



## 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
<p><b>NQF #: 1522</b></p> <p><b>Corresponding Measures:</b></p> <p><b>De.2. Measure Title:</b> ACE/ARB Therapy at Discharge for ICD implant patients with Left Ventricular Systolic Dysfunction</p> <p><b>Co.1.1. Measure Steward:</b> American College of Cardiology</p> <p><b>De.3. Brief Description of Measure:</b> Proportion of ICD implant patients with a diagnosis of LVSD who are prescribed ACE-I or ARB therapy at discharge.</p> <p><b>1b.1. Developer Rationale:</b> This measure allows benchmarking against the national aggregate and against hospitals with similar procedural volume, so that hospitals with low performance rates can engage in quality improvement efforts to improve compliance for this measure and subsequently improve patient outcomes related to this measure.</p>
<p><b>S.4. Numerator Statement:</b> Count of patients with ACE-I or ARB therapy prescribed at discharge.</p> <p><b>S.7. Denominator Statement:</b> 1) Count of patients with an ICD implant with moderate or severe LVSD (LVEF&lt;40%) who are eligible for ACE inhibitors who do not have a contraindication to ACE inhibitors documented</p> <p>AND</p> <p>2)Count of patients with an ICD implant with moderate or severe LVSD (LVEF&lt;40%) who are eligible for ARB therapy who do not have a contraindication to ARB therapy documented</p> <p><b>S.10. Denominator Exclusions:</b> Discharge status of expired</p> <p>Contraindicated or blinded to both ACE inhibitors and ARB therapy</p>
<p><b>De.1. Measure Type:</b> Process</p> <p><b>S.23. Data Source:</b> Registry Data</p> <p><b>S.26. Level of Analysis:</b> Facility</p>
<p><b>IF Endorsement Maintenance – Original Endorsement Date:</b> Jan 18, 2012 <b>Most Recent Endorsement Date:</b> Jan 18, 2012</p>
<p><b>IF this measure is included in a composite, NQF Composite#/title:</b></p> <p><b>IF this measure is paired/grouped, NQF#/title:</b></p> <p><b>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</b> N/A</p>

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
<p>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. <i>Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.</i></p>
<p><b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b> 1522_Evidence_MSF5.0_Data.doc</p>
<p><b>1b. Performance Gap</b></p>

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)

This measure allows benchmarking against the national aggregate and against hospitals with similar procedural volume, so that hospitals with low performance rates can engage in quality improvement efforts to improve compliance for this measure and subsequently improve patient outcomes related to this measure.

**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.

Mean: 0.77

SD: 0.17

Quartile 1: 0.71

Median: 0.79

Quartile 3: 0.87

95%: 1.00

**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.**

90th	:	0.94 (2011-12)	0.99 (2013-14)
75th (Quartile 3)	:	0.87 (2011-12)	0.91 (2013-14)
50th (Median)	:	0.80 (2011-12)	0.82 (2013-14)
25th (Quartile 1)	:	0.72 (2011-12)	0.74 (2013-14)
10th	:	0.62 (2011-12)	0.65 (2013-14)

**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.

Mean by hospital SES (proportion white patients):

0-72.7% white:77.2%

72.7-87.7% white:77.1%

87.7-96.12% white:78.9%

96.13-100% white:74.8%

Mean performance by safety net status (defined as government hospitals or non-governmental hospitals with high medicaid caseload using AHA 2008 data):

Not a safety net hospital: 77.0%

Safety net hospital: 77.0%

**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.**

Unpublished NCDR data

**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, Frequently performed procedure, A leading cause of morbidity/mortality, High resource use, 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.**

Optimal medical therapy is critical to ensure favorable patient outcomes following implantation of an implantable cardiac defibrillator (ICD) to prevent sudden cardiac death (SCD). In 2006, 114,000 inpatient defibrillator implantations were performed. The mean hospital charge for ICD procedures was \$115,763.

Approximately 81 million American adults have 1 or more types of CVD, with 5.8 million having heart failure. Over 30% of all deaths are related to CVD. Over 90% of patients receiving an ICD for primary prevention have ejection fraction under 40%, while 70% of patients receiving an ICD for secondary prevention have an ejection fraction under 40%. Therefore, it is critical that these patients receive discharge medications to treat left ventricular systolic dysfunction to reduce associated morbidity and mortality, as well as repeat hospitalizations and procedures.

