



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

### Brief Measure Information

**NQF #: 0639**

**Corresponding Measures:**

**De.2. Measure Title:** Statin Prescribed at Discharge

**Co.1.1. Measure Steward:** Centers for Medicare & Medicaid Services

**De.3. Brief Description of Measure:** Percent of acute myocardial infarction (AMI) patients who are prescribed a statin at hospital discharge.

**1b.1. Developer Rationale:** Several randomized clinical trials have proven the benefits of statin drugs (also known as HMG Co-A reductase inhibitors) in reducing the risk of death and recurrent cardiovascular events in a broad range of patients with established cardiovascular disease, including those with prior myocardial infarction. Number vary from study to study, but the Heart Protection Study, a secondary prevention study which included a large number of patients with AMI, found that treating 23 patients with simvastatin for five years would prevent one MI or stroke and treating 56 patients for five years would prevent one death from any cause. These are relatively low Numbers Needed to Treat (NNTs) for a medication that is well-tolerated and is in many cases relatively inexpensive. The magnitude of benefit with statins matches or exceeds benefits with other secondary prevention medications such as aspirin, beta-blockers, and angiotensin-converting enzyme inhibitors (ACEIs) after MI. Because statins are generally well-tolerated, most patients with AMI are appropriate candidates for this therapy.

**S.4. Numerator Statement:** AMI patients who are prescribed a statin medication at hospital discharge.

**S.7. Denominator Statement:** AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91)

**S.10. Denominator Exclusions:**

- Patients less than 18 years of age

- Patients who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients enrolled in clinical trials
- Patients discharged to another hospital
- Patients who left against medical advice
- Patients who expired
- Patients discharged to home for hospice care
- Patients discharged to a health care facility for hospice care
- Patients with LDL less than 100 mg/dL within the first 24 hours after hospital arrival or 30 days prior to hospital arrival and not discharged on a statin
- Patients with a Reason For Not Prescribing Statin Medication at Discharge

**De.1. Measure Type:** Process

**S.23. Data Source:** Claims, Paper Medical Records

**S.26. Level of Analysis:** Facility, Other, Population : Regional and State

**IF Endorsement Maintenance – Original Endorsement Date:** Jan 29, 2010 **Most Recent Endorsement Date:** Jan 29, 2010

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret**

results?

**1. Evidence, Performance Gap, Priority – Importance to Measure and Report**

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**

[0639\\_Evidence\\_MSF5.0\\_Data-635278446421434507.doc](#)

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)**

Several randomized clinical trials have proven the benefits of statin drugs (also known as HMG Co-A reductase inhibitors) in reducing the risk of death and recurrent cardiovascular events in a broad range of patients with established cardiovascular disease, including those with prior myocardial infarction. Number vary from study to study, but the Heart Protection Study, a secondary prevention study which included a large number of patients with AMI, found that treating 23 patients with simvastatin for five years would prevent one MI or stroke and treating 56 patients for five years would prevent one death from any cause. These are relatively low Numbers Needed to Treat (NNTs) for a medication that is well-tolerated and is in many cases relatively inexpensive. The magnitude of benefit with statins matches or exceeds benefits with other secondary prevention medications such as aspirin, beta-blockers, and angiotensin-converting enzyme inhibitors (ACEIs) after MI. Because statins are generally well-tolerated, most patients with AMI are appropriate candidates for this therapy.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.**

Despite the effectiveness of statins in altering subsequent cardiovascular mortality, several prior studies have documented low treatment rates in patients with established coronary artery disease. Current gaps in care are less well characterized, however, because many of these studies involved patients from a single or a limited number of centers, enrolled in randomized clinical trials, or treated before dissemination of the most convincing clinical trial evidence. However, a recent study of all participants in the National Registry of Myocardial Infarction (NRFMI) found that statins were being prescribed only 82% of the time in patients hospitalized with AMI who were eligible for statin therapy. However the hospitals included in this study were voluntary participants in a national quality improvement registry. It is highly likely that this number would be substantially lower across a larger cohort of hospitals (where quality improvement may be less of a focus).

