the cardiovascular measures. All of these pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls.

Post-evaluation comments

The Draft Report went out for Public and Member comment from May 27, 2014 to June 25, 2014. During this commenting period, NQF received 53 comments from ten member organizations:

Consumers – 0	Professional – 3
Purchasers – 0	Health Plans – 2
Providers – 3	QMRI – 0
Supplier and Industry – 2	Public & Community Health - 0

Additionally, comments were received from 12 members of the general public.

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Six major themes were identified in the post-evaluation comments, as follows:

1. Measures for which consensus was not reached by the Committee (measures #2452 and #0643)
2. Costs and burdens to participate in multiple registries multiple
3. Recommendations for improved measures or alternative approaches
4. Harmonization of medications in related measures
5. Age specifications

Theme 1 - Measures for which consensus was not reached by the Committee

2452 Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy (ACC/AHA/PCPI

This new composite measure is the clinician-level version of measure 0964. The only difference in specifications is that this clinician-level measure has additional exceptions for medical reasons, patient reasons and system reasons. Committee members also noted that attribution may be an issue as it is not clear how often the discharge medications are prescribed by the operator doing the PCI, rather than another cardiologist or primary provider. The developers also noted recent attention toward capture of the NPI provider number that had previously been problematic. Committee members were divided on whether to include the clinician-level of analysis in measure 0964 rather than having a separate measure. The need for complete harmonization was emphasized.

NQF staff and the developers for measures #0964 and #2450 met on June20, 2014 to discuss harmonization and the possibility of combining the two measures into one. A response letter from the developers was submitted [link can be found here] re-iterating their position that the measures are fully harmonized but insist they must remain as separate measures due to issues of measure stewardship. The developers provided an additional document [link can be found here]with a side by side comparison between measures #964 and #2450 that is referenced within the response letter.

Two comments were submitted for the measure:

- A comment from AHIP stated "We recommend revising this process measure to capture if a patient who has undergone a PCI is adherent to these medications, rather than assessing if the medication was prescribed. Data collection for such an outcome measure would be feasible as pharmacy claims could be used to assess P2Y12 agent and statin adherence."
- A comment from AstraZeneca regarding the need for harmonization of drug inclusions in measures 2450, 0964 and 2379. The developers have been asked to respond to the comments.

> ***ACTION ITEM:*** After reviewing the letter from the developers and the comment, the Committee will re-vote on whether to recommend measure #2450 for endorsement.

0643 Cardiac Rehabilitation Patient Referral From an Outpatient Setting (American College of Cardiology)

During the initial review the Committee was very supportive of the importance of cardiac rehabilitation, but concern was raised that the specifications of the measure require patients with chronic stable angina to be referred to cardiac rehabilitation annually, which is not supported by the evidence. Additionally, some Committee members voiced concern that providers could be penalized by both this measure and by the companion measure, if a patient is referred to cardiac rehabilitation prior to discharge from an inpatient admission but has not enrolled prior to the outpatient visit with the same provider. The developer proposed revised description to address the Committee concern related to chronic stable angina patients:

"Percentage of patients evaluated in an outpatient setting who in the previous 12 months have experienced an acute myocardial infarction, New or worsening angina that does not meet criteria for unstable angina (1), or who have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation, who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention program for the qualifying event, and who are referred to an outpatient cardiac rehabilitation/secondary prevention program."

NQF received 13 comments addressing measure 0643:

- Nine comments support the continued endorsement of the measure. Several comments addressed the specific concerns raised by the Committee.
- One comment identified concerns with the "complication of the measure" and that it seems too burdensome for discerning numerator and denominator and lacks strong evidence.
- One recommendation that the measure should capture whether the patient actually received rehabilitation services rather than just the referral – the data can be captured in administrative claims.
- One commenter states that the denominator is incorrect and should state ""Number of patients in an outpatient clinical practice who have had a qualifying cardiovascular event in the previous 12 months and who do not meet any of the criteria listed in the denominator exclusion section below."
- One comment points out that the age inclusions were only noted in the algorithm.