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

American Heart Association. Heart disease and stroke statistics- 2010 update: A report of the American Heart Association. Available at: <http://circ.ahajournals.org/cgi/content/abstract/CIRCULATIONAHA.109.192667v1>. Accessed December 3, 2010.

**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):

**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.)

<https://www.ncdr.com/webncdr/icd/home/datacollection>

**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)

Attachment **Attachment:** [icd\\_v2\\_datadictionary\\_codersdictionary\\_2-1.pdf](#)

**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.

Count of patients with ACE-I or ARB therapy prescribed at 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.)

1 year

**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.

If eligible for ACE-I and given, then code "Yes"

If eligible for ACE-I and not given, then code "No, not given"

If eligible for ACE-I but contraindicated, then code "contraindicated/blinded"

If eligible for ARB therapy and given, then code "Yes"

If eligible for ARB therapy and not given, then code "No, not given"

If eligible for ARB therapy but contraindicated, then code "contraindicated/blinded"

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

1) Count of patients with an ICD implant with moderate or severe LVSD (LVEF<40%) who are eligible for ACE inhibitors who do not have a contraindication to ACE inhibitors documented

AND

2)Count of patients with an ICD implant with moderate or severe LVSD (LVEF<40%) who are eligible for ARB therapy who do not have a contraindication to ARB therapy documented

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

Populations at Risk

**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)

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

Discharge status of expired

Contraindicated or blinded to both ACE inhibitors and ARB therapy

**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)

Contraindications must be documented explicitly by the physician, or clearly evidenced within the medical record

Blinded supporting definition:

Patient was in research study or clinical trial and administration of this specific medication is unknown

**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)

Better quality = Higher 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.)

- 1) Remove patients whose discharge status is expired
- 2) Check if given patient is eligible for 1 of the 2 medication therapies
- 3) If eligible for at least 1 medication, then keep this patient.
- 4) If not eligible for any of the 2 medications, then patient is removed from eligibility.
- 5)

If eligible for ACE and given, then code "Yes"

If eligible for ACE and not given, then code "No, not given"

If eligible for ACE but contraindicated, then code "contraindicated/blinded"

If eligible for ARB and given, then code "Yes"

If eligible for ARB and not given, then code "No, not given"

If eligible for ARB but contraindicated, then code "contraindicated/blinded"

- 6) If any "No, not given" present, then performance not met, Else performance met.

**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)

<p><b>S.20. Sampling</b> (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)  <u>IF a PRO-PM</u>, identify whether (and how) proxy responses are allowed.  <a href="#">N/A</a></p> <p><b>S.21. Survey/Patient-reported data</b> (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)  <u>IF a PRO-PM</u>, specify calculation of response rates to be reported with performance measure results.</p> <p><b>S.22. Missing data</b> (specify how missing data are handled, e.g., imputation, delete case.)  <u>Required for Composites and PRO-PMs.</u></p>
<p><b>S.23. Data Source</b> (Check <b>ONLY</b> the sources for which the measure is SPECIFIED AND TESTED).          If other, please describe in S.24.  <a href="#">Registry Data</a></p> <p><b>S.24. Data Source or Collection Instrument</b> (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)  <u>IF a PRO-PM</u>, identify the specific PROM(s); and standard methods, modes, and languages of administration.  <a href="#">National Cardiovascular Data Registry (NCDR)® ICD Registry™</a></p> <p><b>S.25. Data Source or Collection Instrument</b> (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)  <a href="#">URL</a></p> <p><b>S.26. Level of Analysis</b> (Check <b>ONLY</b> the levels of analysis for which the measure is SPECIFIED AND TESTED)  <a href="#">Facility</a></p> <p><b>S.27. Care Setting</b> (Check <b>ONLY</b> the settings for which the measure is SPECIFIED AND TESTED)  <a href="#">Inpatient/Hospital</a>          If other:</p>
<p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form  <b>2b. Validity</b> – See attached Measure Testing Submission Form  <a href="#">1522_MeasureTesting_MS5.0_Data.doc</a></p>
<p><b>3. Feasibility</b></p> <p>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.</p> <p><b>3a. Byproduct of Care Processes</b>          For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p><b>3a.1. Data Elements Generated as Byproduct of Care Processes.</b>  <a href="#">generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition,</a></p>

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*)

Yes

**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.**

**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.**

Beta testing with a sample of registry participants takes place with each new registry version to identify errors in the data collection tool. In addition, modifications are made to metrics based on feedback during a public comment period.