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

- Fonarow GC, French WJ, Frederick PD. Trends in the use of lipid-lowering medications at discharge in patients with acute myocardial infarction: 1998 to 2006. *American Heart Journal*. 2009 Jan;157(1):185-194.e2.
- Frolkis JP, Zyzanski SJ, Schwartz JM, Suhan PS. Physician noncompliance with the 1993 National Cholesterol Education Program (NCEPATPII) guidelines. *Circulation*. 1998;98:851-5.
- Majumdar SR, Gurwitz JH, Soumerai SB. Undertreatment of hyperlipidemia in the secondary prevention of coronary artery disease. *J Gen Intern Med*. 1999;14:711-7.
- McBride P, Schrott HG, Plane MB, et al. Primary care practice adherence to National Cholesterol Education Program guidelines for patients with coronary heart disease. *Arch Intern Med*. 1998;158:1238-44.
- Miller M, Byington R, Hunninghake D, et al. Sex bias and underutilization of lipid-lowering therapy in patients with coronary artery disease at academic medical centers in the United States and Canada: Prospective Randomized Evaluation of the Vascular Effects of Norvasc Trial (PREVENT) Investigators. *Arch Intern Med*. 2000;160:343-7.

- Schrott HG, Bittner V, Vittinghoff E, et al. Adherence to National Cholesterol Education Program treatment goals in postmenopausal women with heart disease: the Heart and Estrogen/Progestin Replacement Study (HERS): the HERS Research Group. JAMA. 1997;277:1281–6.
- Sueta CA, Chowdhury M, Boccuzzi SJ, et al. Analysis of the degree of undertreatment of hyperlipidemia and congestive heart failure secondary to coronary artery disease. Am J Cardiol. 1999;83:1303–7.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

There are a number of studies which have examined the use of lipid-lowering therapy across various subgroups and have found important disparities in terms of race, gender, and age. In a study from NRM in 2006, patients classified as black were prescribed lipid-lowering therapy 78.7% of the time, compared to 84.0% white patients and 86.4% of patients classified as “other” race. Additionally, men were more likely to be prescribed a lipid-lowering agent than women (87.0% versus 78.6%). Furthermore, there was a large disparity in treatment rates for elderly patients (79.0% for patients aged 65 years and older, compared to 89.6% for patients aged less than 65 years).

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

- Fonarow GC, French WJ, Frederick PD. Trends in the use of lipid-lowering medications at discharge in patients with acute myocardial infarction: 1998 to 2006. American Heart Journal. 2009 Jan;157(1):185-194.e2.

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality, Severity of illness

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**

The estimated annual incidence of MI in the United States (including both STEMI and NSTEMI) is 600,000 new and 320,000 recurrent events. In 2004, AMI resulted in 695,000 hospital stays and \$31 billion in hospital charges. The risk of further cardiovascular complications, including recurrent MI, sudden cardiac death, heart failure, stroke, and angina pectoris, for those who survive AMI is substantial.

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

- Rosamond W, Flegal K, Furie K, et al. Heart disease and stroke statistics—2008 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Circulation. 2008;117:e25–146.
- Russo CA, Andrews RM. The National Hospital Bill: The Most Expensive Conditions, by Payer, 2004. Rockville, MD: Agency for Healthcare Research and Quality; 2006. HCUP statistical brief No. 13.

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful.** *(Describe how and from whom their input was obtained.)*

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Cardiovascular, Cardiovascular : Coronary Artery Disease (AMI)

**De.6. Non-Condition Specific** (check all the areas that apply):

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870> - Section 2 - Measurement Information | Section 2.1 - Acute Myocardial Infarction (AMI)

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

AMI patients who are prescribed a statin medication at hospital discharge.

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

From hospital arrival to time of hospital discharge.

**S.6. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Refer to

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870>:

- Section 1 - Data Dictionary | Alphabetical Data Dictionary – pages 1-403 through 1-404.
- Appendices | Appendix C - Medication Tables – page Appendix C-57.
- Section 2 - Measurement Information | Section 2.1 - Acute Myocardial Infarction (AMI) – page AMI-10-1.

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

AMI patients (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code of AMI:

410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91)

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Elderly

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

ICD-9-CM Principal Diagnosis codes:

410.00: Anterolateral wall, acute myocardial infarction-episode of care unspecified  
410.01: Anterolateral wall, acute myocardial infarction-initial episode  
410.10: Other anterior wall, acute myocardial infarction-episode of care unspecified  
410.11: Other anterior wall, acute myocardial infarction-initial episode  
410.20: Inferolateral wall, acute myocardial infarction-episode of care unspecified  
410.21: Inferolateral wall, acute myocardial infarction-initial episode  
410.30: Inferoposterior wall, acute myocardial infarction-episode of care unspecified  
410.31: Inferoposterior wall, acute myocardial infarction-initial episode  
410.40: Other inferior wall, acute myocardial infarction-episode of care unspecified  
410.41: Other inferior wall, acute myocardial infarction-initial episode  
410.50: Other lateral wall, acute myocardial infarction-episode of care unspecified  
410.51: Other lateral wall, acute myocardial infarction-initial episode  
410.60: True posterior wall, acute myocardial infarction-episode of care unspecified  
410.61: True posterior wall, acute myocardial infarction-initial episode  
410.70: Subendocardial, acute myocardial infarction-episode of care unspecified  
410.71: Subendocardial, acute myocardial infarction-initial episode  
410.80: Other specified sites, acute myocardial infarction-episode of care unspecified  
410.81: Other specified sites, acute myocardial infarction-initial episode  
410.90: Unspecified site, acute myocardial infarction-episode of care unspecified  
410.91: Unspecified site, acute myocardial infarction-initial episode

**S.10. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

- Patients less than 18 years of age
- Patients who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented
- Patients enrolled in clinical trials
- Patients discharged to another hospital
- Patients who left against medical advice
- Patients who expired
- Patients discharged to home for hospice care
- Patients discharged to a health care facility for hospice care
- Patients with LDL less than 100 mg/dL within the first 24 hours after hospital arrival or 30 days prior to hospital arrival and not discharged on a statin
- Patients with a Reason For Not Prescribing Statin Medication at Discharge

**S.11. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Refer to

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870>:

- Section 1 - Data Dictionary | Alphabetical Data Dictionary – pages 1-19 through 1-20, 1-96, 1-106 through 1-108, 1-111 through 1-114, 1-123 through 1-127, 1-209, 1-254 through 1-255, and 1-380 through 1-383.
- Appendices | Appendix C - Medication Tables PDF – page Appendix C-57, and Appendix H - Miscellaneous Tables – page Appendix H-5.
- Section 2 - Measurement Information | Section 2.1 - Acute Myocardial Infarction (AMI) – pages AMI-4 plus AMI-10-1 through AMI-

10-2.

**S.12. Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

N/A

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

**S.18. Calculation Algorithm/Measure Logic** (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Refer to

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773564870>:  
Section 2 - Measurement Information | Section 2.1 - Acute Myocardial Infarction (AMI) – pages AMI-5 plus AMI-10-4 through AMI-10-5.

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Patients admitted to the hospital for inpatient acute care with an ICD-9-CM Principal Diagnosis Code for AMI as defined in section 2a.8, a patient age greater than or equal to 18 years, and a length of stay less than or equal to 120 days would be included in the initial patient population and eligible to be sampled.

Monthly Sample Size Based on Population Size (Average monthly initial patient population size: Minimum required sample size):

<sup>3</sup> 516: 104

131-515: 20% of Initial Patient Population size

26-130: 26

< 26: 100%



**S.21. Survey/Patient-reported data** (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

**S.22. Missing data** (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

**S.23. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims, Paper Medical Records

**S.24. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Final data collection instrument will be incorporated into the Centers for Medicare & Medicaid Services (CMS) Abstraction & Reporting Tool (CART). Vendor tools also available.

**S.25. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

URL

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other, Population : Regional and State

**S.27. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

If other:

**S.28. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

0639\_MeasureTesting\_MSF5.0\_Data-635278446421590509.doc

### 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

#### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

##### 3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

#### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

No

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

The clinical data elements will have to be specified for electronic capture. That process will be undertaken in the near future.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

N/A

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** (*e.g., value/code set, risk model, programming code, algorithm*).

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Planned	Current Use (for current use provide URL)
Public Reporting	
Payment Program	
Quality Improvement (Internal to the specific organization)	

**4a.1. For each CURRENT use, checked above, provide:**

- Name of program and sponsor



- Purpose
- Geographic area and number and percentage of accountable entities and patients included

**4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

**4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

#### **4b. Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)**

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

**4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

#### **4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

The data element definitions for Statin Medication Prescribed at Discharge and Reason For Not Prescribing Statin Medication at Discharge were built by TJC's Stroke measure team from data elements used in our existing AMI and Heart Failure medication measures that have a similar measure construct. Revisions in abstraction guidelines have been made to address issues that have surfaced in data collection (e.g., how to handle documentation of a hold on statins at discharge or a plan to prescribe statins after discharge, what constitutes acceptable physician documentation of a reason for not prescribing a statin). Issues which may surface in Q&As submitted by users will be closely monitored to identify any additional problems, and abstraction guideline revisions will be made if warranted. If this measure is added to the RHQDAPU measure set, additional sources to monitor and use to ensure good quality data will include Clinical Data Abstraction Center (CDAC) validation work (which compares hospital-abstracted data to CDAC-abstracted data) and internal abstractor-reabstractor agreement/accuracy data from the CDAC.

### **5. Comparison to Related or Competing Measures**

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

### 5a. Harmonization

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

N/A

Related Measures: NQF #0074 - CAD: Drug Therapy for Lowering LDL-Cholesterol; NQF #0118 - Anti-Lipid Treatment Discharge; NQF #0439 - Discharged on Statin Medication; NQF #0543 - Coronary Artery Disease and Medication Possession Ratio for Statin Therapy; NQF #0545 - Diabetes Mellitus and Medication Possession Ratio (MPR) for Chronic Medications; NQF #0547 - Diabetes and Medication Possession Ratio for Statin Therapy

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment:**

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Corette, Byrd, [corette.byrd@cms.hhs.gov](mailto:corette.byrd@cms.hhs.gov), 410-786-8532-

**Co.3 Measure Developer if different from Measure Steward:** Centers for Medicare & Medicaid Services

**Co.4 Point of Contact:** Kristie, Baus, [kristie.baus@cms.hhs.org](mailto:kristie.baus@cms.hhs.org), 410-786-8161-

**Additional Information****Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

This AMI statin measure was adapted from TJC's Stroke measure "Discharged on Statin Medication" endorsed by the NQF in July 2008. Necessary revisions were made to customize the exclusion criteria to fit the AMI patient, in accordance with ACC/AHA clinical guidelines and the ACC/AHA STEMI/NSTEMI performance measure "Statin Prescribed at Discharge" developed by the ACC/AHA Task Force on Performance Measures (Writing Committee to Develop Performance Measures for ST-Elevation and Non-ST-Elevation Myocardial Infarction), in collaboration with American Academy of Family Physicians and American College of Emergency Physicians, and endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, Society for Cardiovascular Angiography and Interventions, and Society of Hospital Medicine. In a December 2009 meeting, the Heart Care Technical Expert Panel (TEP) reviewed the proposed measure inclusion/exclusion specifications for this AMI statin measure with the Heart Care inpatient measures team and approved. TEP members present on that conference call:

Frederick Masoudi, MD, MSPH Workgroup Chair: Denver Health Medical Center, University of Colorado at Denver and Health Sciences Center

Javed Butler, MD: American Heart Association

Don Casey, MD: American College of Physicians

Jensen S. Chiu: American College of Cardiology

Elizabeth Delong, PhD: Duke University

Joseph Drozda, MD: American Medical Association

Susan Fitzgerald: American College of Cardiology

David C. Goff, MD, PhD: Wake Forest University School of Medicine

Kathleen Grady, PhD: Northwestern Memorial Hospital

Darryl Gray, PhD: Agency for Healthcare Research and Quality

Ed Havranek, MD: Denver Health Medical Center, University of Colorado School of Medicine

Alice K. Jacobs, MD: Boston University Medical Center

Marvin Konstam, MD: Heart Failure Society of America

Harlan Krumholz, MD, MSc: Yale University School of Medicine

Ann [Hiniker] Loth, PhD: Mayo Foundation, Rochester, Minnesota

Martha Radford, MD: New York University School of Medicine

Rose Marie Robertson, MD: American Heart Association

John Rumsfeld, MD, PhD: Denver Veterans Affairs Medical Center

Melanie Shahriary: American College of Cardiology

John Spertus, MD, MPH: University of Missouri, Kansas City

Janet Wright, MD: American College of Cardiology

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:**

**Ad.3 Month and Year of most recent revision:**

**Ad.4 What is your frequency for review/update of this measure?** Bi-annually

**Ad.5 When is the next scheduled review/update for this measure?**

**Ad.6 Copyright statement:**

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**