Developer's Response regarding the specifications: The denominator description statement is correct as it is currently written. Patients who have had a qualifying inpatient cardiovascular event and who have already been referred to an outpatient CR program, would not be included in the outpatient measure since they would have already been referred from an inpatient setting. The focus of the referral measure from an outpatient setting is to include those patients who have had a qualifying event, but who have not yet been referred to an outpatient CR program.

> ***ACTION ITEM:*** After reviewing the comments, developer responses and further discussion, the Committee will re-vote on whether to recommend measure #0643 for endorsement.

Theme 2 Recommendations for improved measures or alternative approaches

AHIP submitted several comments requesting revisions to measures to capture more meaningful information:

- **0642 and 0643: Inpatient/Outpatient referral to cardiac rehabilitation**
  - Assess whether patient received cardiac rehabilitation services rather than just assess whether a referral was made
- **2411 Percutaneous Coronary Intervention (PCI): Comprehensive Documentation of Indications for PCI**
  - Measure appropriateness of PCI, not just documentation.
- **2455: Heart Failure: Post-Discharge Appointment for Heart Failure Patients**
  - Capture whether the patient had a follow-up visit, not just the appointment
- **0964 Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients**
  - Measure to adherence to medication post-discharge rather than whether the prescription was given

ACTION ITEM: Should the Committee reconsider their recommendations of these measures? How should this Committee and NQF encourage more meaningful measures?

Theme 3 Costs and burden to participate in multiple registries

A commenter noted that the data elements of the NCDR CathPCI registry and the NCDR ACTION registry greatly overlap and that it is costly and burdensome to participate in multiple registries.

ACTION ITEM: Should the Committee reconsider recommending measures from multiple registries because it puts too great a burden on participants?

Theme 4 Harmonization of medications in related measures

AstraZeneca requested harmonization of similar measures, specifically the drugs specifications for oral anti-platelet medications in measures 0964, 2452 and 2479 as well as other measures in the portfolio addressing anti-platelet agents. Side by side of specifications for the three measures:

0964 Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients and 2452: Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy	2379: Adherence to Antiplatelet Therapy after Stent Implantation
P2Y12 agent (clopidogrel, prasurgel, or ~~ticlopidine~~ ticagrelor)**	Clopidogrel, prasurgel, ticagrelor

** During the work group calls the committee and developer agreed that there was a typographical error in the specifications and that ticlopidine should not be included and that ticagrelor should be listed.

ACTION ITEM: Should the anti-platelet medications included in measures for secondary prevention of CAD, post-AMI and post-CABG be harmonized with the medications for post-PCI?

Theme 5 Age specifications

Several comments from the Children's Hospital Association note lack of specificity with age inclusions for several measures stating "we would like to encourage NQF and the measure developers to standardize the way in which measures are presented with regard to the target population."

ACTION ITEM: The Cardiovascular portfolio has several measures specific for the pediatric population. As part of measure evaluation should the Committee consider whether children and/or adolescents should be included in measures?

Measure Specific Comments

eMeasure Testing for #2473: Hospital 30-Day Risk-Standardized Acute Myocardial Infarction (AMI) Mortality eMeasure

One comment questioned the testing of this new eMeasure noting "there appears to have been no testing or validation of success to the automatic submission of such data. We highly recommend that this process be validated with the EHR vendors and healthcare facilities that will be expected to develop methods for electronic submission. Without this assurance, the collection of this data will become a labor intensive chart abstraction process with manual entry of data."

Developer response: We agree that testing of the data elements within the actual electronic health record is important. To this end, we have tested the feasibility and validity of the data elements across multiple EHR systems. The results of those analyses support the ability of providers to map and extract these data elements from current EHR software systems automatically, consistently, and accurately. CMS plans to test the electronic submission of the data prior to putting the measure into implementation.

ACTION ITEM: After reviewing the comment and the developer response, does the Committee wish to change its recommendation of the measure?

2450: Heart Failure: Symptom and Activity Assessment

Three comments expressed concerns with endorsing this measure:

- The evidence supporting symptom and activity assessment is based only on expert consensus, and there is therefore a lack of data suggesting that better performance would lead to improved patient outcomes.
- This measure only assesses if an activity assessment occurred and it does not capture actions taken based on the survey results. Additionally, not every physician office visit by a patient with heart failure pertains to cardiovascular care, and evaluation of activity level and clinical symptoms may be unnecessary and duplicative.
- The AAFP agrees with the Committee's comments regarding the time to complete the survey as well as literacy levels may be a barrier to successful implementation. The survey may be appropriate for a cardiologist, but the AAFP has concerns about adding another mandate to the already short face-to-face time with patients during a visit.

ACTION ITEM: After review of the comments and discussion, does the Committee wish to reconsider its recommendation of this measure?

2459: In-hospital Risk Adjusted Rate of Bleeding Events for patients undergoing PCI

Two comments were received:

- Support this patient safety measure.
- Cleveland Clinic expresses concern that patients may be misled by the measure results and perhaps be dissuaded from going to a high quality center. The commenter notes flaws in the measure:
    - Patients undergoing other surgical procedures such as valve surgery, large bore catheter procedures such as TAVR or balloon valvuloplasty, or other major non-CABG surgeries who are also at additional bleeding risk, are currently included in this metric. Our internal data suggests that when we include other major cardiac procedures like valve surgery, Transcatheter Aortic Valve Replacement (TAVR)etc without CABG, bleeding rates are higher therefore negatively impacting the current NCDR PCI bleeding measure which currently does not exclude these other procedures.
    - As large volumes of combined PCI and other non-CABG major cardiac operations tend to be done in institutions and by physicians with particular expertise in specialized cardiac procedures, patients may well get the wrong impression that such providers have high complication rates simply because their procedure mix is more complicated
    - We would like to routine and scientifically acceptable auditing of the data being submitted to assure data validity. We are concerned that the current mechanism of auditing NCDR data is not sufficient to ensure the high level of accuracy needed for national quality reporting or pay for performance metric. If this NCDR data is going to be included in national quality reporting or for pay for performance programs, then the audits should include more sites instead of the current randomly selected 25 sites per year (out of >1,620 participating hospitals) as well as selecting/evaluating all consecutive cases from a specified time period so that sites may not selectively choose the cases that are to be audited. We have concerns that the current auditing methodology is not specifically focused on the components of those metrics (including inclusion and exclusion criteria) that impact current and proposed NQF quality measures that will be used in national quality reporting and pay for performance programs.

Developer Response: The risk adjustment model employed for this measure has undergone substantial validation to ensure that it accounts for numerous aspects of case mix. More broadly, the measure conforms to the stringent methodology delineated by the ACC and AHA for the development of outcomes measures.

As is the case for all of its measures, the ACC will continue to perform surveillance to ensure that the measures characteristics (inclusions, exclusions, and risk modeling) remain valid and relevant. This will include an assessment of the extent to which the small minority of patients (<1.5%) who undergo major surgery during the episode of care during which their PCI occurred, influences the results of the measure.

The NCDR applies an extensive data quality program that includes but is not limited to an audit. The audit program continues to expand in scope to include additional sites and includes outlier assessment to facilitate targeted audits. Because of the importance of the risk-adjusted

outcomes models, the variables underlying all of these models are particularly high-priority candidates for audits.

The comprehensive NCDR data quality program is described in greater detail in Messenger JC, Ho KL, Young CH, et al. The National Cardiovascular Data Registry (NCDR) Data Quality Brief: The NCDR Data Quality Program in 2012. J Am Coll Cardiol. 2012;60(16):1484-1488. doi:10.1016/j.jacc.2012. 07.020.

> ***ACTION ITEM:*** After review of the comments and discussion, does the Committee wish to reconsider its recommendation of this measure?

2379: Adherence to Antiplatelet Therapy after Stent Implantation

AAFP is concerned about the use of administrative data for compliance noting that "claims data could be troublesome as it will not take into account drug samples, generic prescriptions off the $4 program, or the maneuvering physicians often do to ensure their patient's prescriptions last longer due to the inability to afford their medications."

Developer response: Currently we are not aware of any P2Y12 inhibitors offered as $4 prescriptions. Therefore missing claims from these programs will not affect measure rates. We acknowledge that there may be other sources of missing data (e.g., drug samples) that cannot be accounted for with administrative data; however, at this time, we do not believe that the impact will be significant in overall measure rates, and attempting to capture these data by revising the measure would put an undue burden on providers

> ***ACTION ITEM:*** After review of the comments and discussion, does the Committee wish to reconsider its recommendation of this measure?

0286: Aspirin at Arrival

The Committee rated this measure low on *1b. Opportunity for Improvement* because it is "topped out." The Committee elected not to recommend the measure for Reserve status.

One comment notes that there "may instances where a previously endorsed NQF measure is still needed and in use and removal of the endorsement gives the impression that the measure is no longer credible, reliable or lacks evidence when that may not be the case." Reserve status was created to address this concern.

> ***ACTION ITEM:*** Does the Committee wish to reconsider a recommendation of Reserve status for this measure?

Appendix A

June 27, 2014

Mary George, MD, MSPH, FACS, FAHA

Thomas Kottke, MD, MSPH

Co-chairs, Cardiovascular Standing Committee

National Quality Forum

1030 15th Street NW
Suite 800
Washington DC 20005

Dear Dr. George and Dr. Kottke:

Thank you for the opportunity to comment on the draft report, "NQF-endorsed Measures for Cardiovascular Conditions: 2014." As developers for NQF #2452 (Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy), the American College of Cardiology Foundation (ACCF), the American Heart Association (AHA), and the American Medical Association-Convened Physician Consortium for Performance Improvement® (PCPI®) are writing to request that the Cardiovascular Standing Committee review their concerns surrounding measure NQF # 2452 and reconsider recommending the measure for endorsement.

Measure # 2452 is an individual clinician-level composite measure that focuses on optimal post-operative medical therapy for PCI patients in order to prevent stent thrombosis and reduce the risk of adverse outcomes such as MI or death. Each component of the composite includes a distinct medical therapy (ie, aspirin, statin, P2Y12 inhibitor) which together are recommended as the optimal regimen for patients following PCI with the placement of a stent. These agents have individually and together been shown to improve patient outcomes. During its evaluation of measure # 2452, the Cardiovascular Standing Committee failed to reach consensus on an overall vote for endorsement despite rating the measure favorably according to the four NQF endorsement criteria (voting results are as follows: 1a. Evidence: H-13; M-7; L-1; I-0; IE-0; 1b. Performance Gap: H-8; M-13; L-1; I-0; 1c. Impact: H-18; M-4; L-0; I-0 / Reliability: H-3; M-13; L-3; I-2; 2b. Validity: H-2; M-17; L-0; I-0/ Feasibility: H-18; M-4; L-0; I-0/ Use and Usability: H-19; M-3; L-0; I-0). We understand that there was some reluctance to recommend measure # 2452 for endorsement, given that a facility level ACCF's measure (NQF #0964: Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients) addressing the same measure focus and the same target population had been recommended for endorsement.

We strongly believe that measure #2452 would provide valuable information regarding the quality of care provided by *PCI operators* and facilitate the identification of opportunities for improvement. Similarly, measure #0964 is vitally important for assessing the performance of

facilities where PCI procedures are performed and to improve the rates of post-operative medical therapy. While both measures serve distinct functions by assessing performance at different levels of measurement, they are complimentary to each other and both share the same end goal of improving outcomes for patients undergoing PCI procedures. It's important to recognize that most, if not all, of today's public reporting and accountability programs are focused on different levels of measurement. Endorsement from NQF would better ensure these measures are included in key national public reporting and payment programs and provide an avenue to promote use of the measures for facility and physician accountability and quality improvement.

Throughout NQF's vast portfolio of endorsed measures, there are many examples of two similar measures addressing different levels of measurement. These include measures addressing tobacco screening and cessation interventions, the administration of prophylactic antibiotics for patients undergoing surgical procedures, medical therapy for patients following a stroke, and influenza immunization. In those cases,

NQF acknowledged not only that the measures were used for different levels of measurement, but that measure users and the public could benefit from both measures being endorsed by NQF. Recommending measure # 2452 for endorsement would therefore be consistent with previous NQF endorsement recommendations, recognize the 2 distinct pathways these measures were developed, and would highlight the importance of optimal post-operative medical therapy for patients undergoing PCI.

When similar measures exist and are available for use, we do appreciate that harmonization is a necessity to minimize the burden of data collection. NQF has previously described harmonization according to both the *conceptual* descriptions of the concepts or constructs being addressed in a measure (e.g., numerator and denominator statements) and *technical* details of how to operationalize or implement the conceptual intent of the measure (e.g., specific data elements, code sets, and code values). We have carefully reviewed the two measures and believe they are almost fully harmonized both conceptually and technically as outlined in the attached document.

Given that both measures are harmonized to the extent possible, we do not believe that there would be any added value by only moving one measure forward for NQF endorsement. The ACCF has a proprietary interest for measure #0964, while ACCF, AHA, and PCPI jointly have an interest in measure #2452. We do not believe that removing the ownership interests of any organizations, in an effort to move forward only one reconciled measure, would be beneficial for measure development given the expense undertaken by the respective organizations in measure development, testing, validating, and promoting adoption of the measure in appropriate programs. In fact, we believe that moving only one measure forward could serve as an indication to measure developers seeking NQF endorsement that respective committee may seek to push only one measure forward, in an effort to harmonize at the expense of intellectual property for an organization or organizations involved in that measure development work.

The ACCF, the AHA and the PCPI support your overall efforts to expand the NQF portfolio of cardiovascular measures and to ensure that only the best measures become NQF-endorsed voluntary consensus standards. We appreciate your time and consideration of the comments above and throughout the review process and look forward to future opportunities to work together towards our common goal of improving the quality of health care provided to all Americans.

Sincerely,

William J. Oetgen, MD, MBA,
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Appendix B

The two measures, # 0964 and # 2452 have been conceptually or technically harmonized to the greatest extent possible by the measure stewards. The variation from this harmonization exists only in the treatment of patients who are contraindicated to the specific medication therapies.

Patients within measure # 0964: 'Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients,' that have relevant medications coded as "contraindicated" due to a clinically determined medical exceptions or patient reasons, are treated as "performance met" and are included in the numerator.

Patients within measure # 2452: 'Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy,' that have relevant medications coded "contraindicated" due to a clinically determined medical exceptions or patient reasons, are removed entirely from consideration.

A side by side comparison of the harmonization between each factor of these two measures is copied below.

	Measure # 0964 **Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients**	**Measure # 2452** **Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy**	**Measure Developer comment: Level of harmonization**
Measure Title (De.1)	Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients	Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy	Conceptually harmonized
Brief Description of Measure (De.2)	Patients undergoing PCI who receive prescriptions for all medications (aspirin, P2Y12 and statins) for which they are eligible for at discharge	Percentage of patients aged 18 years and older for whom PCI is performed who are prescribed optimal medical therapy at discharge	Conceptually harmonized
Level of Analysis	Facility	Clinician: Individual	
Measure Focus/ Numerator Statement	Patients who receive all medications for which they are eligible. 1. Aspirin prescribed at discharge (if eligible for aspirin as described in denominator) AND 2. P2Y12 agent (clopidogrel, prasurgel, or ticlopidine) prescribed at discharge (if eligible for P2Y12 as described in denominator) AND 3. Statin prescribed at discharge (if eligible for statin as described in	Patients who are prescribed* all of the medications, for which they are eligible, at discharge *Prescribed may include prescription given to the patient for medications at discharge OR patient already taking medications as documented in current medication list	Conceptually & Technically harmonized

	denominator)		
Time Window	1 year	For Perioperative Measures: Once for each surgical procedure performed during the measurement period	Conceptually harmonized
Target Population/ Denominator Statement	Patients surviving hospitalization who are eligible to receive any of the three medication classes: 1) Eligibile for aspirin (ASA): Patients undergoing PCI who do not have a contraindication to aspirin documented AND 2) Eligible for P2Y12 agent (clopidogrel, prasugrel, or ticlopidine): Patients undergoing PCI with stenting who do not have a contraindication to P2Y12 agent documented AND 3) Eligible for statin therapy: Patients undergoing PCI who do not have a contraindication to statin therapy.	All patients aged 18 years and older for whom PCI is performed who are eligible for any of the following medications (ie, patient has no contraindication, allergy, intolerance): • Aspirin • P2Y12 inhibitor (only for PCIs with stenting) • Statin	Conceptually & Technically harmonized
Exclusions from Target Population/ Denominator	• Discharge status of expired; • patients who left against medical advice, • patients discharged to hospice or for whom comfort care measures only is documented; • patients discharged to other acute hospital	• Patients who expired • Patients who left against medical advice • Patient discharged to hospice or for whom comfort care measures only is documented • Patient discharged to other acute care hospital	Conceptually harmonized, not technically harmonized
Exclusion Details	NCDR has a clear distinction between absolute “Exclusions” (e.g., death, transfer) and relative “Exceptions”, (e.g., contraindications). While patients with exclusions are always automatically removed from the denominator and numerator, exceptions allow clinicians the opportunity to identify an intervention/process/medication as not clinically indicated based on the unique patient scenario.	According to the ACCF/AHA/PCPI methodology, exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For this measure, exclusions include patients who died, etc. etc.	

	Each of the three medications incorporated into this composite may be coded as Yes (medication prescribed), No (medication not prescribed), Blinded (pt. involved in a clinical trial, medication type unavailable for data entry), and Contraindicated (used to capture many of the medical exceptions used in measure #2452).	Exclusions, including applicable value sets, are included in the measure specifications. Additional details by data source are as follows: The electronic specifications for registry reporting necessary to capture the excluded population are included in the Appendix, attached to Section A.1 in the 'Additional' tab.	
Exceptions	Note: Contraindicated and those participating in blinded studies are also considered as exceptions and performance met.	The Exception Justification intended for this measure is described in the Nallamothu BK, Tommaso CL, Anderson H, et al. ACC/AHA/SCAI/AMA–Convened PCPI/NCQA 2013 Performance Measures for Adults Undergoing Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures, the Society for Cardiovascular Angiography and Interventions, the American Medical Association–Convened Physician Consortium for Performance Improvement, and the National Committee for Quality Assurance. J Am Coll Cardiol. 2014;63(7):722-745. doi:10.1016/j.jacc.2013.12.003. The PCI Work Group agreed to include a medical reason exception so that clinicians can exclude patients for whom the prescription of aspirin, P2Y12 inhibitor, or statin therapy may not be appropriate (eg, allergy, intolerance, other medical reasons for not prescribing the therapy at discharge). A patient reason exception has been included for patients who might decline any of these particular pharmacologic agents	Conceptually harmonized, not technically harmonized