The Data Quality Report (DQR) program has been developed to ensure data are valid and complete. The DQR is a process for submitting data files to the NCDR. Participants use their data collection tool software to create a submission file which is uploaded to the NCDR website. After uploading, the data in the file are automatically checked for errors and completeness. Passing the DQR ensures well-formed data and a statistically significant submission. Types of errors detected by the DQR include:

Schema: Structure doesn't match NCDR requirements

Dates: Inconsistent dates

Selection: Missing or mismatched data; can be parent/child errors where a field requests more data

Outlier: Anomalies or exceptions; data exceeds the possible limits.

**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)
Payment Program	
Regulatory and Accreditation Programs	

#### 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 NCDR program takes a number of steps to minimize any potential for inaccuracies or errors in data used to report on performance back to hospitals. The process begins with support to data abstractors, including webinars, meetings, resource guides on the website, and clinical quality consultants available via e-mail or toll free phone number, to ensure consistent data collection. The NCDR establishes a unified electronic platform for data capture and submission that includes a certification process of the technical data collection tool selected by the hospital (either a commercially available software vendor product, the NCDR's own web-based data collection tool, or a hospital's customized electronic medical record system) that must occur prior to any data submissions. The certification process provides edit checks of data elements within the data collection tool to ensure a high quality data submission.

The NCDR data submission process includes a Data Quality Report (DQR) process that checks for validity in submissions based upon predetermined thresholds for element and composite completeness. The NCDR is putting in place a new strategy to systematically review the DQR results.

The NCDR on-site audit program has been developed to assess the reliability of data abstraction. This annual process reviews key elements at a select number of patient reports at a select number of sites and provides feedback scores to the hospitals. Any elements not currently included in the on-site audit process and deemed critical to capture for this measure will be added upon NQF endorsement.

## 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.  
Yes

**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.)**

Related Measures: #162: HF patients who are prescribed an ACEI or ARB at hospital discharge, #137: ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients, #162:Heart Failure: Angiotensin converting enzyme inhibitor (ACEI) for left ventricular systolic dysfunction (LVSD)

## 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):** American College of Cardiology

**Co.2 Point of Contact:** Penelope, Solis, [comment@acc.org](mailto:comment@acc.org), 202-375-6576-

**Co.3 Measure Developer if different from Measure Steward:** American College of Cardiology Foundation (ACCF)

**Co.4 Point of Contact:** Kristyne, McGuinn, [kmcguinn@acc.org](mailto:kmcguinn@acc.org), 202-375-6529-

## 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.**

ICD Registry Steering Committee:

Mark S. Kremers, MD, FACC, FHRS Chair

Stephen C. Hammill, MD, FACC, FHRS Ex-Officio

Sana M. Al-Khatib, MD, FACC

Charles I. Berul, MD, FACC

Jeptha P. Curtis, MD, FACC

Paul A. Heidenreich, MD, FACC

Illeana L. Pina, MD, FACC

Matthew R. Reynolds, MD, FACC

Lynne Warner Stevenson, MD, FACC

Mary Norine Walsh, MD, FACC

Public Reporting Workgroup:

Fred Masoudi, MD, MSPH, FACC, FAHA, FACP

H. Vernon Anderson, MD, FACC, FSCAI

David Malenka, MD, FACC

Matt Roe, MD, FACC

Steve Hammill, MD, FHRS, FACC

Jeptha Curtis, MD, FACC

Paul Heidenreich, MD, MS, FACC

Brahmajee Nallamothu, MD, MPH, FACC

Mark Kremers, MD, FACC

Christopher White MD, FACC

Carl Tommaso, MD, FACC, FAHA, FSCAI

Sunil Rao, MD, FACC, FSCAI

Andrea Russo, MD, FACC, FHRS

Debabrata Mukherjee MD, FACC
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2</b> Year the measure was first released: 2006 <b>Ad.3</b> Month and Year of most recent revision: 12, 2010 <b>Ad.4</b> What is your frequency for review/update of this measure? Every 3-4 years or if guideline updates warrant more frequent update, or with new dataset version. <b>Ad.5</b> When is the next scheduled review/update for this measure? 06, 2011
<b>Ad.6</b> Copyright statement: © 2010 American College of Cardiology Foundation All Rights Reserved <b>Ad.7</b> Disclaimers:
<b>Ad.8</b> Additional Information/Comments: