

PERFORMANCE MEASURE

2017 AHA/ACC Clinical Performance and Quality Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction

A Report of the American College of Cardiology/American Heart Association
 Task Force on Performance Measures

*Developed in Collaboration With the Society for Cardiovascular Angiography and Interventions
 Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation*

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PREAMBLE

The American College of Cardiology (ACC)/American Heart Association (AHA) performance measure sets serve as vehicles to accelerate translation of scientific evidence into clinical practice. Measure sets developed by the ACC/AHA are intended to provide practitioners and institutions that deliver cardiovascular services with tools to measure the quality of care provided and identify opportunities for improvement.

Writing committees are instructed to consider the methodology of performance measure development (1) and to ensure that the measures developed are aligned with ACC/AHA clinical practice guidelines. The writing committees also are charged with constructing measures that maximally capture important aspects of care quality, including timeliness, safety, effectiveness, efficiency, equity, and patient-centeredness, while minimizing, when possible, the reporting burden imposed on hospitals, practices, and/or practitioners.

Potential challenges from measure implementation may lead to unintended consequences. The manner in which challenges are addressed is dependent on several factors, including the measure design, data collection method, performance attribution, baseline performance rates, reporting methods, and incentives linked to these reports.

The ACC/AHA Task Force on Performance Measures (Task Force) distinguishes quality measures from performance measures. Quality measures are those metrics that may be useful for local quality improvement but are not yet appropriate for public reporting or pay for performance programs (uses of performance measures). New measures are initially evaluated for potential inclusion as performance measures. In some cases, a measure is insufficiently supported by the guidelines. In other instances, when the guidelines support a measure, the writing committee may feel it is necessary to have the measure tested to identify the consequences of measure implementation. Quality measures may then be promoted to the status of performance measures as supporting evidence becomes available.

Gregg C. Fonarow, MD, FACC, FAHA

Chair, ACC/AHA Task Force on Performance Measures

1. INTRODUCTION

In the summer of 2015, the Task Force convened the writing committee to begin the process of revising the existing set of performance measures for adult patients hospitalized with ST-Elevation and Non-ST-Elevation Myocardial Infarction (STEMI and NSTEMI, respectively), that was last updated in 2008 (2). The writing committee

was charged with the task of developing new measures to benchmark and improve the quality of care for patients with STEMI and NSTEMI.

All the measures included in the measure set are briefly summarized in [Table 1](#), which provides information on the measure number, title, care setting, attribution, and domain. The detailed measure specifications (available in [Appendix A](#)) provide not only the information included in [Table 1](#), but also more detailed information including the measure description, numerator, denominator (including denominator exclusions and exceptions), rationale for the measure, guideline recommendations that support the measure, measurement period, and sources of data.

The writing committee has developed a comprehensive STEMI/NSTEMI measure set that includes 24 total measures of which 17 are performance measures and 7 are quality measures (as reflected in [Table 1](#) and [Appendix A](#)). The writing committee believes that implementation of this measure set by healthcare providers, physician practices, and hospital systems will enhance the quality of care and likely improve outcomes of patients with STEMI and NSTEMI.

1.1. Scope of the Problem

Acute myocardial infarction (AMI) is a frequent cause of hospital admission in the United States and is associated with significant short- and long-term mortality and morbidity. Every 42 seconds, approximately 1 American will suffer an AMI, and the estimated annual incidences of new and recurrent MI events are 550,000 and 200,000 events, respectively (3).

Fortunately, the rates of hospitalization and 30-day mortality for AMI have been on the decline (4,5). This reduction in mortality is likely related to the shift in the pattern of clinical presentation of AMI as well as to improved acute treatments and long-term care. Yeh and colleagues examined age- and sex-adjusted incidence rates for STEMI and NSTEMI from a community-based population (Northern California) between 1999 and 2008, and demonstrated an overall significant decrease in AMI incidence rate after 2000 (6). Although the adjusted 30-day mortality rate after AMI decreased significantly (driven by a significant reduction in NSTEMI mortality), the overall mortality rate in 2008 after an AMI was still 7.8% at 30 days (6).

Importantly, AMI patients who survive the initial event have substantial risk for future cardiovascular events, including recurrent MI, death, heart failure, and stroke. In the PLATO (Platelet Inhibition and Patient Outcomes) trial, the rate of the combined cardiovascular endpoint (vascular death, MI, or stroke) was 11.7% at 12 months among AMI patients treated with aspirin and clopidogrel (7). This included a 6.9% rate of recurrent MI at 12 months

TABLE 1 2017 AHA/ACC STEMI and NSTEMI Myocardial Infarction Clinical Performance and Quality Measures

| No. | Measure Title | Care Setting | Attribution | Measure Domain |
|-----------------------------|---|--------------|----------------------------|--|
| Performance Measures | | | | |
| PM-1 | Aspirin at Arrival | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-2 | Aspirin Prescribed at Discharge | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-3 | Beta Blocker Prescribed at Discharge | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-4 | High-Intensity Statin Prescribed at Discharge | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-5 | Evaluation of LVEF | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-6 | ACEI or ARB Prescribed for LVSD | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-7 | Time to Fibrinolytic Therapy* | Inpatient | Facility or Provider Level | Communication and Care Coordination |
| PM-8 | Time to Primary PCI* | Inpatient | Facility or Provider Level | Communication and Care Coordination |
| PM-9 | Reperfusion Therapy* | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-10 | Time From ED Arrival at STEMI Referral Facility to ED Discharge From STEMI Referral Facility in Patients Transferred for Primary PCI* | Inpatient | Facility Level | Communication and Care Coordination |
| PM-11 | Time From FMC (At or Before ED Arrival at STEMI Referral Facility) to Primary PCI at STEMI Receiving Facility Among Transferred Patients* | Inpatient | Facility Level | Communication and Care Coordination |
| PM-12 | Cardiac Rehabilitation Patient Referral From an Inpatient Setting | Inpatient | Facility or Provider Level | Communication and Care Coordination |
| PM-13 | PY12 Receptor Inhibitor Prescribed at Discharge | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-14 | Immediate Angiography for Resuscitated Out-of-Hospital Cardiac Arrest in STEMI Patients* | Inpatient | Facility or Provider Level | Effective Clinical Care |
| PM-15 | Noninvasive Stress Testing Before Discharge in Conservatively Treated Patients | Inpatient | Facility or Provider Level | Efficiency and Cost Reduction |
| PM-16 | Early Cardiac Troponin Measurement† (Within 6 Hours of Arrival) | Inpatient | Facility or Provider Level | Efficiency and Cost Reduction |
| PM-17 | Participation in ≥1 Regional or National Registries That Include Patients With Acute Myocardial Infarction Registry | Inpatient | Facility Level | Community, Population, and Public Health |
| Quality Measures | | | | |
| QM-1 | Risk Stratification of NSTEMI Patients With a Risk Score† | Inpatient | Facility or Provider Level | Effective Clinical Care |
| QM-2 | Early Invasive Strategy (Within 24 Hours) in High-Risk NSTEMI Patients† | Inpatient | Facility or Provider Level | Effective Clinical Care |
| QM-3 | Therapeutic Hypothermia for Comatose STEMI Patients With Out-of-Hospital Cardiac Arrest* | Inpatient | Facility or Provider Level | Effective Clinical Care |
| QM-4 | Aldosterone Antagonist Prescribed at Discharge | Inpatient | Facility or Provider Level | Effective Clinical Care |
| QM-5 | Inappropriate In-Hospital Use of NSAIDs | Inpatient | Facility or Provider Level | Patient Safety |
| QM-6 | Inappropriate Prescription of Prasugrel at Discharge in Patients With a History of Prior Stroke or TIA | Inpatient | Facility or Provider Level | Patient Safety |
| QM-7 | Inappropriate Prescription of High-Dose Aspirin With Ticagrelor at Discharge | Inpatient | Facility or Provider Level | Patient Safety |

*These measures apply only to patients with STEMI. †These measures apply only to patients with NSTEMI.

ACC indicates American College of Cardiology; ACEI, angiotensin-converting enzyme inhibitor; AHA, American Heart Association; ARB, angiotensin receptor blocker; ED, emergency department; FMC, first medical contact; LVEF, left ventricular ejection fraction; LVSD, left ventricular systolic dysfunction; NSAIDs, nonsteroidal anti-inflammatory drugs; NSTEMI, non-ST-elevation myocardial infarction; PCI, percutaneous coronary intervention; PM, performance measures; QM, quality measures; STEMI, ST-elevation myocardial infarction; and TIA, transient ischemic attack.

(7). In 2010 alone, about 595,000 inpatient hospital discharges were attributed to AMI (3). AMI is also associated with a substantial direct and indirect cost burden, and is classified among the top 10 most expensive hospital principal discharge diagnoses (3).

As indicated in the Third Universal Definition of Myocardial Infarction consensus document published in

2012 (8), AMI is defined by the detection of a rise and/or fall of cardiac biomarkers (preferably cardiac troponin levels) with at least 1 value above the 99th percentile upper reference limit and with at least one of the following: (a) symptoms of ischemia; (b) new or presumed new significant ST-segment-T wave changes or new left bundle branch block; (c) development of pathological Q

waves in the electrocardiogram (ECG); (d) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality; (e) identification of an intracoronary thrombus by angiography or autopsy. The Third Universal Definition of Myocardial Infarction consensus document, published in 2012, classifies MI into 5 types, based on pathological, clinical, and prognostic differences, along with different treatment strategies (8). The performance and quality measures described in the current document are predominantly pertinent to patients with spontaneous MI, or MI type 1. MI type 1 is an event related to atherosclerotic plaque disruption (e.g., rupture, ulceration, erosion) with superimposed thrombus formation in a coronary artery, resulting in acute reduction in myocardial blood supply and/or distal embolization with subsequent myonecrosis. MI type 2 is myocardial injury caused by conditions other than coronary artery disease that results in an imbalance between myocardial oxygen supply and/or demand (e.g., coronary artery embolism or spasm, tachyarrhythmias, anemia, respiratory failure, profound hypotension).

The measure set developed by our writing committee applies only to MI type 1 and does not uniformly apply to the other 4 types of MI. In fact, some of those measures are even contraindicated with certain MI type, such as aspirin or P2Y₁₂ receptor inhibitor therapies, which are contraindicated in patients with a MI type 2 resulting from severe hemorrhage and anemia. Given the widespread use of very sensitive assays for markers of myocardial necrosis (e.g., the highly sensitive and specific cardiac troponin [cTn] biomarkers) and advanced imaging modalities, very small amounts of myonecrosis unrelated to ischemia can be detected (e.g., heart failure, renal failure, myocarditis, pulmonary embolism). Our measures also do not apply to these myocardial injury events, which should be differentiated from true AMI events.

For the sake of immediate treatment strategies (e.g., reperfusion therapy), AMI is differentiated into STEMI and NSTEMI, depending on the existence of ST-segment elevation in ≥ 2 contiguous leads on the presenting ECG. Acute STEMI equivalent can, however, manifest as: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of left bundle branch block. The proportion of STEMI versus NSTEMI events varies in different registries and depends on the age of patients, their geographic location, and the type of surveillance used. In general, STEMI patients account for 29% to 47% of all AMI patients (9,10).

Updating the existing STEMI/NSTEMI measure set was a priority for the ACC and AHA. Particular attention was given to evidence-based diagnostic and therapeutic strategies that have high impact on outcomes (e.g., Class I or

III guideline recommendations) of patients with STEMI/NSTEMI and that satisfy the attributes of performance measures (e.g., feasible, reliable, actionable). This writing committee developed the measures in this document after comprehensive examination of the most current relevant guidelines, internal discussion and internal voting, peer review, and public comment.

1.2. Disclosure of Relationships With Industry and Other Entities

The Task Force makes every effort to avoid actual, potential, or perceived conflicts of interest that could arise as a result of relationships with industry or other entities (RWI). Detailed information on the ACC/AHA policy on RWI can be found [online](#). All members of the writing committee, as well as those selected to serve as peer reviewers of this document, were required to disclose all current relationships and those existing within the 12 months before the initiation of this writing effort. ACC/AHA policy also requires that the writing committee chairs and at least 50% of the writing committee have no relevant RWI.

Any writing committee member who develops new RWI during his or her tenure on the writing committee is required to notify staff in writing. These statements are reviewed periodically by the Task Force and by members of the writing committee. Author and peer reviewer RWI which are relevant to the document are included in the appendixes: Please see [Appendix B](#) for relevant writing committee RWI and [Appendix C](#) for relevant peer reviewer RWI. Additionally, to ensure complete transparency, the writing committee members' comprehensive disclosure information, including RWI not relevant to the present document, is available [online](#). Disclosure information for the Task Force is also available [online](#).

The work of the writing committee was supported exclusively by the ACC and the AHA without commercial support. Members of the writing committee volunteered their time for this effort. Meetings of the writing committee were confidential and attended only by writing committee members and staff from the ACC, AHA, and the Society for Cardiovascular Angiography and Interventions who served as a collaborator on this project.

2. METHODOLOGY

2.1. Literature Review

In developing the updated STEMI/NSTEMI measure set, the writing committee reviewed evidence-based guidelines and statements that would potentially impact the construct of the measures. The practice guidelines and statements that most directly contributed to the development of these measures are summarized in [Table 2](#).

TABLE 2 Associated Guidelines and Other Clinical Guidance Documents**CLINICAL PRACTICE GUIDELINES**

1. 2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)
2. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction (12)
3. AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update (13)
4. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (14)
5. 2015 ACC/AHA/SCAI Focused Update on Primary Percutaneous Coronary Intervention for Patients With ST-Elevation Myocardial Infarction: An Update of the 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention and the 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction (15)
6. 2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease (16)
7. 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure (17)

STATEMENTS/PERFORMANCE MEASURES

1. 2015 ACC/AHA Focused Update of Secondary Prevention Lipid Performance Measures (18)
2. Third Universal Definition of Myocardial Infarction (8)
3. ACC/AHA 2008 Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction (2)
4. ACC/AHA 2008 Statement on Performance Measurement and Reperfusion Therapy (19)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; ESC indicates European Society of Cardiology; HFSA, Heart Failure Society of America; and SCAI, Society for Cardiovascular Angiography and Interventions.

2.2. Definition and Selection of Measures

The writing committee reviewed recent clinical practice guidelines and other clinical guidance documents (Table 2). The writing committee also examined available information on disparities in care to address which new measures might be appropriate as performance versus quality measures for this measure set update. To this effect, an extensive environmental scan of the published literature was performed. In a large retrospective analysis of STEMI patients transferred to primary percutaneous coronary intervention (PCI) centers in the ACTION-Get With The Guidelines registry (2007-2010), only 11% had timely door-in-door-out time ≤ 30 minutes (20). In another cohort of STEMI patients transferred from non-PCI-capable hospitals to STEMI receiving centers (2008-2012), timely primary PCI (≤ 120 minutes) was achieved in 65% of transferred patients (21). Another report showed that only 41% of patients were referred to cardiac rehabilitation after AMI (22,23). These reports highlight but a few examples of the persistent disparities in care. Importantly, it appears guideline-directed care can greatly reduce a large proportion of disparities previously noted in women (24,25).

All measures were designed to assess quality of care experienced by individuals who have STEMI or NSTEMI in the inpatient setting. Each measure was designed to limit performance measurement to patients without a valid reason for exclusion from the measure. Measure exclusions were those reasons that remove a patient from the denominator, regardless of whether they would be included in the numerator. For example, all measures excluded patients who were <18 years of age, who received comfort care measures only, or in hospice. In contrast to exclusions, denominator exceptions were those conditions that removed a patient from the denominator only if the numerator criteria were not met. Denominator exceptions were used in select cases to allow for a fairer measurement of quality for those providers with higher risk populations. Exceptions were also used to defer to the clinical judgment of the provider. Several of the measures included exceptions. For example, in the case of the “P2Y₁₂ Inhibitor at Discharge” measure, a care provider may write a prescription for an oral P2Y₁₂ receptor inhibitor (clopidogrel, ticagrelor, or prasugrel) even if the patient revealed that he/she will not take the medication due to a number of reasons (e.g., concerns about its bleeding risk). In this case, the provider would receive credit for the measure. However, if the patient had explicitly expressed to the provider that he/she did not wish to have the medication prescribed, no prescription will be written and the provider can then document in the medical record patient’s refusal of the medication. In this scenario, the provider will not be penalized for this performance measure because a valid patient reason is documented. The writing committee closely deliberated the exceptions to be included with each measure and, in some cases, determined not to include any exceptions (as in the case of the patient safety measures).

During the course of developing the measure set, the writing committee evaluated the potential measures against the ACC/AHA attributes of performance measures (Table 3) to reach consensus on which measures should be advanced for inclusion in the final measure set. After the peer review and public comment period, the writing committee reviewed and discussed the comments received, and further refined the measure set. The writing committee acknowledges that the new measures created in this set will need to be tested and validated over time. By publishing this performance and quality measure set, the writing committee hopes to encourage their widespread and expeditious adoption, as well as facilitate the collection and analysis of data that are needed to continuously assess their relevance over time. In the future, the writing committee members anticipate having data that will allow them to reassess whether any of the measures included in this set should be revised (e.g., modified, deleted, or potentially upgraded from a quality measure to a performance measure).

TABLE 3 ACC/AHA Task Force on Performance Measures: Attributes for Performance Measures (26)**1. Evidence Based**

| | |
|---|--|
| High-impact area that is useful in improving patient outcomes | <p>a) For structural measures, the structure should be closely linked to a meaningful process of care that in turn is linked to a meaningful patient outcome.</p> <p>b) For process measures, the scientific basis for the measure should be well established, and the process should be closely linked to a meaningful patient outcome.</p> <p>c) For outcome measures, the outcome should be clinically meaningful. If appropriate, performance measures based on outcomes should adjust for relevant clinical characteristics through the use of appropriate methodology and high-quality data sources.</p> |
|---|--|

2. Measure Selection

| | |
|-----------------------------------|--|
| Measure definition | a) The patient group to whom the measure applies (denominator) and the patient group for whom conformance is achieved (numerator) are clearly defined and clinically meaningful. |
| Measure exceptions and exclusions | b) Exceptions and exclusions are supported by evidence. |
| Reliability | c) The measure is reproducible across organizations and delivery settings. |
| Face validity | d) The measure appears to assess what it is intended to. |
| Content validity | e) The measure captures most meaningful aspects of care. |
| Construct validity | f) The measure correlates well with other measures of the same aspect of care. |

3. Measure Feasibility

| | |
|----------------------------|---|
| Reasonable effort and cost | a) The data required for the measure can be obtained with reasonable effort and cost. |
| Reasonable time period | b) The data required for the measure can be obtained within the period allowed for data collection. |

4. Accountability

| | |
|---------------------------------|--|
| Actionable | a) Those held accountable can affect the care process or outcome. |
| Unintended consequences avoided | b) The likelihood of negative unintended consequences with the measure is low. |

ACC indicates American College of Cardiology; AHA, American Heart Association.

3. AHA/ACC STEMI AND NSTEMI MEASURE SET PERFORMANCE MEASURES

3.1. Discussion of Changes to 2008 STEMI and NSTEMI Measure Set

After reviewing the existing guidelines, and the 2008 performance and quality measure set (2), the writing committee discussed which measures should be revised to reflect the updated science, and worked to identify which guideline recommendations could serve as the basis for new performance or quality measures. The writing committee also reviewed existing measure sets that were publicly available.

The following subsections serve as a synopsis of the revisions that were made to previous measures, and a description of why the new inpatient measures were created.

3.1.1. Retired Measures

The writing committee decided to retire 1 performance measure for smoking cessation counseling because of the consistently high levels of performance achieved (Table 4). Other quality measures, previously included as

test measures in the 2008 measure set, were retired for the reasons specified in Table 4.

3.1.2. Revised Measures

The writing committee reviewed and made changes to 4 measures, which are summarized in Table 5. Most the changes were made to reflect the new evidence and updated guideline recommendations, to strengthen the measure construct, or to expand the measures to include new proven pharmacotherapies.

3.1.3. New Measures

The new measure set includes 4 performance measures and 7 quality measures. Table 6 includes a list of the new measures and their rationale.

Four of the quality measures are structured in a typical format in which the goal is to seek a score of 100%. However, 3 of the new quality measures (QM-5, QM-6, and QM-7) are safety measures and, in those, the goal is to seek a score of 0% (e.g., 0% use or prescription of an inappropriate treatment reflects an optimal quality of care).

For more detailed information on the measure construct, please refer to the detailed measure specifications summarized in Appendix A.

TABLE 4 Retired STEMI and NSTEMI Measures From the 2008 Set

| # | Care Setting | Measure Title | Rationale for Retiring the Measure |
|-------|--------------|---|---|
| PM-12 | Inpatient | Adult Smoking Cessation Advice/Counseling | This measure is being retired because perfect scores are consistently achieved and the measure appears to have reached a ceiling effect. Therefore, given absence of room for further improvement, the writing committee opted to omit this measure from the inpatient performance measure set for AMI (realizing also that a separate outpatient CAD measure set will likely address smoking cessation advice/counseling). The writing committee also recognizes the importance of the American Medical Association/Physician Consortium for Performance Improvement Tobacco Use: Screening and Cessation Intervention measure that already exists (27). |
| QM-1 | Inpatient | LDL Cholesterol Assessment | This measure is being retired to be concordant with the new lipid guidelines that no longer recommend LDL measurements to target statin prescription and/or dosing. |
| QM-2 | Inpatient | Excessive Initial Heparin Dose | This measure is being retired because it covers only one aspect of medication use (e.g., overdosing) and misses other aspects such as under-dosing and inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-3 | Inpatient | Excessive Initial Enoxaparin Dose | This measure is being retired because it covers only one aspect of medication use (e.g., overdosing) and misses other aspects such as underdosing and inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-4 | Inpatient | Excessive Initial Abciximab Dose | This measure is being retired because it covers only one aspect of medication use, (e.g., overdosing) and misses other aspects such as underdosing and inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-5 | Inpatient | Excessive Initial Eptifibatide Dose | This measure is being retired because it covers only one aspect of medication use (e.g., overdosing) and misses other aspects such as underdosing and inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-6 | Inpatient | Excessive Initial Tirofiban Dose | This measure is being retired because it covers only one aspect of medication use (e.g., overdosing) and misses other aspects such as underdosing and inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-7 | Inpatient | Anticoagulant Dosing Protocol | This measure is being retired because it covers only one aspect of medication use and misses other aspects such as inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines and has shortcomings pertinent to measure feasibility and accountability. |
| QM-8 | Inpatient | Anticoagulant Error Tracking System | This measure is being retired because it covers only limited aspects of medication use and misses other aspects such as inappropriate use. In addition, this is not a direct stand-alone Class I or III recommendation in the guidelines. |

AMI indicates acute myocardial infarction; LDL, low-density lipoprotein; NSTEMI, non-ST-elevation myocardial infarction; PM, performance measure; QM, quality measure; and STEMI, ST-elevation myocardial infarction.

TABLE 5 Revised STEMI and NSTEMI Measures

| # | Care Setting | Measure Title | Rationale for Revision of the Measure |
|-------|--------------|--|---|
| PM-4 | Inpatient | Statin for AMI | This measure is being revised to reflect the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (14), which recommended statin use for all patients with established atherosclerotic cardiovascular disease, including patients with AMI. |
| PM-5 | Inpatient | Evaluation of LVEF | The title of this measure is being revised from "Evaluation of Left Ventricular Systolic Function" to "Evaluation of Left Ventricular Ejection Fraction." The treatment recommendations regarding the use of guideline-directed medication therapies are based on LVEF, not qualitative estimates of left ventricular systolic function. The 2013 ACCF/AHA STEMI guideline (12) explicitly recommended measuring LVEF. The 2014 AHA/ACC NSTEMI-ACS guidelines (11) likewise have medication recommendations based on knowledge of the ejection fraction. |
| PM-12 | Inpatient | Cardiac Rehabilitation Referral | This measure is being adapted from the AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac Rehabilitation/Secondary Prevention Services (28). One modification since the publication of that 2010 measurement set was the removal of patient reasons from the list of measure exceptions. Specifically, patient refusal does not constitute a justifiable reason for a clinician not offering a referral to a patient. If documentation in the medical record exists noting that the provider has informed and discussed referral to cardiac rehabilitation/secondary prevention program with the patient, but that the patient refuses a referral, then the healthcare provider would not be expected to send communication about the patient to the cardiac rehabilitation/secondary prevention program. This is consistent with HIPAA confidentiality regulations and shared decision making, and performance would then be considered met by the provider (preventing unjust penalization of the provider). |
| PM-13 | Inpatient | P2Y ₁₂ Receptor Inhibitor Prescribed at Discharge | In the 2008 ACC/AHA STEMI/NSTEMI measure set (2), a test measure entitled "Clopidogrel at Discharge" was included. Since then, 2 newer FDA-approved medications—ticagrelor and prasugrel—have emerged and demonstrated safety, efficacy, and clinical effectiveness after AMI. All 3 medications are inhibitors of the P2Y ₁₂ receptor and are recommended in addition to aspirin (as part of a dual antiplatelet regimen) to reduce recurrent ischemic events after AMI. |

AACVPR indicates American Association of Cardiovascular and Pulmonary Rehabilitation; ACC, American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; FDA, U.S. Food and Drug Administration; HIPAA, the Health Insurance Portability and Accountability Act; LVEF, left ventricular ejection fraction; NSTEMI, non-ST-elevation myocardial infarction; NSTEMI-ACS, non-ST-segment elevation acute coronary syndromes; PM, performance measure; and STEMI, ST-elevation myocardial infarction.

TABLE 6 New STEMI/NSTEMI Measures

| No. | Care Setting | Measure Title | Rationale for Creating New Measure | Rationale for Designating as a Quality Measure as Opposed to a Performance Measure (If Applicable) |
|-------|--------------|---|---|--|
| PM-14 | Inpatient | Immediate Angiography for Resuscitated Out-of-Hospital Cardiac Arrest in STEMI Patients | This measure seeks to implement a Class I (Level of Evidence B) recommendation in the 2013 ACCF/AHA STEMI guideline (12) that immediate angiography with PCI when indicated should be performed in resuscitated out-of-hospital cardiac arrest patients whose initial ECG shows STEMI. The writing committee opted to include angiography only, which is easily measurable, and not PCI because of the difficulty associated with ascertaining PCI appropriateness or its lack thereof. | Not Applicable |
| PM-15 | Inpatient | Noninvasive Stress Testing Before Discharge in Conservatively Treated Patients | This measure seeks to implement Class I (Level of Evidence B) recommendations in both the 2013 STEMI (12) and 2014 AHA/ACC NSTEMI-ACS (11) guidelines to perform noninvasive stress testing to detect inducible ischemia in medically treated STEMI and NSTEMI patients. | Not Applicable |
| PM-16 | Inpatient | Early Cardiac Troponin Measurement (Within 6 Hours of Arrival) | This measure seeks to implement Class I (Level of Evidence A) recommendations in the 2014 AHA/ACC NSTEMI-ACS guideline (11) to measure serial cardiac troponin levels (at presentation and 3 to 6 h after symptom onset in all patients). | Not Applicable |
| PM-17 | Inpatient | Participation in Regional or National Acute Myocardial Infarction Registry | This measure seeks to implement Class I (Level of Evidence B) and Class IIa (Level of Evidence B) recommendations in the 2013 STEMI (12) and 2014 AHA/ACC NSTEMI-ACS guidelines (11), respectively. The writing group felt that participation in a regional or national AMI registry will help track and assess the outcomes, complications, and quality of care for patients with AMI, and is supported by evidence. | Not Applicable |
| QM-1 | Inpatient | Risk Score Stratification for NSTEMI Patients | This measure seeks to implement a Class I (Level of Evidence A) recommendation in the 2014 AHA/ACC NSTEMI-ACS (11) guideline that risk scores should be used to assess prognosis in patients with NSTEMI-ACS. The writing committee realizes the importance of this measure to dictate the appropriate strategy (invasive versus ischemic-guided) and the timing of the strategy (early versus late invasive) in patients with NSTEMI. | The writing committee felt it was best to keep this as a quality measure because of issues related to the measure feasibility. Most registries do not include risk scores, and most risk scores (e.g., GRACE, TIMI, PURSUIT) are difficult to compute retrospectively from their respective components, and are likely to cause a significant abstraction burden. |
| QM-2 | Inpatient | Early Invasive Strategy (Within 24 Hours) in High-Risk NSTEMI Patients | This measure seeks to implement a Class I (Level of Evidence A) recommendation in the 2014 AHA/ACC NSTEMI-ACS guideline (11) that an early invasive strategy should be performed in initially stabilized high-risk patients with NSTEMI-ACS. | The writing committee felt it was best to keep this as a quality measure for many reasons. The writing group acknowledges that early invasive strategy (compared with a delayed invasive strategy) in high-risk NSTEMI-ACS patients predominantly reduces recurrent ischemia (rather than the hard outcomes of recurrent MI or death). Although this strategy additionally reduces length of stay and costs, it creates a logistical burden on cardiac catheterization labs, especially during weekends. Finally, objective risk stratification by risk scores is usually not available in current registries; thus, ascertaining which patients benefit from early invasive strategy may not be readily feasible. |
| QM-3 | Inpatient | Therapeutic Hypothermia for Comatose STEMI Patients With Out-of-Hospital Cardiac Arrest | This measure seeks to implement a Class I (Level of Evidence B) recommendation in the 2013 ACCF/AHA STEMI guideline (12) that therapeutic hypothermia should be started as soon as possible in comatose patients with STEMI and out-of-hospital cardiac arrest caused by VF or VT. | The writing committee felt it was best to keep this as a quality measure because of newer controversial data pertinent to the effectiveness, timing, and implementation of therapeutic hypothermia. |
| QM-4 | Inpatient | Aldosterone Antagonist at Discharge | This measure seeks to implement Class I recommendations in the 2013 ACCF/AHA STEMI (12) and 2014 AHA/ACC NSTEMI-ACS (11) guidelines supporting the use of aldosterone antagonists in eligible patients with STEMI and NSTEMI, respectively. | The writing committee felt it is best to keep this as a quality measure because of issues related to the measure construct. This measure is likely to present a significant abstraction burden and may be relevant only to a small fraction of AMI patients (given the elaborate inclusion/exclusion criteria in the EPHEUS (29) clinical trial). |

Continued on the next page

TABLE 6 Continued

| No. | Care Setting | Measure Title | Rationale for Creating New Measure | Rationale for Designating as a Quality Measure as Opposed to a Performance Measure (If Applicable) |
|------|--------------|--|--|--|
| QM-5 | Inpatient | Inappropriate In-Hospital Use of NSAIDs | This measure seeks to implement Class III recommendations (Class III Harm, Level of Evidence: B) in both the 2013 ACCF/AHA STEMI (12) and 2014 AHA/ACC NSTEMI-ACS (11) guidelines, cautioning against the use of these drugs after AMI. | The writing committee felt it is best to keep this as a quality measure given the low impact associated with the use of NSAIDs during the brief hospitalization period (this is likely more relevant in the outpatient setting). The existence of an extensive and evolving list of NSAIDs may also create significant abstraction burden. |
| QM-6 | Inpatient | Inappropriate Prescription of Prasugrel at Discharge in Patients With a History of Prior Stroke or TIA | This measure seeks to implement Class III recommendations (Class III HARM, Level of Evidence: B) in both the 2013 ACCF/AHA STEMI (12) and 2014 AHA/ACC NSTEMI-ACS (11) guidelines, cautioning against the use of prasugrel in patients with prior TIA/stroke, because of net clinical harm in these patients. The FDA also issued a black box warning on this. | The writing committee felt it is best to keep this as a quality measure only for the time being until more data become available pertinent to this measure and its impact in real-world patients. |
| QM-7 | Inpatient | Inappropriate Prescription of High-Dose Aspirin With Ticagrelor at Discharge | This measure seeks to implement Class III recommendations (Class III HARM, Level of Evidence: B) in both the 2013 ACCF/AHA STEMI (12) and 2014 AHA/ACC NSTEMI-ACS (11) guidelines, cautioning against the use of high-dose aspirin >100 mg among patients receiving ticagrelor. The FDA also issued a black box warning on this. | The writing committee felt it is best to keep this as a quality measure only for the time being until more data become available pertinent to this measure and its impact in real-world patients. |

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; EPHEUS, Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study; FDA, U.S. Food and Drug Administration; GRACE, Global Registry of Acute Coronary Events; NSAIDs, nonsteroidal anti-inflammatory drugs; NSTEMI-ACS, non-ST-segment elevation-acute coronary syndrome; NSTEMI, non-ST-elevation myocardial infarction; PM, performance measure; PCI, percutaneous coronary intervention; PURSUIT, Platelet Glycoprotein IIb/IIIa in Unstable Angina: Receptor Suppression Using Integrelin; QM, quality measure; STEMI, ST-segment elevation myocardial infarction; TIA, transient ischemic attack; TIMI, Thrombolysis in Myocardial Infarction; VF, ventricular fibrillation; and VT, ventricular tachycardia.

4. AREAS FOR FURTHER RESEARCH

The writing committee recognizes that the ultimate measure of performance lies in the assessment of outcomes, such as mortality (in-hospital or 30-day), health status, and other outcomes (recurrent MI, urgent repeat revascularization). However, the complexity associated with adjustment for the large number of patient characteristics that both influence treatment decisions and impact mortality make these measures less attractive to use. Thirty-day risk-adjusted AMI mortality has been used by CMS for payment incentives and in public reporting. The impact of these and other measures on hospital quality should be the focus of future research. The committee also realizes that many measures are already “topped-out” and can be retired to minimize abstraction burden. Additional research should examine the impact of dropping such measures. Furthermore, continuous research to examine temporal trends and disparities (i.e., with respect to sex, age, ethnicity) in the achievement of performance and quality measures will help guide future revisions as well as the implementation of the current set. While the majority of current measures are binary (for example, yes or no for medication prescription), the next frontier in performance evaluation may be also to measure doses of prescribed pharmacotherapies and compare them to doses used in randomized trials showing benefit. Finally, the ACC ACTION Registry– Get With The

Guidelines implemented a “Defect-Free Care” measure for AMI patients, which was endorsed by the National Quality Forum. Our writing committee did not adopt this measure in the current document to avoid the additional burden of data abstraction and reporting. This is especially important given that we have expanded the performance measure set to include a larger and more comprehensive set of 17 performance measures than previously adopted. Our writing committee acknowledges the importance of the “Defect-Free Care” measure and would like to evaluate its performance and impact in real world before considering it in the future. We also emphasize the importance of assessing the impact of compliance (or lack thereof) to some or all performance measures on short- and long-term clinical outcomes. Our writing committee also recognizes that all performance measures and quality measures are dynamic and can be revised or retired based on the emergence of scientific evidence and new guideline recommendations.

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REFERENCES

1. Spertus JA, Eagle KA, Krumholz HM, et al. American College of Cardiology and American Heart Association methodology for the selection and creation of performance measures for quantifying the quality of cardiovascular care. *Circulation*. 2005;111:1703-12.
2. Krumholz HM, Anderson JL, Bachelder BL, et al. ACC/AHA 2008 performance measures for adults with ST-elevation and non-ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Performance Measures (Writing Committee to Develop Performance Measures for ST-Elevation and Non-ST-Elevation Myocardial Infarction). Developed in collaboration with the American Academy of Family Physicians and American College of Emergency Physicians. *J Am Coll Cardiol*. 2008;52:2046-99.
3. Mozaffarian D, Benjamin EJ, Go AS, et al. Heart disease and stroke statistics—2016 update: a report from the American Heart Association. *Circulation*. 2016;133:e38-360.
4. Krumholz HM, Normand SL, Wang Y. Trends in hospitalizations and outcomes for acute cardiovascular disease and stroke, 1999-2011. *Circulation*. 2014;130:966-75.
5. Yeh RW, Normand SL, Wang Y, et al. Geographic disparities in the incidence and outcomes of hospitalized myocardial infarction: does a rising tide lift all boats? *Circ Cardiovasc Qual Outcomes*. 2012;5:197-204.
6. Yeh RW, Sidney S, Chandra M, et al. Population trends in the incidence and outcomes of acute myocardial infarction. *N Engl J Med*. 2010;362:2155-65.
7. Wallentin L, Becker RC, Budaj A, et al. Ticagrelor versus clopidogrel in patients with acute coronary syndromes. *N Engl J Med*. 2009;361:1045-57.
8. Thygesen K, Alpert JS, Jaffe AS, et al. Third universal definition of myocardial infarction. *J Am Coll Cardiol*. 2012;60:1581-98.
9. Roe MT, Parsons LS, Pollack CV Jr, et al. Quality of care by classification of myocardial infarction: treatment patterns for ST-segment elevation vs non-ST-segment elevation myocardial infarction. *Arch Intern Med*. 2005;165:1630-6.
10. Mandelzweig L, Battler A, Boyko V, et al. The second Euro Heart Survey on acute coronary syndromes: characteristics, treatment, and outcome of patients with ACS in Europe and the Mediterranean Basin in 2004. *Eur Heart J*. 2006;27:2285-93.
11. Amsterdam EA, Wenger NK, Brindis RG, et al. 2014 AHA/ACC guideline for the management of patients with non-ST-elevation acute coronary syndromes: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2014;64:e139-228.
12. O'Gara PT, Kushner FG, Ascheim DD, et al. 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2013;61:e78-140.
13. Smith SC Jr, Benjamin EJ, Bonow RO, et al. AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation. *J Am Coll Cardiol*. 2011;58:2432-46.
14. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2014;63:2889-934.
15. Levine GN, O'Gara PT, Bates ER, et al. 2015 ACC/AHA/SCAI Focused Update on primary percutaneous coronary intervention for patients with ST-elevation myocardial infarction: an update of the 2011 ACCF/AHA/SCAI guideline for percutaneous coronary intervention and the 2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. *J Am Coll Cardiol*. 2015;67:1235-50.
16. Levine GN, Bates ER, Bittl JA, et al. 2016 ACC/AHA guideline focused update on duration of dual antiplatelet therapy in patients with coronary artery disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2016;68:1082-115.
17. Yancy CW, Jessup M, Bozkurt B, et al. 2016 ACC/AHA/HFSA focused update on new pharmacological therapy for heart failure: an update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *J Am Coll Cardiol*. 2016;68:1476-88.
18. Drozda JP Jr, Ferguson TB Jr, Jneid H, et al. 2015 ACC/AHA focused update of secondary prevention lipid performance measures: a report of the American College of Cardiology/American Heart Association Task Force on Performance Measures. *J Am Coll Cardiol*. 2016;67:558-87.
19. Masoudi FA, Bonow RO, Brindis RG, et al. ACC/AHA 2008 statement on performance measurement and reperfusion therapy: a report of the ACC/AHA Task Force on Performance Measures (Work Group to address the challenges of Performance Measurement and Reperfusion Therapy). *J Am Coll Cardiol*. 2008;52:2100-12.
20. Wang TY, Nallamothu BK, Krumholz HM, et al. Association of door-in to door-out time with reperfusion delays and outcomes among patients transferred for primary percutaneous coronary intervention. *JAMA*. 2011;305:2540-7.
21. Dauerman HL, Bates ER, Kontos MC, et al. Nationwide analysis of patients with ST-segment-elevation myocardial infarction transferred for primary percutaneous intervention: findings from the American Heart Association Mission: Lifeline Program. *Circ Cardiovasc Interv*. 2015;8:e002450.
22. Jneid H. Cardiac rehabilitation after myocardial infarction: unmet needs and future directions. *JAMA Cardiol*. 2016;1:978-9.
23. Aragam KG, Dai D, Neely ML, et al. Gaps in referral to cardiac rehabilitation of patients undergoing percutaneous coronary intervention in the United States. *J Am Coll Cardiol*. 2015;65:2079-88.
24. Bangalore S, Fonarow GC, Peterson ED, et al. Age and gender differences in quality of care and outcomes for patients with ST-segment elevation myocardial infarction. *Am J Med*. 2012;125:1000-9.
25. Li S, Fonarow GC, Mukamal KJ, et al. Sex and race/ethnicity-related disparities in care and outcomes after hospitalization for coronary artery disease among older adults. *Circ Cardiovasc Qual Outcomes*. 2016;9:S36-44.
26. Normand SL, McNeil BJ, Peterson LE, et al. Eliciting expert opinion using the Delphi technique: identifying performance indicators for cardiovascular disease. *Int J Qual Health Care*. 1998;10:247-60.
27. Physician Consortium for Performance Improvement. Tobacco Use: Screening and Cessation Intervention. Available at: <https://www.thepcpi.org/pcpi/media/PCPI-Maintained-Measures/Preventive-Care-and-Screening-Updated-June-2016.pdf>. Accessed June 2, 2017.
28. Thomas RJ, King M, Lui K, et al. AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac

Rehabilitation/Secondary Prevention Services. *J Am Coll Cardiol*. 2010;56:1159-67.

29. Pitt B, Remme W, Zannad F, et al. Eplerenone, a selective aldosterone blocker, in patients with left ventricular dysfunction after myocardial infarction. *N Engl J Med*. 2003;348:1309-21.

30. ISIS-2 (Second International Study of Infarct Survival Collaborative Group. Randomised trial of intravenous streptokinase, oral aspirin, both, or neither among 17,187 cases of suspected acute myocardial infarction: ISIS-2. *Lancet*. 1988;2:349-60.

31. Xian Y, Wang TY, McCoy LA, et al. Association of discharge aspirin dose with outcomes after acute myocardial infarction: insights from the Treatment with ADP Receptor Inhibitors: Longitudinal Assessment of Treatment Patterns and Events after Acute Coronary Syndrome (TRANSLATE-ACS) study. *Circulation*. 2015;132:174-81.

32. Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *BMJ*. 2002;324:71-86.

33. Mehta SR, Bassand JP, Chrolavicius S, et al. Dose comparisons of clopidogrel and aspirin in acute coronary syndromes. *N Engl J Med*. 2010;363:930-42.

34. Grosser T, Fries S, Lawson JA, et al. Drug resistance and pseudoresistance: an unintended consequence of enteric coating aspirin. *Circulation*. 2013;127:377-85.

35. Barnathan ES, Schwartz JS, Taylor L, et al. Aspirin and dipyridamole in the prevention of acute coronary thrombosis complicating coronary angioplasty. *Circulation*. 1987;76:125-34.

36. Jolly SS, Pogue J, Haladyn K, et al. Effects of aspirin dose on ischaemic events and bleeding after percutaneous coronary intervention: insights from the PCI-CURE study. *Eur Heart J*. 2009;30:900-7.

37. Chen ZM, Jiang LX, Chen YP, et al. Addition of clopidogrel to aspirin in 45,852 patients with acute myocardial infarction: randomised placebo-controlled trial. *Lancet*. 2005;366:1607-21.

38. Sabatine MS, Cannon CP, Gibson CM, et al. Addition of clopidogrel to aspirin and fibrinolytic therapy for myocardial infarction with ST-segment elevation. *N Engl J Med*. 2005;352:1179-89.

39. Baigent C, Blackwell L, Collins R, et al. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials. *Lancet*. 2009;373:1849-60.

40. Mahaffey KW, Wojdyla DM, Carroll K, et al. Ticagrelor compared with clopidogrel by geographic region in the Platelet Inhibition and Patient Outcomes (PLATO) trial. *Circulation*. 2011;124:544-54.

41. Mehta SR, Tanguay JF, Eikelboom JW, et al. Double-dose versus standard-dose clopidogrel and high-dose versus low-dose aspirin in individuals undergoing percutaneous coronary intervention for acute coronary syndromes (CURRENT-OASIS 7): a randomised factorial trial. *Lancet*. 2010;376:1233-43.

42. Yusuf S, Zhao F, Mehta SR, et al. Effects of clopidogrel in addition to aspirin in patients with acute coronary syndromes without ST-segment elevation. *N Engl J Med*. 2001;345:494-502.

43. Levine GN, Bates ER, Blankenship JC, et al. 2011 ACCF/AHA/SCAI guideline for percutaneous coronary intervention: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. *J Am Coll Cardiol*. 2011;58:e44-122.

44. Popma JJ, Berger P, Ohman EM, et al. Antithrombotic therapy during percutaneous coronary intervention: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. *Chest*. 2004;126:576S-99S.

45. CAPRIE Steering Committee. A randomised, blinded, trial of clopidogrel versus aspirin in patients at risk of ischaemic events (CAPRIE). *Lancet*. 1996;348:1329-39.

46. Deleted in press.

47. Schomig A, Neumann FJ, Kastrati A, et al. A randomized comparison of antiplatelet and anticoagulant therapy after the placement of coronary-artery stents. *N Engl J Med*. 1996;334:1084-9.

48. Freemantle N, Cleland J, Young P, et al. Beta blockade after myocardial infarction: systematic review and meta regression analysis. *BMJ*. 1999;318:1730-7.

49. BHAT Study Investigators. A randomized trial of propranolol in patients with acute myocardial infarction. I. Mortality results. *JAMA*. 1982;247:1707-14.

50. Randomised trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian Simvastatin Survival Study (4S). *Lancet*. 1994;344:1383-9.

51. Sacks FM, Pfeffer MA, Moye LA, et al. The effect of pravastatin on coronary events after myocardial infarction in patients with average cholesterol levels. Cholesterol and Recurrent Events Trial investigators. *N Engl J Med*. 1996;335:1001-9.

52. Wilt TJ, Bloomfield HE, MacDonald R, et al. Effectiveness of statin therapy in adults with coronary heart disease. *Arch Intern Med*. 2004;164:1427-36.

53. Baigent C, Blackwell L, Emberson J, et al. Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomised trials. *Lancet*. 2010;376:1670-81.

54. Larsson H, Areskog M, Areskog NH, et al. Should the exercise test (ET) be performed at discharge or one month later after an episode of unstable angina or non-Q-wave myocardial infarction? *Int J Card Imaging*. 1991;7:7-14.

55. Mahmarian JJ, Shaw LJ, Filipchuk NG, et al. A multinational study to establish the value of early adenosine technetium-99m sestamibi myocardial perfusion imaging in identifying a low-risk group for early hospital discharge after acute myocardial infarction. *J Am Coll Cardiol*. 2006;48:2448-57.

56. Nyman I, Larsson H, Areskog M, et al. The predictive value of silent ischemia at an exercise test before discharge after an episode of unstable coronary artery disease. RISC Study Group. *Am Heart J*. 1992;123:324-31.

57. Starling MR, Crawford MH, Kennedy GT, et al. Treadmill exercise tests predischarge and six weeks post-myocardial infarction to detect abnormalities of known prognostic value. *Ann Intern Med*. 1981;94:721-7.

58. Marwick TH, Anderson T, Williams MJ, et al. Exercise echocardiography is an accurate and cost-efficient technique for detection of coronary artery disease in women. *J Am Coll Cardiol*. 1995;26:335-41.

59. Pfeffer MA, Braunwald E, Moye LA, et al. Effect of captopril on mortality and morbidity in patients with left ventricular dysfunction after myocardial infarction. Results of the survival and ventricular enlargement trial. The SAVE Investigators. *N Engl J Med*. 1992;327:669-77.

60. Torp-Pedersen C, Kober L. Effect of ACE inhibitor trandolapril on life expectancy of patients with reduced left-ventricular function after acute myocardial infarction. TRACE Study Group. Trandolapril Cardiac Evaluation. *Lancet*. 1999;354:9-12.

61. ACE inhibitor Myocardial Infarction Collaborative Group. Indications for ACE inhibitors in the early treatment of acute myocardial infarction: systematic overview of individual data from 100,000 patients in randomized trials. ACE Inhibitor Myocardial Infarction Collaborative Group. *Circulation*. 1998;97:2202-12.

62. Pfeffer MA, McMurray JJ, Velazquez EJ, et al. Valsartan, captopril, or both in myocardial infarction complicated by heart failure, left ventricular dysfunction, or both. *N Engl J Med*. 2003;349:1893-906.

63. Ball SG, Hall AS, Murray GD. ACE inhibition, atherosclerosis and myocardial infarction—the AIRE Study in practice. Acute Infarction Ramipril Efficacy Study. *Eur Heart J* 1994; 15 suppl B:20-5, 26-30.

64. Kober L, Torp-Pedersen C, Carlsen JE, et al. A clinical trial of the angiotensin-converting-enzyme inhibitor trandolapril in patients with left ventricular dysfunction after myocardial infarction. Trandolapril Cardiac Evaluation (TRACE) Study Group. *N Engl J Med*. 1995;333:1670-6.

65. Pfeffer MA, Greaves SC, Arnold JM, et al. Early versus delayed angiotensin-converting enzyme inhibition therapy in acute myocardial infarction: the healing and early afterload reducing therapy trial. *Circulation*. 1997;95:2643-51.

66. Maggioni AP, Fabbri G. VALIANT (VALsartan In Acute myocardial iNfarcTion) trial. *Expert Opin Pharmacother*. 2005;6:507-12.

67. Garg R, Yusuf S. Overview of randomized trials of angiotensin-converting enzyme inhibitors on mortality and morbidity in patients with heart failure. Collaborative Group on ACE Inhibitor Trials. *JAMA*. 1995;273:1450-6.

68. Yusuf S, Sleight P, Pogue J, et al. Effects of an angiotensin-converting-enzyme inhibitor, ramipril, on cardiovascular events in high-risk patients. The Heart Outcomes Prevention Evaluation Study Investigators. *N Engl J Med*. 2000;342:145-53.

69. Yusuf S, Teo KK, Pogue J, et al. Telmisartan, ramipril, or both in patients at high risk for vascular events. *N Engl J Med*. 2008;358:1547-59.

70. Fibrinolytic Therapy Trialists' (FTT) Collaborative Group. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet*. 1994;343:311-22.

71. Boersma E, Maas AC, Deckers JW, et al. Early thrombolytic treatment in acute myocardial

infarction: reappraisal of the golden hour. *Lancet*. 1996;348:771-5.

72. Goldberg RJ, Mooradd M, Gurwitz JH, et al. Impact of time to treatment with tissue plasminogen activator on morbidity and mortality following acute myocardial infarction (The second National Registry of Myocardial Infarction). *Am J Cardiol*. 1998;82:259-64.

73. Milavetz JJ, Giebel DW, Christian TF, et al. Time to therapy and salvage in myocardial infarction. *J Am Coll Cardiol*. 1998;31:1246-51.

74. Nallamothu BK, Bates ER. Percutaneous coronary intervention versus fibrinolytic therapy in acute myocardial infarction: is timing (almost) everything? *Am J Cardiol*. 2003;92:824-6.

75. Pinto DS, Kirtane AJ, Nallamothu BK, et al. Hospital delays in reperfusion for ST-elevation myocardial infarction: implications when selecting a reperfusion strategy. *Circulation*. 2006;114:2019-25.

76. Chareonthaitawee P, Gibbons RJ, Roberts RS, et al. The impact of time to thrombolytic treatment on outcome in patients with acute myocardial infarction. For the CORE investigators (Collaborative Organisation for RheothRx Evaluation). *Heart*. 2000;84:142-8.

77. McNamara RL, Herrin J, Wang Y, et al. Impact of delay in door-to-needle time on mortality in patients with ST-segment elevation myocardial infarction. *Am J Cardiol*. 2007;100:1227-32.

78. Newby LK, Rutsch WR, Califf RM, et al. Time from symptom onset to treatment and outcomes after thrombolytic therapy. GUSTO-1 Investigators. *J Am Coll Cardiol*. 1996;27:1646-55.

79. The ISAM Study Group. A prospective trial of intravenous streptokinase in acute myocardial infarction (I.S.A.M.). Mortality, morbidity, and infarct size at 21 days. *N Engl J Med*. 1986;314:1465-71.

80. Rossi P, Bolognese L. Comparison of intravenous urokinase plus heparin versus heparin alone in acute myocardial infarction. Urochinas per via Sistemica nell'Infarto Miocardico (USIM) Collaborative Group. *Am J Cardiol*. 1991;68:585-92.

81. AIMS Trial Study Group. Effect of intravenous APSAC on mortality after acute myocardial infarction: preliminary report of a placebo-controlled clinical trial. *Lancet*. 1988;1:545-9.

82. LATE Study Group. Late Assessment of Thrombolytic Efficacy (LATE) study with alteplase 6-24 hours after onset of acute myocardial infarction. *Lancet*. 1993;342:759-66.

83. EMERAS (Estudio Multicentrico Estreptoquinasa Republicas de America del Sur) Collaborative Group. Randomised trial of late thrombolysis in patients with suspected acute myocardial infarction. *Lancet*. 1993;342:767-72.

84. Early effects of tissue-type plasminogen activator added to conventional therapy on the culprit coronary lesion in patients presenting with ischemic cardiac pain at rest. Results of the Thrombolysis in Myocardial Ischemia (TIMI IIIA) Trial. *Circulation*. 1993;87:38-52.

85. Barrabes JA, Figueras J, Moure C, et al. Prognostic value of lead aVR in patients with a first non-ST-segment elevation acute myocardial infarction. *Circulation*. 2003;108:814-9.

86. de Winter RJ, Verouden NJ, Wellens HJ, et al. A new ECG sign of proximal LAD occlusion. *N Engl J Med*. 2008;359:2071-3.

87. Jong GP, Ma T, Chou P, et al. Reciprocal changes in 12-lead electrocardiography can predict left main coronary artery lesion in patients with acute myocardial infarction. *Int Heart J*. 2006;47:13-20.

88. French JK, Feldman HA, Assmann SF, et al. Influence of thrombolytic therapy, with or without intra-aortic balloon counterpulsation, on 12-month survival in the SHOCK trial. *Am Heart J*. 2003;146:804-10.

89. Morrow DA, Antman EM, Charlesworth A, et al. TIMI risk score for ST-elevation myocardial infarction: A convenient, bedside, clinical score for risk assessment at presentation: An intravenous nPA for treatment of infarcting myocardium early II trial substudy. *Circulation*. 2000;102:2031-7.

90. The Global Use of Strategies to Open Occluded Coronary Arteries in Acute Coronary Syndromes (GUSTO IIb) Angioplasty Substudy Investigators. A clinical trial comparing primary coronary angioplasty with tissue plasminogen activator for acute myocardial infarction: GUSTO IIb. *N Engl J Med*. 1997;336:1621-8.

91. Zijlstra F, Hoortniet JC, de Boer MJ, et al. Long-term benefit of primary angioplasty as compared with thrombolytic therapy for acute myocardial infarction. *N Engl J Med*. 1999;341:1413-9.

92. Keeley EC, Boura JA, Grines CL. Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: a quantitative review of 23 randomised trials. *Lancet*. 2003;361:13-20.

93. Andersen HR, Nielsen TT, Vesterlund T, et al. Danish multicenter randomized study on fibrinolytic therapy versus acute coronary angioplasty in acute myocardial infarction: rationale and design of the DANISH trial in Acute Myocardial Infarction-2 (DANAMI-2). *Am Heart J*. 2003;146:234-41.

94. Dalby M, Bouzamondo A, Lechat P, et al. Transfer for primary angioplasty versus immediate thrombolysis in acute myocardial infarction: a meta-analysis. *Circulation*. 2003;108:1809-14.

95. Le May MR, So DY, Dionne R, et al. A citywide protocol for primary PCI in ST-segment elevation myocardial infarction. *N Engl J Med*. 2008;358:231-40.

96. Rokos IC, French WJ, Koenig WJ, et al. Integration of pre-hospital electrocardiograms and ST-elevation myocardial infarction receiving center (SRC) networks: impact on Door-to-Balloon times across 10 independent regions. *JACC Cardiovasc Interv*. 2009;2:339-46.

97. Sorensen JT, Terkelsen CJ, Norgaard BL, et al. Urban and rural implementation of pre-hospital diagnosis and direct referral for primary percutaneous coronary intervention in patients with acute ST-elevation myocardial infarction. *Eur Heart J*. 2011;32:430-6.

98. Andersen HR, Nielsen TT, Rasmussen K, et al. A comparison of coronary angioplasty with fibrinolytic therapy in acute myocardial infarction. *N Engl J Med*. 2003;349:733-42.

99. Nielsen PH, Terkelsen CJ, Nielsen TT, et al. System Delay and Timing of Intervention in Acute Myocardial Infarction (from the Danish Acute Myocardial Infarction-2 [DANAMI-2] Trial). *Am J Cardiol*. 2011;108:776-81.

100. Grzybowski M, Clements EA, Parsons L, et al. Mortality benefit of immediate revascularization of

acute ST-segment elevation myocardial infarction in patients with contraindications to thrombolytic therapy: a propensity analysis. *JAMA*. 2003;290:1891-8.

101. Zahn R, Schuster S, Schiele R, et al. Comparison of primary angioplasty with conservative therapy in patients with acute myocardial infarction and contraindications for thrombolytic therapy. Maximal Individual Therapy in Acute Myocardial Infarction (MITRA) Study Group. *Catheter Cardiovasc Interv*. 1999;46:127-33.

102. Hochman JS, Sleeper LA, Webb JG, et al. Early revascularization in acute myocardial infarction complicated by cardiogenic shock. SHOCK Investigators. Should we emergently revascularize occluded coronaries for cardiogenic shock. *N Engl J Med*. 1999;341:625-34.

103. Hochman JS, Lamas GA, Buller CE, et al. Coronary intervention for persistent occlusion after myocardial infarction. *N Engl J Med*. 2006;355:2395-407.

104. Thune JJ, Hoefsten DE, Lindholm MG, et al. Simple risk stratification at admission to identify patients with reduced mortality from primary angioplasty. *Circulation*. 2005;112:2017-21.

105. Wu AH, Parsons L, Every NR, et al. Hospital outcomes in patients presenting with congestive heart failure complicating acute myocardial infarction: a report from the Second National Registry of Myocardial Infarction (NORMI-2). *J Am Coll Cardiol*. 2002;40:1389-94.

106. Glickman SW, Lytle BL, Ou FS, et al. Care processes associated with quicker door-in-door-out times for patients with ST-elevation-myocardial infarction requiring transfer: results from a statewide regionalization program. *Circ Cardiovasc Qual Outcomes*. 2011;4:382-8.

107. Hochman JS, Sleeper LA, White HD, et al. One-year survival following early revascularization for cardiogenic shock. *JAMA*. 2001;285:190-2.

108. Eagle KA, Guyton RA, Davidoff R, et al. ACC/AHA 2004 guideline update for coronary artery bypass graft surgery: summary article. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery). *J Am Coll Cardiol*. 2004;44:e213-310.

109. Antman EM, Hand M, Armstrong PW, et al. 2007 focused update of the ACC/AHA 2004 guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2008;51:210-47.

110. Anderson JL, Adams CD, Antman EM, et al. ACC/AHA 2007 guidelines for the management of patients with unstable angina/non-ST-Elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Revise the 2002 Guidelines for the Management of Patients With Unstable Angina/Non-ST-Elevation Myocardial Infarction). Developed in collaboration with the American College of Emergency Physicians, the Society for Cardiovascular Angiography and Interventions, and the Society of Thoracic Surgeons. *J Am Coll Cardiol*. 2007;50:e1-157.

111. Fraker TD Jr, Fihn SD, Gibbons RJ, et al. 2007 chronic angina focused update of the ACC/AHA 2002

guidelines for the management of patients with chronic stable angina: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Group to Develop the Focused Update of the 2002 Guidelines for the Management of Patients With Chronic Stable Angina). *J Am Coll Cardiol*. 2007;50:2264-74.

112. Hunt SA. ACC/AHA 2005 guideline update for the diagnosis and management of chronic heart failure in the adult: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure). *J Am Coll Cardiol*. 2005;46:e1-82.

113. Mosca L, Banka CL, Benjamin EJ, et al. Evidence-based guidelines for cardiovascular disease prevention in women: 2007 update. *Circulation*. 2007;115:1481-501.

114. King SB III, Smith SC Jr, Hirshfeld JW Jr, et al. 2007 focused update of the ACC/AHA/SCAI 2005 guideline update for percutaneous coronary intervention: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2008;51:172-209.

115. Montalescot G, Wiwiot SD, Braunwald E, et al. Prasugrel compared with clopidogrel in patients undergoing percutaneous coronary intervention for ST-elevation myocardial infarction (TRITON-TIMI 38): double-blind, randomised controlled trial. *Lancet*. 2009;373:723-31.

116. Wiwiot SD, Braunwald E, McCabe CH, et al. Prasugrel versus clopidogrel in patients with acute coronary syndromes. *N Engl J Med*. 2007;357:2001-15.

117. Steg PG, James S, Harrington RA, et al. Ticagrelor versus clopidogrel in patients with ST-elevation acute coronary syndromes intended for reperfusion with primary percutaneous coronary intervention: A Platelet Inhibition and Patient Outcomes (PLATO) trial subgroup analysis. *Circulation*. 2010;122:2131-41.

118. James SK, Storey RF, Khurmi NS, et al. Ticagrelor versus clopidogrel in patients with acute coronary syndromes and a history of stroke or transient ischemic attack. *Circulation*. 2012;125:2914-21.

119. Shishebor MH, Topol EJ, Mukherjee D, et al. Outcome of multivessel coronary intervention in the contemporary percutaneous revascularization era. *Am J Cardiol*. 2006;97:1585-90.

120. Mehta SR, Yusuf S, Peters RJ, et al. Effects of pretreatment with clopidogrel and aspirin followed by long-term therapy in patients undergoing percutaneous coronary intervention: the PCI-CURE study. *Lancet*. 2001;358:527-33.

121. Steinhilbl SR, Bhatt DL, Brennan DM, et al. Aspirin to prevent cardiovascular disease: the association of aspirin dose and clopidogrel with thrombosis and bleeding. *Ann Intern Med*. 2009;150:379-86.

122. Bendz B, Eritsland J, Nakstad AR, et al. Long-term prognosis after out-of-hospital cardiac arrest and primary percutaneous coronary intervention. *Resuscitation*. 2004;63:49-53.

123. Borger van der Burg AE, Bax JJ, Boersma E, et al. Impact of percutaneous coronary intervention or coronary artery bypass grafting on outcome after nonfatal cardiac arrest outside the hospital. *Am J Cardiol*. 2003;91:785-9.

124. Bulut S, Aengevaeren WR, Luijten HJ, et al. Successful out-of-hospital cardiopulmonary resuscitation: what is the optimal in-hospital treatment strategy? *Resuscitation*. 2000;47:155-61.

125. Garot P, Lefevre T, Eltchaninoff H, et al. Six-month outcome of emergency percutaneous coronary intervention in resuscitated patients after cardiac arrest complicating ST-elevation myocardial infarction. *Circulation*. 2007;115:1354-62.

126. Gorjup V, Radsel P, Kocjancic ST, et al. Acute ST-elevation myocardial infarction after successful cardiopulmonary resuscitation. *Resuscitation*. 2007;72:379-85.

127. Hosmane VR, Mustafa NG, Reddy VK, et al. Survival and neurologic recovery in patients with ST-segment elevation myocardial infarction resuscitated from cardiac arrest. *J Am Coll Cardiol*. 2009;53:409-15.

128. Kahn JK, Glazier S, Swor R, et al. Primary coronary angioplasty for acute myocardial infarction complicated by out-of-hospital cardiac arrest. *Am J Cardiol*. 1995;75:1069-70.

129. Keelan PC, Bunch TJ, White RD, et al. Early direct coronary angioplasty in survivors of out-of-hospital cardiac arrest. *Am J Cardiol*. 2003;91:1461-3, A6.

130. Kern KB, Rahman O. Emergent percutaneous coronary intervention for resuscitated victims of out-of-hospital cardiac arrest. *Catheter Cardiovasc Interv*. 2010;75:616-24.

131. Marcusohn E, Roguin A, Sebbag A, et al. Primary percutaneous coronary intervention after out-of-hospital cardiac arrest: patients and outcomes. *Isr Med Assoc J*. 2007;9:257-9.

132. Nichol G, Thomas E, Callaway CW, et al. Regional variation in out-of-hospital cardiac arrest incidence and outcome. *JAMA*. 2008;300:1423-31.

133. Pleskot M, Babu A, Hazukova R, et al. Out-of-hospital cardiac arrests in patients with acute ST elevation myocardial infarctions in the East Bohemian region over the period 2002-2004. *Cardiology*. 2008;109:41-51.

134. Quintero-Moran B, Moreno R, Villarreal S, et al. Percutaneous coronary intervention for cardiac arrest secondary to ST-elevation acute myocardial infarction. Influence of immediate paramedical/medical assistance on clinical outcome. *J Invasive Cardiol*. 2006;18:269-72.

135. Richling N, Herkner H, Holzer M, et al. Thrombolytic therapy vs primary percutaneous intervention after ventricular fibrillation cardiac arrest due to acute ST-segment elevation myocardial infarction and its effect on outcome. *Am J Emerg Med*. 2007;25:545-50.

136. Spaulding CM, Joly LM, Rosenberg A, et al. Immediate coronary angiography in survivors of out-of-hospital cardiac arrest. *N Engl J Med*. 1997;336:1629-33.

137. Werling M, Thoren AB, Axelsson C, et al. Treatment and outcome in post-resuscitation care after out-of-hospital cardiac arrest when a modern therapeutic approach was introduced. *Resuscitation*. 2007;73:40-5.

138. Leppo JA, O'Brien J, Rothendler JA, et al. Dipyridamole-thallium-201 scintigraphy in the prediction of future cardiac events after acute myocardial infarction. *N Engl J Med*. 1984;310:1014-8.

139. Marwick TH, Nakatani S, Haluska B, et al. Provocation of latent left ventricular outflow tract gradients with amyl nitrite and exercise in hypertrophic cardiomyopathy. *Am J Cardiol*. 1995;75:805-9.

140. Theroux P, Waters DD, Halphen C, et al. Prognostic value of exercise testing soon after myocardial infarction. *N Engl J Med*. 1979;301:341-5.

141. Vilella A, Maggioni AP, Vilella M, et al. Prognostic significance of maximal exercise testing after myocardial infarction treated with thrombolytic agents: the GISSI-2 data-base. Gruppo Italiano per lo Studio della Sopravvivenza Nell'Infarto. *Lancet*. 1995;346:523-9.

142. Keller T, Zeller T, Ojeda F, et al. Serial changes in highly sensitive troponin I assay and early diagnosis of myocardial infarction. *JAMA*. 2011;306:2684-93.

143. Eggers KM, Jaffe AS, Venge P, et al. Clinical implications of the change of cardiac troponin I levels in patients with acute chest pain - an evaluation with respect to the Universal Definition of Myocardial Infarction. *Clin Chim Acta*. 2011;412:91-7.

144. Apple FS, Smith SW, Pearce LA, et al. Delta changes for optimizing clinical specificity and 60-day risk of adverse events in patients presenting with symptoms suggestive of acute coronary syndrome utilizing the ADVIA Centaur Tnl-Ultra assay. *Clin Biochem*. 2012;45:711-3.

145. Giannitsis E, Becker M, Kurz K, et al. High-sensitivity cardiac troponin T for early prediction of evolving non-ST-segment elevation myocardial infarction in patients with suspected acute coronary syndrome and negative troponin results on admission. *Clin Chem*. 2010;56:642-50.

146. Lindahl B, Venge P, James S. The new high-sensitivity cardiac troponin T assay improves risk assessment in acute coronary syndromes. *Am Heart J*. 2010;160:224-9.

147. Reichlin T, Irfan A, Twerenbold R, et al. Utility of absolute and relative changes in cardiac troponin concentrations in the early diagnosis of acute myocardial infarction. *Circulation*. 2011;124:136-45.

148. Apple FS, Pearce LA, Smith SW, et al. Role of monitoring changes in sensitive cardiac troponin I assay results for early diagnosis of myocardial infarction and prediction of risk of adverse events. *Clin Chem*. 2009;55:930-7.

149. Hammarsten O, Fu ML, Sigurjonsdottir R, et al. Troponin T percentiles from a random population sample, emergency room patients and patients with myocardial infarction. *Clin Chem*. 2012;58:628-37.

150. Santalo M, Martin A, Velilla J, et al. Using high-sensitivity troponin T: the importance of the proper gold standard. *Am J Med*. 2013;126:709-17.

151. Aguirre FV, Varghese JJ, Kelley MP, et al. Rural interhospital transfer of ST-elevation myocardial infarction patients for percutaneous coronary revascularization: the Stat Heart Program. *Circulation*. 2008;117:1145-52.

152. Henry TD, Sharkey SW, Burke MN, et al. A regional system to provide timely access to percutaneous coronary intervention for ST-elevation myocardial infarction. *Circulation*. 2007;116:721-8.

153. Jollis JG, Roettig ML, Aluko AO, et al. Implementation of a statewide system for coronary reperfusion for ST-segment elevation myocardial infarction. *JAMA*. 2007;298:2371-80.

154. American Heart Association. Get With The Guidelines. Available at: http://www.heart.org/HEARTORG/HealthcareResearch/GetWithTheGuidelines/HFStroke/Get-With-The-Guidelines-HFStroke_UCM_001099_SubHomePage.jsp. Accessed: June 2, 2017.
155. ASSENT-4 PCI Investigators. Primary versus tenecteplase-facilitated percutaneous coronary intervention in patients with ST-segment elevation acute myocardial infarction (ASSENT-4 PCI): randomised trial. *Lancet*. 2006;367:569-78.
156. Bonow RO, Masoudi FA, Rumsfeld JS, et al. ACC/AHA classification of care metrics: performance measures and quality metrics: a report of the American College of Cardiology/American Heart Association Task Force on Performance Measures. *J Am Coll Cardiol*. 2008;52:2113-7.
157. Le May MR, So DY, Dionne R, et al. A citywide protocol for primary PCI in ST-segment elevation myocardial infarction. *N Engl J Med*. 2008;358:231-40.
158. National Cardiovascular Data Registry. Action Registry-GWTG. Available at: <http://www.ncdr.com/webncdr/ACTION/Default.aspx>. Accessed: June 2, 2017.
159. QualityNet.com. Measure Comparison (Inpatient Hospital Quality Measures). Available at: <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900297065>. Accessed: June 10, 2009.
160. The Joint Commission. Acute Myocardial Infarction Core Measure Set. Available at: http://www.jointcommission.org/core_measure_sets.aspx. Accessed: August 28, 2014.
161. Granger CB, Goldberg RJ, Dabbous O, et al. Predictors of hospital mortality in the Global Registry of Acute Coronary Events. *Arch Intern Med*. 2003;163:2345-53.
162. Morrow DA, Antman EM, Giugliano RP, et al. A simple risk index for rapid initial triage of patients with ST-elevation myocardial infarction: an InTIME II substudy. *Lancet*. 2001;358:1571-5.
163. Antman EM, Cohen M, Bernink PJ, et al. The TIMI risk score for unstable angina/non-ST elevation MI: A method for prognostication and therapeutic decision making. *JAMA*. 2000;284:835-42.
164. Boersma E, Pieper KS, Steyerberg EW, et al. Predictors of outcome in patients with acute coronary syndromes without persistent ST-segment elevation. Results from an international trial of 9461 patients. The PURSUIT Investigators. *Circulation*. 2000;101:2557-67.
165. Abu-Assi E, Ferreira-Gonzalez I, Ribera A, et al. "Do GRACE (Global Registry of Acute Coronary events) risk scores still maintain their performance for predicting mortality in the era of contemporary management of acute coronary syndromes?". *Am Heart J*. 2010;160:826-34.
166. Eagle KA, Lim MJ, Dabbous OH, et al. A validated prediction model for all forms of acute coronary syndrome: estimating the risk of 6-month postdischarge death in an international registry. *JAMA*. 2004;291:2727-33.
167. Go J, Narmi A, Sype J, et al. Impact of renal dysfunction on the prognostic value of the TIMI risk score in patients with non-ST elevation acute coronary syndrome. *Coron Artery Dis*. 2011;22:411-5.
168. Huynh T, Nasmith J, Luong TM, et al. Complementary prognostic values of ST segment deviation and Thrombolysis In Myocardial Infarction (TIMI) risk score in non-ST elevation acute coronary syndromes: Insights from the Platelet Receptor Inhibition in Ischemic Syndrome Management in Patients Limited by Unstable Signs and Symptoms (PRISM-PLUS) study. *Can J Cardiol*. 2009;25:e417-21.
169. Meune C, Drexler B, Haaf P, et al. The GRACE score's performance in predicting in-hospital and 1-year outcome in the era of high-sensitivity cardiac troponin assays and B-type natriuretic peptide. *Heart*. 2011;97:1479-83.
170. Pollack CV Jr, Sites FD, Shofer FS, et al. Application of the TIMI risk score for unstable angina and non-ST elevation acute coronary syndrome to an unselected emergency department chest pain population. *Acad Emerg Med*. 2006;13:13-8.
171. Cannon CP, Weintraub WS, Demopoulos LA, et al. Comparison of early invasive and conservative strategies in patients with unstable coronary syndromes treated with the glycoprotein IIb/IIIa inhibitor tirofiban. *N Engl J Med*. 2001;344:1879-87.
172. Dolor RJ, Melloni C, Chatterjee R, et al. Treatment strategies for women with coronary artery disease. Comparative effectiveness review No. 66. Rockville, MD: Agency for Healthcare Research and Quality. Available at: https://www.effectivehealthcare.ahrq.gov/ehc/products/218/1227/CER66_Treatment-Coronary-Artery-Disease_FinalReport_20120816.pdf. Accessed: July 30, 2014.
173. Glaser R, Herrmann HC, Murphy SA, et al. Benefit of an early invasive management strategy in women with acute coronary syndromes. *JAMA*. 2002;288:3124-9.
174. Effects of tissue plasminogen activator and a comparison of early invasive and conservative strategies in unstable angina and non-Q-wave myocardial infarction. Results of the TIMI IIIB Trial. Thrombolysis in Myocardial Ischemia. *Circulation*. 1994;89:1545-56.
175. Lagerqvist B, Safstrom K, Stahle E, et al. Is early invasive treatment of unstable coronary artery disease equally effective for both women and men? FRISC II Study Group Investigators. *J Am Coll Cardiol*. 2001;38:41-8.
176. O'Donoghue ML, Vaidya A, Afsal R, et al. An invasive or conservative strategy in patients with diabetes mellitus and non-ST-segment elevation acute coronary syndromes: a collaborative meta-analysis of randomized trials. *J Am Coll Cardiol*. 2012;60:106-11.
177. Fox KA, Clayton TC, Damman P, et al. Long-term outcome of a routine versus selective invasive strategy in patients with non-ST-segment elevation acute coronary syndrome: a meta-analysis of individual patient data. *J Am Coll Cardiol*. 2010;55:2435-45.
178. O'Donoghue M, Boden WE, Braunwald E, et al. Early invasive vs conservative treatment strategies in women and men with unstable angina and non-ST-segment elevation myocardial infarction: a meta-analysis. *JAMA*. 2008;300:71-80.
179. Damman P, Hirsch A, Windhausen F, et al. 5-year clinical outcomes in the ICTUS (Invasive versus Conservative Treatment in Unstable coronary Syndromes) trial: a randomized comparison of an early invasive versus selective invasive management in patients with non-ST-segment elevation acute coronary syndrome. *J Am Coll Cardiol*. 2010;55:858-64.
180. Cannon CP, Weintraub WS, Demopoulos LA, et al. Comparison of early invasive and conservative strategies in patients with unstable coronary syndromes treated with the glycoprotein IIb/IIIa inhibitor tirofiban. *N Engl J Med*. 2001;344:1879-87.
181. de Winter RJ, Windhausen F, Cornel JH, et al. Early invasive versus selectively invasive management for acute coronary syndromes. *N Engl J Med*. 2005;353:1095-104.
182. Fox KA, Poole-Wilson PA, Henderson RA, et al. Interventional versus conservative treatment for patients with unstable angina or non-ST-elevation myocardial infarction: the British Heart Foundation RITA 3 randomised trial. Randomized Intervention Trial of unstable Angina. *Lancet*. 2002;360:743-51.
183. Invasive compared with non-invasive treatment in unstable coronary-artery disease: FRISC II prospective randomised multicentre study. FRAGmin and Fast Revascularisation during Instability in Coronary artery disease Investigators. *Lancet*. 1999;354:708-15.
184. Damman P, Clayton T, Wallentin L, et al. Effects of age on long-term outcomes after a routine invasive or selective invasive strategy in patients presenting with non-ST segment elevation acute coronary syndromes: a collaborative analysis of individual data from the FRISC II - IC. *Heart*. 2012;98:207-13.
185. Devlin G, Gore JM, Elliott J, et al. Management and 6-month outcomes in elderly and very elderly patients with high-risk non-ST-elevation acute coronary syndromes: The Global Registry of Acute Coronary Events. *Eur Heart J*. 2008;29:1275-82.
186. Gale CP, Cattle BA, Woolston A, et al. Resolving inequalities in care? Reduced mortality in the elderly after acute coronary syndromes. The Myocardial Ischaemia National Audit Project 2003-2010. *Eur Heart J*. 2012;33:630-9.
187. Alexander KP, Newby LK, Cannon CP, et al. Acute coronary care in the elderly, part I: non-ST-segment-elevation acute coronary syndromes: a scientific statement for healthcare professionals from the American Heart Association Council on Clinical Cardiology. *Circulation*. 2007;115:2549-69.
188. Bach RG, Cannon CP, Weintraub WS, et al. The effect of routine, early invasive management on outcome for elderly patients with non-ST-segment elevation acute coronary syndromes. *Ann Intern Med*. 2004;141:186-95.
189. Fox KA, Poole-Wilson P, Clayton TC, et al. 5-year outcome of an interventional strategy in non-ST-elevation acute coronary syndrome: the British Heart Foundation RITA 3 randomised trial. *Lancet*. 2005;366:914-20.
190. Mehta SR, Cannon CP, Fox KA, et al. Routine vs selective invasive strategies in patients with acute coronary syndromes: a collaborative meta-analysis of randomized trials. *JAMA*. 2005;293:2908-17.
191. Bhatt DL, Roe MT, Peterson ED, et al. Utilization of early invasive management strategies for high-risk patients with non-ST-segment elevation acute coronary syndromes: results from the CRUSADE Quality Improvement Initiative. *JAMA*. 2004;292:2096-104.

192. Bernard SA, Gray TW, Buist MD, et al. Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia. *N Engl J Med.* 2002;346:557–63.

193. HACA Study Group. Mild therapeutic hypothermia to improve the neurologic outcome after cardiac arrest. *N Engl J Med.* 2002;346:549–56.

194. Peberdy MA, Callaway CW, Neumar RW, et al. Part 9: post-cardiac arrest care: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation.* 2010; 122 18 suppl 3:S768–86.

195. Gislason GH, Jacobsen S, Rasmussen JN, et al. Risk of death or reinfarction associated with the use of selective cyclooxygenase-2 inhibitors and nonselective nonsteroidal antiinflammatory drugs after acute myocardial infarction. *Circulation.* 2006;113:2906–13.

196. Kearney PM, Baigent C, Godwin J, et al. Do selective cyclo-oxygenase-2 inhibitors and traditional non-steroidal anti-inflammatory drugs increase the risk of atherothrombosis? Meta-analysis of randomised trials. *BMJ.* 2006;332:1302–8.

197. Silverman HS, Pfeifer MP. Relation between use of anti-inflammatory agents and left ventricular free wall

rupture during acute myocardial infarction. *Am J Cardiol.* 1987;59:363–4.

198. Bulkley BH, Roberts WC. Steroid therapy during acute myocardial infarction. A cause of delayed healing and of ventricular aneurysm. *Am J Med.* 1974; 56:244–50.

KEY WORDS ACC/AHA Performance Measures, ST-elevation myocardial infarction, non-ST-elevation myocardial infarction, acute myocardial infarction, performance measures, quality measures, quality indicators

APPENDIX A. STEMI AND NSTEMI PERFORMANCE MEASURES

Performance Measures for Use in Patients With Inpatient STEMI and NSTEMI

Inpatient Measures

SHORT TITLE: PM-1 Aspirin at Arrival**PM-1: AMI: Aspirin Received at Arrival****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI who received aspirin within 24 h before or after hospital arrival.

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|-------------------------------|--|
| Numerator | Patients with AMI who have received aspirin within 24 h before or after hospital arrival |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice on day of or day after arrival • Patients who die during hospitalization on day of or day after arrival • Patients who are on comfort measures/hospice only documented on day of or day after arrival • Patients who are transferred to another hospital for inpatient care on day of or day after arrival • Patients received in transfer from the inpatient, outpatient, or ED of another facility • Patients discharged on day of or day after arrival |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing aspirin at arrival (e.g., aspirin allergy or intolerance, oral anticoagulant therapy as prearrival medication, active bleeding) • Patient currently enrolled in a clinical trial precluding the use of aspirin in its protocol (e.g., trials of triple versus dual therapy in atrial fibrillation patients) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Coronary heart disease with atherosclerotic plaque disruption (e.g., rupture, erosion, ulceration) and superimposed platelet-rich thrombus formation are the main pathophysiological mechanisms causing MI (type 1 or spontaneous MI).

Acute occlusion of the coronary artery by the "plaque + superimposed thrombus complex" results in acute imbalance in myocardial oxygen demand and supply which, when prolonged and unabated, leads to myocardial cell necrosis and infarction.

Acute and complete occlusion of the coronary artery usually results in STEMI, which usually presents with persistent ST-elevation on the ECG or as an STEMI equivalent (hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST-elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB). On the other hand, severely obstructive but incompletely occlusive coronary lesions usually result in NSTEMI, characterized by the absence of persistent ST elevation on ECG, but rather the presence of ST depression, T-wave inversion or other nonspecific changes.

Aspirin inhibits the formation of thromboxane A₂, a potent stimulator of platelet aggregation, and is the first-line therapy for AMI (30). A loading dose of 162 to 325 mg of non-enteric-coated aspirin formulation should be administered as soon as possible (to be crushed or chewed to achieve rapid absorption), followed preferably by an 81-mg daily dose to minimize bleeding risk. (30-34)

In the ISIS-2 (Second International Study of Infarct Survival) trial (30), aspirin therapy administered within the first 24 h after acute STEMI resulted in a 23% relative risk reduction in 5-week vascular mortality (or 2.4% absolute risk reduction) in patients with STEMI. Significant reductions in the incidence of non-fatal reinfarction and stroke were also observed with aspirin (30).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Aspirin 162 to 325 mg should be given before primary PCI (33,35,36). (Class I, Level of Evidence: B)
2. Aspirin (162- to 325-mg loading dose) and clopidogrel (300-mg loading dose for patients <75 years of age, 75-mg dose for patients >75 years of age) should be administered to patients with STEMI who receive fibrinolytic therapy (30,37,38). (Class I, Level of Evidence: A)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. Non-enteric-coated, chewable aspirin (162 mg to 325 mg) should be given to all patients with NSTEMI-ACS without contraindications as soon as possible after presentation, and a maintenance dose of aspirin (81 mg/d to 162 mg/d) should be continued indefinitely (7,39-42). (Class I, Level of Evidence: A)
2. Patients not on aspirin therapy should be given non-enteric-coated aspirin (325 mg) as soon as possible before PCI (35,36,43,44). (Class I, Level of Evidence: B)
3. In patients with NSTEMI-ACS who are unable to take aspirin because of hypersensitivity or major gastrointestinal intolerance, a loading dose of clopidogrel followed by a daily maintenance dose should be administered (45). (Class I, Level of Evidence: B)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; ED, emergency department; ISIS-2, Second International Study of Infarct Survival; LBBB, left bundle branch block; MI, myocardial infarction; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; NSTEMI, non-ST-elevation myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-2 Aspirin at Discharge**PM-2: AMI: Aspirin Prescribed at Discharge****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI who are prescribed aspirin at hospital discharge.

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| Numerator | Patients with AMI who are prescribed aspirin at hospital discharge |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing aspirin at discharge (e.g., aspirin allergy or intolerance, oral anticoagulant therapy at discharge, active bleeding) • Patient currently enrolled in a clinical trial precluding the use of aspirin in its protocol (e.g., trials of triple versus dual therapy in atrial fibrillation patients) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Coronary heart disease with atherosclerotic plaque disruption (e.g., rupture, erosion, ulceration) and superimposed platelet-rich thrombus formation are the main pathophysiological mechanisms causing MI (type 1 or spontaneous MI).

Acute occlusion of the coronary artery by the "plaque + superimposed thrombus complex" results in acute imbalance in myocardial oxygen demand and supply which, when prolonged and unabated, leads to myocardial cell necrosis and infarction.

Aspirin inhibits the formation of thromboxane A₂, a potent stimulator of platelet aggregation, and is the first-line therapy for AMI (30). Following an initial loading dose of 162 to 325 mg of non-enteric-coated aspirin, an 81-mg daily dose is preferred to higher doses to minimize bleeding risk (31-34).

Aspirin should be continued indefinitely after a MI (46). The Antithrombotic Trialists' Collaboration's meta-analyses firmly confirmed the benefits of long-term aspirin therapy in patients at high-risk of occlusive vascular events, including patients with prior or acute MI (32). A subsequent meta-analysis inclusive of 16 secondary prevention trials (n=17,000 patients) compared long-term aspirin versus control and demonstrated that aspirin allocation was associated with a 1.5% significantly lower risk of serious vascular events per year, as well as significant reductions in coronary events and total stroke events (39).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. After PCI, aspirin should be continued indefinitely (13,32,47). (Class I, Level of Evidence: A)
2. Aspirin should be continued indefinitely (30,37,38) (Class I, Level of Evidence: A), and clopidogrel (75 mg daily) should be continued for at least 14 days (37,38) (Class I, Level of Evidence: A) and up to 1 year (Class I, Level of Evidence: C) in patients with STEMI who receive fibrinolytic therapy.

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. After PCI, aspirin should be continued indefinitely at a dose of 81 mg to 325 mg daily (13,39,47). (Class I, Level of Evidence: B)
2. Aspirin should be continued indefinitely. The maintenance dose should be 81 mg daily in patients treated with ticagrelor and 81 mg to 325 mg daily in all other patients (39,40,42). (Class I, Level of Evidence: A)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; MI, myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-3 Beta Blocker at Discharge**PM-3: AMI: Beta Blocker Prescribed at Discharge****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI, who are prescribed a beta blocker at hospital discharge.

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| Numerator | Patients with AMI who are prescribed a beta blocker* at hospital discharge *Appropriate beta blockers to be used in patients with AMI and LVSD are: bisoprolol, carvedilol, extended-release metoprolol. |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing a beta blocker at hospital discharge (e.g., beta-blocker allergy or intolerance, advanced heart block and no pacemaker, significant bradycardia or hypotension prior to discharge, active asthma or reactive airways disease, increased risk of heart failure/cardiogenic shock, recent history of cocaine or methamphetamine use with signs of acute intoxication) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Beta blockers are excellent anti-ischemic and antianginal medications that decrease myocardial oxygen demand by reducing the heart rate, blood pressure, and contractility. They also reduce cardiac automaticity and the risk of VF after MI. In addition, they improve coronary perfusion by prolonging diastole. Oral beta blockers should therefore be administered to all patients with MI without contraindications for their use. Common contraindications for beta blockers use include heart failure or risk for cardiogenic shock, bradycardia, hypotension, heart block, or active bronchospasm, or acute cocaine ingestion. Patients with initial contraindications to beta blockers in the first 24 h after an AMI should be reevaluated to determine their subsequent eligibility.

A systematic review of randomized controlled trials inclusive of 54,234 patients with acute or prior MI demonstrated that beta blockers are effective in secondary prevention after MI and impart a 23% reduction in the odds of death in long-term trials (48). Notably, the evidence is established predominantly in the pre-reperfusion era among patients with STEMI. The effects of beta blockers appear also to be greatest among patients with MI complicated by heart failure, systolic cardiomyopathy, or ventricular arrhythmias (48).

Although not prospectively studied, the AHA/ACCF secondary prevention guidelines recommend a 3-year treatment course with beta blockers for patients with uncomplicated MI (13). Many of these patients, however, have either hypertension or heart failure/systolic cardiomyopathy, and are usually continued on an oral beta blocker indefinitely.

It is advisable to use beta blockers without intrinsic sympathomimetic activity, and in patients with MI complicated with systolic cardiomyopathy with or without heart failure, 1 of the 3 proven beta blockers should be used: carvedilol, sustained-release metoprolol succinate, or bisoprolol.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Beta blockers should be continued during and after hospitalization for all patients with STEMI and with no contraindications to their use (48,49).
(Class I, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. In patients with concomitant NSTEMI-ACS, *stabilized* HF, and reduced systolic function, it is recommended to continue beta-blocker therapy with 1 of the 3 drugs proven to reduce mortality in patients with HF: sustained-release metoprolol succinate, carvedilol, or bisoprolol. (Class I, Level of Evidence: C)
2. Beta blockers should not be administered to patients with ACS with a recent history of cocaine or methamphetamine use who demonstrate signs of acute intoxication due to the risk of potentiating coronary spasm. (Class III, Level of Evidence: C)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute coronary syndrome; AHA, American Heart Association; AMI, acute myocardial infarction; HF, heart failure; LVSD, left ventricular systolic dysfunction; MI, myocardial infarction; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; STEMI, ST-elevation myocardial infarction; and VF, ventricular fibrillation.

APPENDIX A. CONTINUED

SHORT TITLE: PM-4 High-Intensity Statin at Discharge**PM-4: AMI: High-Intensity Statin Prescribed at Discharge****Measure Description:** Percentage of patients age ≥ 18 y, hospitalized with AMI, who were prescribed a high-intensity statin at hospital discharge.

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| Numerator | Patients with AMI who are prescribed a high-intensity statin* at hospital discharge *High-intensity statin dose is defined in Table 5 of the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (14) |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age < 18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are discharged to hospice or who are on comfort care measures only • Patients who are transferred to another acute care hospital |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing a high-intensity statin (e.g., allergy, intolerance or contraindications to high-intensity statin(s), risk of interaction between drugs, or other medical reasons) • Documentation of prescription of a moderate-intensity statin for patients > 75 y of age • Documentation of a patient reason for not prescribing a statin (e.g., patient refusal) • Patient currently enrolled in a clinical trial related to lipid-lowering therapy |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Patients with an MI are at high risk for recurrent cardiovascular events. Statins inhibit the HMG-CoA reductase enzyme, the rate-limiting step in cholesterol biosynthesis, and are powerful drugs for lowering LDL-C, with reductions $\geq 50\%$ observed with the high-intensity statin regimens.

Statins have been shown in multiple secondary prevention trials to reduce cardiovascular events, including coronary heart disease death, recurrent MI, cerebrovascular events, coronary revascularization, and all-cause mortality ([50-52](#)). They have also been shown to delay coronary atherosclerosis progression and possibly induce plaque regression, on serial angiographic and intravascular ultrasonographic studies.

Given that the clinical evidence does not support the notion of titrating statin therapy to achieve a proposed LDL-C target and that statins are beneficial in all patients at high cardiovascular risk irrespective of their LDL-C levels, the paradigm of treating patients to LDL-C targets is largely abandoned ([14,18](#)). On the other hand, high-intensity statin therapy appears to confer incremental clinical benefit compared with less intensive therapy ([53](#)). The Cholesterol Treatment Trialists conducted meta-analyses of individual participant data from randomized trials of more versus less intensive statin regimens (5 trials; 39,612 patients) ([53](#)). They demonstrated that more intensive regimens produced a highly significant 15% further reduction in major vascular events, driven by reductions in coronary death or non-fatal MI, coronary revascularization, and ischemic stroke ([53](#)).

The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults recommends treatment of patients ≤ 75 y of age who have clinical atherosclerotic cardiovascular disease (including those with MI) with high-intensity statin ([14](#)). Moderate-intensity statins are recommended in their counterparts > 75 y of age and in those who have contraindications/intolerance to high-intensity regimens. The guideline emphasizes that statin therapy should be individualized in persons > 75 y of age according to the potential for ASCVD risk-reduction benefits, adverse effects, drug-drug interactions, and patient preferences ([14](#)). Improved compliance with therapy is an impetus for timing the initiation of statin therapy before discharge in patients hospitalized with acute MI.

Clinical Recommendation(s)**The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults ([14](#)):**

1. High-intensity statin therapy should be initiated or continued as first-line therapy in women and men ≤ 75 years of age who have *clinical* ASCVD, unless contraindicated. (*Class I, Level of Evidence: A*)
2. In individuals with *clinical* ASCVD* in whom high-intensity statin therapy would otherwise be used, when high-intensity statin therapy is contraindicated† or when characteristics predisposing to statin-associated adverse effects are present, moderate-intensity statin therapy should be used as the second option if tolerated. (*Class I, Level of Evidence: A*)
3. In individuals with *clinical* ASCVD* > 75 years of age, it is reasonable to evaluate the potential for ASCVD risk-reduction benefits and for adverse effects, drug-drug interactions and to consider patient preferences, when initiating a moderate- or high-intensity statin. It is reasonable to continue statin therapy in those who are tolerating it. (*Class IIA; Level of Evidence: B*)

*Clinical ASCVD includes acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin.

†Contraindications, warnings, and precautions are defined for each statin according to the manufacturer's prescribing information ([14](#)).

ACC indicates American College of Cardiology; ASCVD, atherosclerotic cardiovascular disease; AHA, American Heart Association; AMI, acute myocardial infarction; HMG-CoA, 3-hydroxy-3-methylglutaryl-coenzyme A; LDL-C, low-density lipoprotein-cholesterol; MI, myocardial infarction; and TIA, transient ischemic attack.

APPENDIX A. CONTINUED

SHORT TITLE: PM-5 Evaluation of LVEF**PM-5: AMI: Evaluation of LVEF**

Measure Description: Percentage of patients, age ≥ 18 y, hospitalized with AMI, with documentation in the hospital record that LVEF is evaluated during hospitalization or is planned for after discharge.

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|-------------------------------|---|
| Numerator | Patients with AMI with documentation in the hospital record that LVEF assessment, which can be either qualitative or quantitative, is done during the hospitalization or is planned for after discharge |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age < 18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | None |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

LVEF is important from a therapeutic and prognostic standpoint for patients with acute AMI for many reasons:

- Patients with reduced LVEF may benefit from specific medical therapies, such as inhibitors of the renin-angiotensin-aldosterone system.
- The presence of LVSD may help inform and guide the invasive strategy and revascularization modality (e.g., further risk stratification in patients with NSTEMI, use of percutaneous circulatory assist devices during percutaneous coronary interventions, choice of surgical revascularization).
- LVEF is one of the strongest predictors of long-term survival following AMI.
- LVEF measurement during hospitalization provides a baseline and dictates outpatient reassessment a few weeks later in patients with initially depressed post-MI LVEF. This will help guide the need for device therapy.

LV function can be assessed by a variety of modalities (e.g., contrast ventriculography, echocardiography, CT angiography). However, a transthoracic echocardiogram is most useful. It is noninvasive, relatively inexpensive, and helps provide a comprehensive assessment of the LV function (regional and global) and size, and rule out post-MI mechanical and other complications.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. LVEF should be measured in all patients with STEMI. (*Class I, Level of Evidence: C*)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. A noninvasive imaging test is recommended to evaluate LV function in patients with definite ACS (54–58). (*Class I, Level of Evidence: C*)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute coronary syndrome; AHA, American Heart Association; AMI, acute myocardial infarction; CT, computed tomography; LV, left ventricular; LVEF, left ventricular ejection fraction; LVSD, left ventricular systolic dysfunction; LVSF, left ventricular systolic function; MI, myocardial infarction; NSTEMI, non ST-elevation myocardial infarction; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-6 ACEI or ARB for LVSD**PM-6: AMI: ACEI or ARB Prescribed for LVSD at Discharge****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI and LVSD who are prescribed an ACEI or ARB at hospital discharge.

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|-------------------------------|---|
| Numerator | Patients with AMI with LVSD (defined as chart documentation of a LVEF $< 40\%$ or a narrative description of LVSD consistent with moderate or severe systolic dysfunction) who are prescribed an ACEI or ARB* at hospital discharge *Fixed dose combination medications that contain ACEI or ARB therapy fulfill the numerator criteria if prescribed (e.g., the ARNI, sacubitril/valsartan, contains the ARB valsartan and would fulfill the measure criteria if prescribed). |
| Denominator | All AMI patients with LVSD |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age < 18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of medical reasons for not prescribing an ACEI and not prescribing an ARB at discharge (e.g., allergy or intolerance to ACEI and ARB including: angioedema, hyperkalemia, hypotension, renal artery stenosis, worsening renal function) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

ACEIs improve survival in patients with AMI, particularly in those with reduced LVEF. They attenuate LV remodeling and infarct expansion and have a variety of additional beneficial effects (effects on ischemic preconditioning, fibrinolysis, recurrent MI, sudden death). The SAVE (Survival and Ventricular Enlargement) trial demonstrated the benefits of captopril in reducing mortality, recurrent MI and HF hospitalization in AMI patients with an LVEF $< 40\%$, but without overt HF on entry (59). Other studies showed comparable findings (60,61).

ARBs are reasonable alternatives to ACEIs in patients with AMI and LVSD and can be used for patients who are intolerant to ACEIs. In the VALIANT (Valsartan in Acute Myocardial Infarction) trial, losartan was noninferior to captopril in patients with MI complicated by LVSD, HF, or both (62).

Common contraindications to the use of these agents include hypotension, shock, bilateral renal artery stenosis, worsening of renal function with ACEI/ARB exposure, and drug allergy.

The ARNI, valsartan/sacubitril, is the first approved ARNI for the treatment of patients with HF and reduced ejection fraction. Compared with the ACEI, enalapril, it reduced the composite endpoint of cardiovascular death or HF hospitalization in the pivotal PARADIGM-HF (Prospective Comparison of ARNI with ACEI to Determine Impact on Global Mortality and Morbidity in Heart Failure) trial (17). The ARNI is even recommended as a replacement therapy for symptomatic HF reduced ejection fraction with New York Heart Association class II or III who tolerate an ACEI or ARB (17). An ACEI should not be added to AMI patients already treated with an ARNI given the increased risk of angioedema and other complications (e.g., hypotension, renal insufficiency). Additionally, an ARB is already a component of the ARNI regimen and as such, adding ARB is not clinically advocated.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. An angiotensin-converting enzyme inhibitor (ACE) should be administered within the first 24 hours to all patients with STEMI with anterior location, HF, or ejection fraction (EF) less than or equal to 0.40, unless contraindicated (59,63-65). (Class I, Level of Evidence: A)
2. An angiotensin receptor blocker (ARB) should be given to patients with STEMI who have indications for but are intolerant of ACE inhibitors (62,66). (Class I, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. ACE inhibitors should be started and continued indefinitely in all patients with LVEF < 0.40 and in those with hypertension, diabetes mellitus, or stable chronic kidney disease (CKD), unless contraindicated (67,68). (Class I, Level of Evidence: A)
2. ARBs are recommended in patients with HF or MI with LVEF less than 0.40 who are ACE inhibitor intolerant (62,69). (Class I, Level of Evidence: A)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACEI, angiotensin-converting enzyme inhibitor; AHA, American Heart Association; AMI, acute myocardial infarction; ARB, angiotensin receptor blocker; ARNI, angiotensin receptor-neprilysin inhibitor; HF, heart failure; LV, left ventricular; LVEF, left ventricular ejection fraction; LVSD, left ventricular systolic dysfunction; LVSD, left ventricular systolic dysfunction; MI, myocardial infarction; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-7 Door-to-Needle Time**PM-7: Acute STEMI: Time to Fibrinolytic Therapy**

Measure Description: Percentage of patients, age ≥ 18 y, with acute STEMI, or its equivalent, who receive fibrinolytic therapy (as the primary reperfusion modality) with a time from hospital arrival to fibrinolysis ≤ 30 min.

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|-------------------------------|--|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, whose time from hospital arrival to fibrinolytic therapy (DTN time) is ≤ 30 min *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with acute STEMI and its equivalent |
| Denominator Exclusions | <ul style="list-style-type: none"> Patients age < 18 y Patients received in transfer from the inpatient, outpatient, or ED of another facility |
| Denominator Exceptions | <ul style="list-style-type: none"> Documentation of a medical reason for delayed fibrinolytic therapy (e.g., cardiopulmonary arrest, initial suspicion of bleeding/stroke or other contraindications to use fibrinolytic therapy, respiratory failure requiring intubation, intra-aortic balloon pump insertion, late presentation > 12 h after symptom onset) Documentation of a patient reason (e.g., initial patient concern with bleeding hazards) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

In the ISIS-2 (Second International Study of Infarct Survival) trial (30), the fibrinolytic streptokinase significantly reduced 5-week vascular mortality by 2.8% compared to placebo, which remained significant at a median follow-up of 15 mo. In that trial, the combination of streptokinase and aspirin was also associated with significantly fewer reinfarction, stroke, and death events compared to placebo (30). The benefits of acute reperfusion with fibrinolytic therapy in patients with STEMI was further corroborated by the report from the Fibrinolytic Therapy Trialists, which included nine trials randomizing a total of 58,600 patients to fibrinolytic therapy versus control (70). The aforementioned collaborative report also demonstrated an inverse relation between the benefit from fibrinolytic therapy and delay from symptom onset, with highly significant absolute mortality reductions of 3% for patients presenting within 0 to 6 h and 2% for those presenting 7 to 12 h from symptom onset (70).

The ACCF/AHA guideline for the management of STEMI (12) recommends that patients who present with STEMI to a non-PCI-capable hospital should receive timely fibrinolytic therapy, if interhospital timely transfer time for primary PCI is not feasible (to achieve mechanical reperfusion within ≤ 120 min of FMC). Despite the lack of strong supporting evidence, the clinical consensus is also to consider fibrinolytic administration in symptomatic STEMI patients presenting > 12 h after symptom onset with STEMI when PCI is not feasible and when there is a large myocardium at jeopardy or hemodynamic instability (12).

The survival benefit observed with fibrinolytic agents is greatest when they are administered within the first 2 h after the onset of STEMI symptoms (71-73). As the length of time between patient's presentation and the delivery of fibrinolytic therapy (DTN time) increases, the benefit from therapy decreases and progressive increase in infarct size and reduction in LVEF ensue. Thus, the benefit of fibrinolytic therapy is most effective when provided promptly, and the ACCF/AHA guideline set a benchmark time goal from hospital arrival to drug administration, or DTN time, to be ≤ 30 min (12).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

- In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI at non-PCI-capable hospitals when the anticipated FMC-to-device time at a PCI-capable hospital exceeds 120 minutes because of unavoidable delays (70,74,75). (Class I, Level of Evidence: B)
- When fibrinolytic therapy is indicated or chosen as the primary reperfusion strategy, it should be administered within 30 minutes of hospital arrival* (71,73,76-78). (Class I, Level of Evidence: B)
- In the absence of contraindications, fibrinolytic therapy should be given to patients with STEMI and onset of ischemic symptoms within the previous 12 hours when it is anticipated that primary PCI cannot be performed within 120 minutes of FMC (30,70,79-83). (Class I, Level of Evidence: A)
- Fibrinolytic therapy should not be administered to patients with ST depression except when a true posterior (inferobasal) MI is suspected or when associated with ST elevation in lead aVR (70,84-87). (Class III, Level of Evidence: B)
- In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI and cardiogenic shock who are unsuitable candidates for either PCI or CABG (70,88,89). (Class I, Level of Evidence: B)

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; CABG, coronary artery bypass graft; DTN, door-to-needle; ED, emergency department; FMC, first medical contact; LBBB, left bundle branch block; LVEF, left ventricular ejection fraction; MI, myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-8 First Medical Contact-Device Time**PM-8: Acute STEMI: Time to Primary PCI**

Measure Description: Percentage of patients, age ≥ 18 y, with acute STEMI, or its equivalent, who receive primary PCI during the hospital stay with a time from FMC-to-device time ≤ 90 min.

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|-------------------------------|--|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, whose FMC-to-device time during primary PCI is ≤ 90 min *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with acute STEMI or its equivalent who receive primary PCI |
| Denominator Exclusions | <ul style="list-style-type: none"> Patients age < 18 y Patients received in transfer from the inpatient, outpatient, or ED of another facility |
| Denominator Exceptions | <ul style="list-style-type: none"> Documentation of a medical reason for delayed primary PCI (e.g., cardiopulmonary arrest, cardiogenic shock, vascular access or lesion-crossing issues, percutaneous circulatory assist device insertion, respiratory failure requiring intubation, and late presentation > 12 h after symptom onset) Patients have received fibrinolytic therapy as the initial reperfusion therapy (e.g., nonprimary PCI, rescue PCI) Patient currently enrolled in a clinical trial related to reperfusion therapy |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Primary PCI has been shown to be superior to fibrinolytic therapy in recanalizing the infarct-related artery and imparts better clinical outcomes (90,91). In a meta-analysis of 23 trials randomizing a total of 7,739 patients with acute STEMI to primary angioplasty or fibrinolytic therapy, primary angioplasty was superior in reducing short-term mortality, nonfatal reinfarction, stroke, and the combined cardiovascular endpoint (92). Primary angioplasty also resulted in higher rates of infarct artery patency, TIMI flow, lower rates of recurrent ischemia, emergency repeat revascularization procedures, and intracranial hemorrhage (92). The benefits of primary angioplasty persisted during long-term follow-up and were independent of the type of fibrinolytic therapy used (92).

Clinical Recommendation(s)**2013 ACCF/AHA Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Primary PCI is the recommended method of reperfusion when it can be performed in a timely fashion by experienced operators (92-94). (*Class I, Level of Evidence: A*)
2. EMS transport directly to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI, with an ideal FMC-to-device time system goal of 90 minutes or less* (95-97). (*Class I, Level of Evidence: B*)
3. Primary PCI should be performed in patients with STEMI and ischemic symptoms of less than 12 hours' duration (90-92). (*Class I, Level of Evidence: A*)

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; ED, emergency department; EMS, emergency medical services; FMC, first medical contact; LBBB, left bundle branch block; MI, myocardial infarction; PCI, percutaneous coronary intervention; STEMI, ST-elevation myocardial infarction; and TIMI, Thrombolysis in Myocardial Infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-9 Reperfusion Therapy**PM-9: Acute STEMI: Reperfusion Therapy**

Measure Description: Percentage of patients, age ≥ 18 y, with acute STEMI, or its equivalent, who receive fibrinolytic therapy or primary PCI.

| | |
|-------------------------------|---|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, who receive fibrinolytic therapy or primary PCI *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with acute STEMI and its equivalent |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice shortly/immediately after arrival • Patients who are on comfort care measures only or hospice documented on arrival |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not receiving reperfusion therapy (e.g., active major bleeding, acute stroke, terminal illness/futile culprit artery too small, no identifiable culprit or spontaneous reperfusion of the infarct artery without an obstructive lesion, severe CAD necessitating urgent/emergency CABG, attempted but unsuccessful PCI, late presentation >12 h after symptom onset) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Overall, patients presenting with acute STEMI can undergo either pharmacologic (fibrinolytic therapy) or mechanical (primary angioplasty/PCI) reperfusion. Given its superiority to fibrinolytic therapy, the ACCF/AHA guideline for the management of STEMI (12) outlines that primary PCI is the preferred treatment and should be performed timely in patients with acute STEMI. However, if primary PCI cannot be performed in a timely manner (within FMC-to-device time) ≤ 90 min, including the inability to transfer the patient timely from a non-PCI-capable to a PCI-capable hospital to achieve FMC-to-device time ≤ 120 min, timely fibrinolytic therapy (within DTN ≤ 30 min) is an acceptable alternative therapeutic strategy. On the other hand, if fibrinolytic therapy is contraindicated or if the complications of cardiogenic shock or acute severe heart failure ensue, primary PCI should be undertaken irrespective of the time delay from FMC or STEMI symptom onset.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Reperfusion therapy should be administered to all eligible patients with STEMI with symptom onset within the prior 12 hours (70,92). (Class I, Level of Evidence: A)
2. Primary PCI is the recommended method of reperfusion when it can be performed in a timely fashion by experienced operators (92-94). (Class I, Level of Evidence: A)
3. EMS transport directly to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI, with an ideal FMC-to-device time system goal of 90 minutes or less* (95-97). (Class I, Level of Evidence: B)
4. Immediate transfer to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI who initially arrive at or are transported to a non-PCI-capable hospital, with an FMC-to-device time system goal of 120 minutes or less* (93,94,98,99). (Class I, Level of Evidence: B)
5. In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI at non-PCI-capable hospitals when the anticipated FMC-to-device time at a PCI-capable hospital exceeds 120 minutes because of unavoidable delays (70,74,75). (Class I, Level of Evidence: B)
6. Primary PCI should be performed in patients with STEMI and ischemic symptoms of less than 12 hours' duration (90-92). (Class I, Level of Evidence: A)
7. Primary PCI should be performed in patients with STEMI and ischemic symptoms of less than 12 hours' duration who have contraindications to fibrinolytic therapy, irrespective of the time delay from FMC (100,101). (Class I, Level of Evidence: B)
8. Primary PCI should be performed in patients with STEMI and cardiogenic shock or acute severe HF, irrespective of time delay from MI onset (102-105). (Class I, Level of Evidence: B)
9. In the absence of contraindications, fibrinolytic therapy should be given to patients with STEMI and onset of ischemic symptoms within the previous 12 hours when it is anticipated that primary PCI cannot be performed within 120 minutes of FMC (30,70,79-83). (Class I, Level of Evidence: A)

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

ACCF indicates American College of Cardiology Foundation; AHA American Heart Association; CABG, coronary artery bypass graft; CAD, coronary artery disease; DTN, door-to-needle; EMS, emergency medical services; FMC, first medical contact; HF, heart failure; LBBB, left bundle branch block; MI, myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-10 Door-in-Door-Out Time**PM-10: Acute STEMI: Time From ED Arrival at STEMI Referral Facility to ED Discharge From STEMI Referral Facility in Patients Transferred for Primary PCI**

Measure Description: Percentage of patients, age ≥ 18 y, with acute STEMI, or its equivalent, whose median time from the ED arrival at STEMI referral facility to ED discharge from STEMI referral facility is ≤ 30 min.

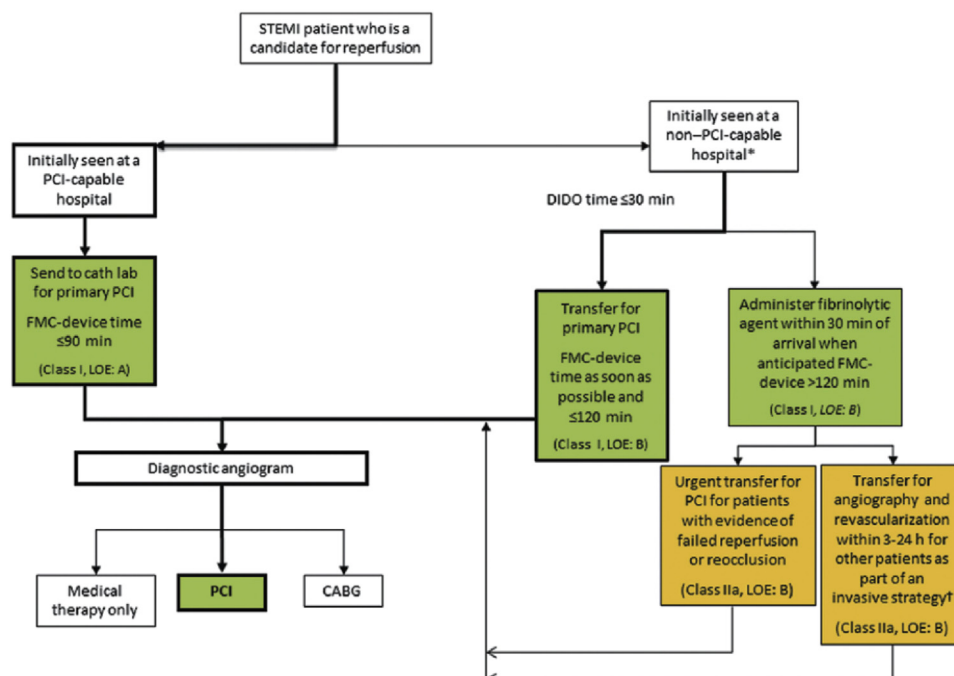
| | |
|-------------------------------|--|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, who are seen initially at a non-PCI-capable hospital and who are transferred to a PCI-capable hospital within DIDO time ≤ 30 min *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with acute STEMI, or its equivalent, who are seen initially at a non-PCI-capable hospital and who are transferred to a PCI-capable hospital |
| Denominator Exclusions | <ul style="list-style-type: none"> Patients age < 18 y Patients who are transferred for a PCI that is described as nonprimary treatment for AMI by a healthcare provider (e.g., patients who receive fibrinolytic therapy as the primary reperfusion therapy) |
| Denominator Exceptions | <ul style="list-style-type: none"> Documentation of a medical reason for the delay (e.g., cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation) Documentation of a patient reason for the delay (e.g., initial concern, patient choice) Patient currently enrolled in a clinical trial related to AMI and reperfusion therapy |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility level Only STEMI referral facility (non-PCI-capable facility) is accountable for this measure. |
| Care Setting | Inpatient |

Rationale

Clinical trials have demonstrated improved outcome for patients with STEMI who are transferred to a primary PCI hospital in a timely manner. Current guidelines recommend that transfer occur immediately with an overall goal of FMC-to-device time of ≤ 120 min; this can be best achieved by shortening the time in the first ED and transferring the STEMI patient within DIDO of ≤ 30 min (20,98,99,106)

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Immediate transfer to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI who initially arrive at or are transported to a non-PCI-capable hospital, with an FMC-to-device time system goal of 120 minutes or less* (93,94,98,99). (Class I, Level of Evidence: B)
2. Immediate transfer to a PCI-capable hospital for coronary angiography is recommended for suitable patients with STEMI who develop cardiogenic shock or acute severe HF, irrespective of the time delay from MI onset (107). (Class I, Level of Evidence: B)



*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; CABG, coronary artery bypass graft; DIDO, door-in-door-out; ED, emergency department; FMC, first medical contact; LBBB, left bundle branch block; MI, myocardial infarction; LOE, level of evidence; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-11 Time to Primary PCI Among Transferred Patients**PM-11: Acute STEMI: Time From FMC (at or Before ED Arrival at STEMI Referral Facility) to Primary PCI at STEMI Receiving Facility Among Transferred Patients**

Measure Description: Percentage of patients, age ≥ 18 y, with acute STEMI, or its equivalent, whose median time from FMC (at or before ED arrival to the STEMI referral facility [e.g., non-PCI-capable facility]) to primary PCI at the STEMI receiving facility (PCI-capable facility) is ≤ 120 min.

| | |
|-------------------------------|--|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, who are transferred to a PCI-capable hospital and have received primary PCI ≤ 120 min from FMC *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with acute STEMI, or its equivalent, who are seen initially at non-PCI-capable hospital and who are transferred to a PCI-capable hospital and have received primary PCI |
| Denominator Exclusions | <ul style="list-style-type: none"> Patients age < 18 y Patients who are transferred for a PCI that is described as nonprimary by a healthcare provider (e.g., patients who receive fibrinolytic therapy at the referral facility as the primary reperfusion therapy) |
| Denominator Exceptions | <ul style="list-style-type: none"> Documentation of a medical reason for the delay (e.g., cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation) Documentation of a patient reason for the delay (e.g., initial patient concern) Patient currently enrolled in a clinical trial related to STEMI and reperfusion therapy |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility* level *Both STEMI referral facility (non-PCI-capable) and STEMI receiving facility (PCI-capable) are accountable for this measure. |
| Care Setting | Inpatient |

Rationale

Patient outcome is improved if patients, initially presenting to a non-PCI-capable hospital, can be quickly transferred to a PCI-capable hospital for primary PCI. (93,94,98,99)

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Immediate transfer to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI who initially arrive at or are transported to a non-PCI-capable hospital, with an FMC-to-device time system goal of 120 minutes or less* (93,94,98,99). (Class I, Level of Evidence: B)

*The proposed time windows are system goals. For any individual patient, every effort should be made to provide reperfusion therapy as rapidly as possible.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; ED, emergency department; FMC, first medical contact; LBBB, left bundle branch block; MI, myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-12 Cardiac Rehabilitation Referral**PM-12: AMI: CR Patient Referral From an Inpatient Setting**

Measure Description: Percentage of patients, age ≥ 18 y, hospitalized with AMI who are referred to an outpatient CR/secondary prevention program during their AMI hospital stay.

| | |
|-------------------------------|--|
| Numerator | AMI patients who are referred to outpatient CR/secondary prevention program prior to hospital discharge |
| Denominator | Number of hospitalized patients in the reporting period hospitalized with qualifying event/diagnosis |
| Denominator Exclusions | None |
| Denominator Exceptions | <ul style="list-style-type: none"> • Provider-oriented criteria (patient deemed to have a high-risk condition or a contraindication to exercise, for example) • Healthcare system barriers (e.g., financial barriers or lack of CR programs near a patient's home) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

A key component to outpatient CR program utilization is the appropriate and timely referral of patients. Generally, the most important time for this referral to take place is while the patient is hospitalized for a qualifying event/diagnosis (e.g., MI, chronic stable angina, CABG, PCI, cardiac valve surgery, or cardiac transplantation). This performance measure has been developed to help healthcare systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.

This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (e.g., following MI, CABG surgery). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.

Effective referral of appropriate inpatients to an outpatient CR program is the responsibility of the healthcare team within a healthcare system that is primarily responsible for providing cardiovascular care to the patient during the hospitalization.

Clinical Recommendation(s)**ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery (108)**

1. Cardiac rehabilitation should be offered to all eligible patients after CABG. (*Class I, Level of Evidence: B*).

ACC/AHA 2007 Update of the Guidelines for the Management of Patients With ST-Elevation Myocardial Infarction (109)

1. Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (e.g., recent acute coronary syndrome or revascularization, HF) is recommended (*Class I, Level of Evidence: B*).

ACC/AHA 2007 Guidelines for the Management of Patients With Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction (110)

1. Cardiac rehabilitation/secondary prevention programs are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and/or those moderate- to high-risk patients in whom supervised exercise training is particularly warranted. (*Class I, Level of Evidence: B*)
2. Cardiac rehabilitation/secondary prevention programs, when available, are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and those moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. (*Class I, Level of Evidence: B*)

ACC/AHA 2007 Chronic Angina Focused Update of the Guidelines for the Management of Patients With Chronic Stable Angina (111)

1. Medically supervised programs (cardiac rehabilitation) are recommended for at-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure). (*Class I, Level of Evidence: B*)

ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult (112)

1. Exercise training is beneficial as an adjunctive approach to improve clinical status in ambulatory patients with current or prior symptoms of HF and reduced LVEF. (*Class I, Level of Evidence: B*)

AHA Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women: 2007 Update (113)

1. A comprehensive risk-reduction regimen, such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program, should be recommended to women with a recent acute coronary syndrome or coronary intervention, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I, Level of Evidence: A*), or current/prior symptoms of heart failure and an LVEF $\leq 40\%$. (*Class I, Level of Evidence: B*)

ACC/AHA/SCAI 2007 Focused Update of the Guidelines for Percutaneous Coronary Intervention (114)

1. Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure) is recommended. (*Class I, Level of Evidence: B*)

ACC indicates American College of Cardiology; AHA, American Heart Association; AMI, acute myocardial infarction; CABG, coronary artery bypass graft; CR, cardiac rehabilitation; LVEF, left ventricular ejection fraction; MI, myocardial infarction; PCI, percutaneous coronary intervention; SCAI, the Society for Cardiac Angiography and Interventions; and UA/NSTEMI, unstable angina/non-ST-segment elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-13 P2Y₁₂ Inhibitor at Discharge**PM-13: AMI: P2Y₁₂ Receptor Inhibitor Prescribed at Discharge**

Measure description: Percentage of patients, age ≥ 18 y, hospitalized with AMI who are prescribed an appropriate P2Y₁₂ receptor inhibitor at hospital discharge.

| | |
|-------------------------------|--|
| Numerator | Patients with AMI who are prescribed an appropriate P2Y ₁₂ receptor inhibitor at hospital discharge Appropriate P2Y ₁₂ receptor inhibitors include: <ul style="list-style-type: none"> • Clopidogrel, prasugrel, or ticagrelor in PCI-treated patients • Clopidogrel or ticagrelor in medically treated patients • Clopidogrel or prasugrel in STEMI patients receiving fibrinolytic therapy |
| Denominator | All patients with AMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing a P2Y₁₂ receptor inhibitor at hospital discharge (e.g., allergy or intolerance to each of the three P2Y₁₂ receptor inhibitors, oral anticoagulant therapy at discharge, active bleeding, patients with planned CABG procedure done after discharge) • Documentation of a patient reason for not prescribing a P2Y₁₂ receptor inhibitor at hospital discharge • Patient currently enrolled in a clinical trial related to AMI and involving new antiplatelet therapies |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Coronary heart disease with atherosclerotic plaque disruption (e.g., rupture, erosion, ulceration) and superimposed platelet-rich thrombus formation are the main pathophysiological mechanisms causing MI (type 1 or spontaneous MI). Dual antiplatelet therapy has become the mainstay treatment strategy after AMI. Aspirin inhibits the formation of thromboxane A₂, a potent stimulator of platelet aggregation, and is the first-line therapy for AMI. P2Y₁₂ receptor inhibitors have incremental benefits to aspirin, and patients with acute MI who are treated with P2Y₁₂ receptor inhibitor at discharge have improved cardiovascular outcomes (predominantly, lower recurrent MI events) (11,12).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

- P2Y₁₂ inhibitor therapy should be given for 1 year to patients with STEMI who receive a stent (bare-metal or drug-eluting) during primary PCI using the following maintenance doses:
 - Clopidogrel 75 mg daily (115,116) (Class I, Level of Evidence: B); or
 - Prasugrel 10 mg daily (115) (Class I, Level of Evidence: B); or
 - Ticagrelor 90 mg twice a day* (117) (Class I, Level of Evidence: B)

*The recommended maintenance dose of aspirin to be used with ticagrelor is 81 mg daily.
- Prasugrel should not be administered to patients with a history of prior stroke or transient ischemic attack (116). (Class III, Level of Evidence: B)
- Aspirin should be continued indefinitely (30,37,38) (Class I, Level of Evidence: A) and clopidogrel (75 mg daily) should be continued for at least 14 days (30,37,38) (Class I, Level of Evidence: A) and up to 1 year (Class I, Level of Evidence: C) in patients with STEMI who receive fibrinolytic therapy.
- Clopidogrel should be provided as follows:
 - A 300-mg loading dose should be given before or at the time of PCI to patients who did not receive a previous loading dose and who are undergoing PCI within 24 hours of receiving fibrinolytic therapy (Class I, Level of Evidence: C);
 - A 600-mg loading dose should be given before or at the time of PCI to patients who did not receive a previous loading dose and who are undergoing PCI more than 24 hours after receiving fibrinolytic therapy (Class I, Level of Evidence: C); and
 - A dose of 75 mg daily should be given after PCI (37,38,116,117). (Class I, Level of Evidence: C)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

- A P2Y₁₂ inhibitor (either clopidogrel or ticagrelor) in addition to aspirin should be administered for up to 12 months to all patients with NSTEMI-ACS without contraindications who are treated with either an early invasive or ischemia-guided strategy. Options include:
 - Clopidogrel: 300-mg or 600-mg loading dose, then 75 mg daily (33,42). (Class I, Level of Evidence: B)
 - Ticagrelor: 180-mg loading dose, then 90 mg twice daily (7,118). (Class I, Level of Evidence: B)
- In patients receiving a stent (bare-metal stent or drug-eluting stent [DES]) during PCI for NSTEMI-ACS, P2Y₁₂ inhibitor therapy should be given for at least 12 months (119). Options include:
 - Clopidogrel: 75 mg daily (120,121) (Class I, Level of Evidence: B) or
 - Prasugrel: 10 mg daily (116) (Class I, Level of Evidence: B) or
 - Ticagrelor: 90 mg twice daily (7) (Class I, Level of Evidence: B)
- In addition to aspirin, a P2Y₁₂ inhibitor (either clopidogrel or ticagrelor) should be continued for up to 12 months in all patients with NSTEMI-ACS without contraindications who are treated with an ischemia-guided strategy. Options include:
 - Clopidogrel: 75 mg daily (42,120) (Class I, Level of Evidence: B) or
 - Ticagrelor: 90 mg twice daily (7,118) (Class I, Level of Evidence: B)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; CABG, coronary artery bypass graft; MI, myocardial infarction; PCI, percutaneous coronary intervention; STEMI, ST-elevation myocardial infarction; and NSTEMI-ACS, non-ST-elevation acute coronary syndrome.

APPENDIX A. CONTINUED

SHORT TITLE: PM-14 Immediate Angiography After Cardiac Arrest**PM-14: STEMI: Immediate Angiography for Resuscitated Out-of-Hospital Cardiac Arrest in STEMI Patients**

Measure Description: Percentage of patients, age ≥ 18 y, who are resuscitated from out-of-hospital cardiac arrest and whose initial ECG shows STEMI, who receive immediate angiography.

| | |
|-------------------------------|---|
| Numerator | <p>Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, who are resuscitated from out-of-hospital cardiac arrest and receive immediate angiography</p> <p>*Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB</p> <p>Note: Immediate angiography is defined as invasive angiography within 120 min after resuscitation from out-of-hospital cardiac arrest.</p> |
| Denominator | All patients with STEMI who are resuscitated from out-of-hospital cardiac arrest |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who die during hospitalization shortly following their out-of-hospital cardiac arrest (<120 min) • Patients who are transferred to hospice or are placed on comfort care measures shortly after their out-of-hospital cardiac arrest (<120 min) • Patients received in transfer from another facility |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not receiving immediate angiography after resuscitated out-of-hospital cardiac arrest (e.g., contraindications to invasive angiography, terminal illness/futile medical condition) • Documentation of a patient reason for not receiving immediate angiography after resuscitated out-of-hospital cardiac arrest (e.g., patient's will or family wishes) • Documentation of a system reason for not receiving immediate angiography after resuscitated out-of-hospital cardiac arrest (e.g., presentation to a non-PCI capable hospital and too unstable to transfer) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Many patients with cardiac arrest and ST elevation on the ECG often have high-risk coronary anatomy, which may benefit from timely coronary angiography to identify severe coronary artery disease and possibly guide/dictate revascularization (usually with PCI) (12,122-137).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Immediate angiography and PCI when indicated should be performed in resuscitated out-of-hospital cardiac arrest patients whose initial ECG shows STEMI (122-137). (Class I, Level of Evidence: B)

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; LBBB, left bundle branch block; MI, myocardial infarction; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-15 Stress Test in Conservatively Treated Patients**PM-15: AMI: Non-Invasive Stress Testing Before Discharge in Conservatively Treated Patients**

Measure Description: Percentage of patients, age ≥ 18 y, hospitalized with AMI, who are initially conservatively managed (have not received invasive coronary angiography) and with documentation in the hospital record that a noninvasive stress testing was performed before discharge.

| | |
|-------------------------------|---|
| Numerator | Patients with AMI who are initially conservatively managed and who received a noninvasive stress test prior to discharge |
| Denominator | All patients with AMI who are initially treated with a conservative management strategy (medical therapies alone without invasive coronary angiography as a planned initial therapy) |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not receiving a noninvasive stress test before discharge (e.g., contraindications to noninvasive stress testing [for instance, patients with intolerance to dobutamine or vasodilator, or patients with ongoing ischemia], terminal illness/futile, not candidate for invasive strategy or revascularization) • Documentation of a patient reason for not receiving a noninvasive stress test before discharge (e.g., patient choice not to undergo ischemic work-up or to postpone to the outpatient setting) • Documentation of cross-over from an initial conservative management to undergo invasive coronary angiography without the need for a noninvasive stress test (as in the case of recurrent spontaneous ischemia) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Some patients with AMI who are managed conservatively (e.g., managed with medical therapies, with coronary angiography not planned as an initial treatment strategy) have high-risk coronary artery disease. These patients may not experience spontaneous ischemia during their hospitalization and need to be further risk stratified before discharge with a stress test (preferably, a submaximal stress test). This will help identify the high-risk patient who needs invasive angiography and possible revascularization, predominantly to mitigate recurrent ischemia/MI (11,12,138-141). A noninvasive stress test can be exercise-based or pharmacological, and the means for detecting ischemia may be via ECG alone or with an added imaging modality.

Notably, many patients with AMI who are managed conservatively initially may cross over to undergo invasive coronary angiography, without undergoing a noninvasive stress test. Common clinical indications for resorting to coronary angiography during the same AMI hospitalization after an initial conservative management trial include, but are not limited to: spontaneous non-inducible ischemia among patients already treated with aggressive medical therapies; LVSD, where a high level of suspicion for left main or multi-vessel coronary artery disease exists. These aforementioned scenarios are to be differentiated (and excluded from the denominator) from those during which coronary angiography is performed in initially conservatively managed AMI patients because of a high-risk noninvasive stress test.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Noninvasive testing for ischemia should be performed before discharge to assess the presence and extent of inducible ischemia in patients with STEMI who have not had coronary angiography and do not have high-risk clinical features for which coronary angiography would be warranted (138,140,141). (Class I, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. Noninvasive stress testing is recommended in low- and intermediate-risk patients who have been free of ischemia at rest or with low-level activity for a minimum of 12 to 24 hours (54-57,139). (Class I, Level of Evidence: B)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; LVSD, left ventricular systolic dysfunction; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-16 Early Troponin Measurement After NSTEMI**PM-16: Acute NSTEMI: Early Cardiac Troponin Measurement (Within 6 Hours of Arrival)****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with acute NSTEMI, who have cardiac troponin biomarkers measured within 6 h of hospital arrival.

| | |
|------------------------|--|
| Numerator | Patients with acute NSTEMI who have at least 1 set of cardiac troponin biomarkers, measured by central laboratory troponin assays and excluding point-of-care assays in the ED or elsewhere, within 6 h of hospital arrival |
| Denominator | All patients with acute NSTEMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice shortly after arrival (<6 h) • Patients who die during hospitalization shortly after arrival (<6 h) • Patients who are on comfort measures/hospice only documented shortly after arrival (<6 h) • Patients who are transferred to another hospital for inpatient care shortly after arrival (<6 h) • Patients received in transfer from the inpatient, outpatient, or ED of another facility • Patients discharged shortly after arrival (<6 h) |
| Denominator Exceptions | None |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Troponins are components of the myocardial cell contractile apparatus. When measured in the circulation, they are very sensitive and specific to diagnose myocardial necrosis. In the correct clinical setting (e.g., angina/ischemic symptoms, ischemic changes on the ECG, imaging evidence of ischemia), a pattern of rise and fall in troponin I or T levels is essential to the diagnosis of AMI. Although STEMI is usually readily diagnosed by the presence of acute current of injury on the presenting ECG, patients with NSTEMI-ACS can present with nonspecific changes on the ECG (e.g., subtle or nonspecific ST or T wave changes). Thus, measuring troponin levels expeditiously help in the early diagnosis and risk stratification of these patients, which can lead to earlier triage and institution of appropriate medical and interventional treatments (11).

Clinical Recommendation(s)**2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)**

1. Serial cardiac troponin I or T levels (when a contemporary assay is used) should be obtained at presentation and 3 to 6 hours after symptom onset in all patients who present with symptoms consistent with ACS to identify a rising and/or falling pattern of values (8,142-147). (*Class I, Level of Evidence: A*)
2. Additional troponin levels should be obtained beyond 6 hours after symptom onset in patients with normal troponin levels on serial examination when changes on ECG and/or clinical presentation confer an intermediate or high index of suspicion for ACS (8,148-150). (*Class I, Level of Evidence: A*)
3. If the time of symptom onset is ambiguous, the time of presentation should be considered the time of onset for assessing troponin values (143,145,150). (*Class I, Level of Evidence: A*)

ACC indicates American College of Cardiology; ACS, acute coronary syndrome; AHA, American Heart Association; AMI, acute myocardial infarction; ED, emergency department; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; NSTEMI, non-ST-elevation myocardial infarction; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: PM-17 AMI Registry Participation**PM-17: AMI: Participation in ≥ 1 Regional or National Registries That Include Patients With Acute Myocardial Infarction****Measure Description:** Participation in a national or regional AMI registry that provides regular performance reports based on benchmarked data.

| | |
|------------------------|---|
| Numerator | Does the facility participate in a national or regional AMI registry* that provides regular performance reports based on benchmarked data? (yes/no) *Examples of such registries include the NCDR ACTION Registry-Get With The Guidelines, Mission Lifeline, and the D2B Alliance. |
| Denominator | Not applicable |
| Denominator Exclusions | None |
| Denominator Exceptions | None |
| Measurement Period | Not applicable |
| Sources of Data | Facility attestation |
| Attribution | Measure reportable at the facility level only |
| Care Setting | Inpatient |

Rationale

Participation in registries allows tracking of quality of care and benchmarking against best practices (12).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. All communities should create and maintain a regional system of STEMI care that includes assessment and continuous quality improvement of emergency medical services and hospital-based activities. Performance can be facilitated by participating in programs such as Mission: Lifeline and the D2B Alliance (95,151–153). (Class I, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients With Non ST-Elevation Acute Coronary Syndromes (11)

1. Participation in a standardized quality-of-care data registry designed to track and measure outcomes, complications, and performance measures can be beneficial in improving the quality of NSTEMI-ACS care (2,152,154–160). (Class IIa, Level of Evidence: B)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI acute myocardial infarction; D2B, Door-to-Balloon; NCDR, National Cardiovascular Data Registry; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED**Quality Improvement Measures for Inpatient STEMI and NSTEMI Patients****Inpatient Measures****SHORT TITLE: QM-1 Risk Score Stratification for NSTEMI****QM-1: NSTEMI: Risk Stratification of NSTEMI Patients With a Risk Score****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with NSTEMI, who have a risk stratification score documented during hospitalization.

| | |
|------------------------|---|
| Numerator | Patients with NSTEMI who have a risk score documented during hospitalization Examples of commonly utilized risk stratification scores include: <ul style="list-style-type: none"> • TIMI risk score • GRACE risk score |
| Denominator | All patients with NSTEMI |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | None |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Objective risk stratification with validated risk scores help triage and dictate the initial treatment strategy in patients with NSTEMI. For example, those at high-risk will likely benefit from an early invasive strategy (within 12 to 24 h), while intermediate-risk patients may receive delayed invasive strategy (within 24 to 72 h). In addition, risk scores, such as the TIMI risk index and GRACE risk model are useful in predicting recurrent cardiovascular outcomes (short- and intermediate-term) following NSTEMI ([11,161,162](#)).

Clinical Recommendation(s)**2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes ([11](#))**

1. Risk scores should be used to assess prognosis in patients with NSTEMI-ACS ([161,163-170](#)). (*Class I, Level of Evidence: A*)

ACC indicates American College of Cardiology; AHA, American Heart Association; GRACE, Global Registry of Acute Coronary Events; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; NSTEMI, non-ST-elevation myocardial infarction; and TIMI, Thrombolysis in Myocardial Infarction.

APPENDIX A. CONTINUED

SHORT TITLE: QM-2 Early Invasive Strategy for High-Risk NSTEMI**QM-2: Acute NSTEMI: Early Invasive Strategy (Within <24 Hours) for High-Risk NSTEMI Patients**

Measure Description: Percentage of patients, age ≥ 18 y, hospitalized with acute NSTEMI, who are at high risk and who receive an early invasive strategy within 24 h of admission.

| | |
|------------------------|--|
| Numerator | Patients with acute NSTEMI who are high risk* and receive early invasive strategy (diagnostic angiography with intent to perform revascularization if appropriate based on coronary anatomy) within 24 h of admission *A high-risk NSTEMI patient is best defined by an objective risk score (e.g., GRACE risk score >140 or TIMI risk score >4). |
| Denominator | All patients with acute NSTEMI who are at high risk |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice on day of or day after arrival • Patients who die early during hospitalization on day of or day after arrival • Patients who are on comfort care measures only or hospice on day of or day after arrival • Patients who are transferred to another hospital for inpatient care on day of or day after arrival • Patients discharged on day of or day after arrival • Patients received in transfer from the inpatient, outpatient, or ED of another facility • Patients who are unstable (refractory angina/ischemia, new or worsening heart failure, mitral regurgitation, hemodynamic instability, sustained ventricular fibrillation or pulseless ventricular tachycardia), need urgent/immediate invasive strategy within 2 h, and are excluded from denominator and numerator |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not receiving an early invasive strategy after high-risk NSTEMI (e.g., extensive clinical comorbidities, contraindications to invasive angiography, terminal illness/futile) • Documentation of a patient reason for not receiving an early invasive strategy after high-risk NSTEMI • Documentation of a system reason for not receiving an early invasive strategy after high-risk NSTEMI (e.g., financial barriers, hospitalization at a facility without a cardiac catheterization laboratory) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Several studies (171-176) and meta-analyses (177,178) have concluded that a strategy of routine invasive therapy is generally superior to an ischemia-guided strategy or a selectively invasive approach. Compared with a delayed invasive strategy (within 24 to 72 h), an early invasive strategy (within the initial 24 h) in patients with NSTEMI reduces recurrent/refractory ischemia, length of stay, and costs. However, there is no definitive evidence that it has an incremental benefit in reducing MI or death.

Patients who are unstable (refractory angina/ischemia, new or worsening heart failure, mitral regurgitation, hemodynamic instability, sustained ventricular fibrillation or ventricular tachycardia) need an urgent/immediate invasive strategy within 2 h, and are excluded from the denominator and numerator.

Clinical Recommendation(s)**2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)**

1. An early invasive strategy (diagnostic angiography with intent to perform revascularization if appropriate based on coronary anatomy) is indicated in initially stabilized patients with NSTEMI-ACS (without serious comorbidities or contraindications to such procedures) who have an elevated risk for clinical events (Table 8) (161,163,179-183). (Class I, Level of Evidence: B)
2. An early invasive strategy (i.e., diagnostic angiography with intent to perform revascularization) is not recommended in patients with:
 - a. (e.g., hepatic, renal, pulmonary failure, cancer), in whom the risks of revascularization and comorbid conditions are likely to outweigh the benefits of revascularization. (Class III, Level of Evidence: C)
 - b. Acute chest pain and a low likelihood of ACS (Class III, Level of Evidence: B) who are troponin-negative, especially women (178). (Class: III, Level of Evidence: C)
3. Older patients with NSTEMI-ACS should be treated with GDMT, an early invasive strategy, and revascularization as appropriate (184-188). (Class I, Level of Evidence: A)
4. Patients with prior CABG and NSTEMI-ACS should receive antiplatelet and anticoagulant therapy according to GDMT and should be strongly considered for early invasive strategy because of their increased risk (143,145,177,178,189,190). (Class I, Level of Evidence: B)
5. Women with NSTEMI-ACS and high-risk features (e.g., troponin positive) should undergo an early invasive strategy (172,173,178,191). (Class I, Level of Evidence: A)

ACC indicates American College of Cardiology; ACS, acute coronary syndromes; AHA, American Heart Association; CABG, coronary artery bypass graft; ED, emergency department; GDMT, guideline-directed medical therapy; GRACE, Global Registry of Acute Coronary Events; MI, myocardial infarction; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; NSTEMI, non-ST-elevation myocardial infarction; and TIMI, Thrombolysis in Myocardial Infarction.

APPENDIX A. CONTINUED

SHORT TITLE: QM-3 Therapeutic Hypothermia for STEMI Patients**QM-3: STEMI: Therapeutic Hypothermia for Comatose STEMI Patients With Out-of-Hospital Cardiac Arrest**

Measure Description: Percentage of patients, age ≥ 18 y, with STEMI who become comatose after resuscitated out-of-hospital cardiac arrest (secondary to VF or pulseless VT) and who receive therapeutic hypothermia.

| | |
|------------------------|--|
| Numerator | Patients with acute STEMI (or its equivalent*) defined by characteristic symptoms of myocardial ischemia with diagnostic ST elevation on ECG, who are comatose after resuscitated out-of-hospital cardiac arrest (VF or pulseless VT), who receive therapeutic hypothermia *Patients with STEMI equivalent on ECG may have: hyperacute T-wave changes, true posterior MI, multilead ST depression with coexistent ST elevation in lead aVR, characteristic diagnostic criteria in the setting of LBBB. |
| Denominator | All patients with STEMI who are comatose after resuscitated out-of-hospital cardiac arrest (VF or pulseless VT) |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who die shortly after arrival (<12 h) • Patients who become comfort care measures only or hospice shortly after arrival (<12 h) • Patients who are transferred to another hospital for inpatient care shortly after arrival (<12 h) • Patients received in transfer from the inpatient setting from another facility |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not receiving therapeutic hypothermia for comatose STEMI patients with out-of-hospital cardiac arrest (e.g., intracranial hemorrhage, severe/active bleeding, significant hypotension refractory to multiple vasopressors, severe sepsis, pregnancy, other evidence of medical futility) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g. administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

Therapeutic hypothermia in comatose patients with acute MI after certain types of cardiac arrest (predominantly related to VF or pulseless VT) has been shown to improve outcomes (e.g., increased survival to hospital discharge with good neurologic function, higher rate of a favorable neurologic outcome, and possibly reduced intermediate-term mortality) (12,192-194).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Therapeutic hypothermia should be started as soon as possible in comatose patients with STEMI and out-of-hospital cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT), including patients who undergo primary PCI (192-194). (Class I, Level of Evidence: B)

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; LBBB, left bundle branch block; MI, myocardial infarction; PCI, percutaneous coronary intervention; STEMI, ST-elevation myocardial infarction; VF, ventricular fibrillation; and VT, ventricular tachycardia.

APPENDIX A. CONTINUED

SHORT TITLE: QM-4 Aldosterone Antagonist at Discharge**QM-4: AMI: Aldosterone Antagonist Prescribed at Discharge****Measure description:** Percentage of eligible patients, age ≥ 18 y, hospitalized with AMI, who are prescribed an aldosterone antagonist at hospital discharge.

| | |
|------------------------|--|
| Numerator | Eligible* patients with AMI who are prescribed an aldosterone antagonist at hospital discharge *Eligible AMI patients for an aldosterone antagonist are patients with no contraindications who are already receiving an ACE inhibitor and beta blocker, and who have an EF $\leq 40\%$, and either HF or diabetes mellitus (aldosterone antagonists are appropriately used when the ACE inhibitor and/or beta blocker cannot be used or tolerated). |
| Denominator | All post-AMI patients who: [a] are receiving an ACE inhibitor and a beta blocker; AND [b] have a LVEF $\leq 40\%$; AND [c] have either diabetes mellitus or HF |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | <ul style="list-style-type: none"> • Documentation of a medical reason for not prescribing an aldosterone antagonist at hospital discharge (e.g., allergy or intolerance to aldosterone antagonist, significant renal dysfunction [Cr >2.5 mg/dL in men; >2.0 mg/dL in women], hyperkalemia [K >5.0 mEq/L]) • Patient currently enrolled in a clinical trial related to AMI (e.g., trials involving renin-angiotensin-aldosterone system inhibitors) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

The EPHEUS (Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival) study demonstrated benefits from adding eplerenone, a selective aldosterone antagonist, to ACE inhibitors or ARBs (in 87% of patients) and beta blockers (75%), including a 15% and 17% reduction in overall and cardiovascular mortality, respectively. Therefore, in the absence of contraindications, post-MI patients with HF may benefit from adding an aldosterone antagonist to an ACE inhibitor or ARB, and a beta blocker. Monitoring of patients' renal function, electrolytes (screening for hyperkalemia, in particular), and blood pressure should be undertaken (11,12,29).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. An aldosterone antagonist should be given to patients with STEMI and no contraindications who are already receiving an ACE inhibitor and beta blocker and who have an EF less than or equal to 0.40 and either symptomatic HF or diabetes mellitus (29). (Class I, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients with Non-ST-Elevation Acute Coronary Syndromes (11)

1. Aldosterone blockade is recommended in post-MI patients without significant renal dysfunction (creatinine >2.5 mg/dL in men or >2.0 mg/dL in women) or hyperkalemia (K >5.0 mEq/L) who are receiving therapeutic doses of ACE inhibitor and beta blocker and have a LVEF 0.40 or less, diabetes mellitus, or HF (29). (Class I, Level of Evidence: A)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACE, angiotensin-converting enzyme; AHA, American Heart Association; AMI, acute myocardial infarction; ARB, angiotensin receptor blockers; Cr, creatinine; EF, ejection fraction; K, potassium; HF, heart failure; LVEF, left ventricular ejection fraction; MI, myocardial infarction; and STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: QM-5 Inappropriate In-Hospital Use of NSAIDs**QM-5: AMI: Inappropriate In-Hospital Use of NSAIDs****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI who are inappropriately prescribed NSAIDs during hospitalization.

| | |
|------------------------|---|
| Numerator | <p>Patients with AMI who were prescribed NSAIDs (with the exception of aspirin) in the hospital</p> <p>For purposes of this measure, a noninclusive list of NSAIDs include these medications:</p> <ul style="list-style-type: none"> • Ibuprofen • Ketoprofen • Sulindac • Naproxen • Etodolac • Fenoprofen • Diclofenac • Flurbiprofen • Ketorolac • Piroxicam • Indomethacin • Mefenamic Acid • Meloxicam • Celecoxib • Nabumetone • Oxaprozin • Ketoprofen • Meclofenamate • Tolmeti • Salsalate |
| Denominator | All patients with AMI |
| Denominator Exclusions | Patients age < 18 y |
| Denominator Exceptions | Documentation of a medical reason for prescribing NSAIDs during the AMI hospitalization (e.g., patient with refractory arthritis pain that is unresponsive to other analgesics) |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry). |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

NSAIDs likely increase the risk of major adverse events in patients with myocardial infarction (e.g., impaired infarct healing, possibly increased risk of rupture following transmural infarction, higher risk of accompanying acute kidney injury, and increased risk of gastrointestinal bleeding in at-risk AMI patients who are already receiving antithrombotic therapies) ([195,196](#)).

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Glucocorticoids and nonsteroidal anti-inflammatory drugs are potentially harmful for treatment of pericarditis after STEMI ([197,198](#)). (*Class III, Level of Evidence: B*)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. Nonsteroidal anti-inflammatory drugs (NSAIDs) (except aspirin) should not be initiated and should be discontinued during hospitalization for NSTEMI-ACS because of the increased risk of MACE associated with their use ([195,196](#)). (*Class III, Level of Evidence: B*)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; MACE, major adverse cardiac events; NSAIDs, nonsteroidal anti-inflammatory drugs; NSTEMI-ACS, non-ST-elevation acute coronary syndrome; STEMI, ST-elevation myocardial infarction.

APPENDIX A. CONTINUED

SHORT TITLE: QM-6 Inappropriate Prasugrel at Discharge in TIA/Stroke Patients**QM-6: AMI: Inappropriate Prescription of Prasugrel at Discharge in Patients With a History of Prior Stroke or TIA**

Measure Description: Percentage of patients, age ≥ 18 y, hospitalized with AMI, who had a history of prior stroke or TIA and who are inappropriately prescribed prasugrel at discharge.

| | |
|------------------------|---|
| Numerator | Patients with AMI who are prescribed prasugrel at discharge |
| Denominator | All patients with AMI and a history of prior stroke (ischemic or hemorrhagic) or TIA |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | None |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

The TRITON-TIMI 38 (Trial to Assess Improvement in Therapeutic Outcomes by Optimizing Platelet Inhibition with Prasugrel-Thrombolysis in Myocardial Infarction) randomized clinical trial demonstrated the superiority of prasugrel over clopidogrel in reducing the composite of cardiovascular death, nonfatal MI, or nonfatal stroke among AMI patients (albeit with an increased risk of major bleeding).

Although the elderly and underweight patients did not experience net clinical benefit from the use of prasugrel, the subgroup of patients with TIA or stroke had an increased net clinical harm with prasugrel compared with clopidogrel (12,116). Notably, a history of ischemic or hemorrhagic stroke or TIA symptoms were considered exclusion criteria in the TRITON-TIMI 38 trial, although a small group ended up being randomized in error and exhibited increased harm with prasugrel. Subsequently, the FDA issued a boxed warning cautioning against the use of prasugrel in patients with TIA or stroke. Overall, patients with prior history of ischemic or hemorrhagic stroke or TIA symptoms should not receive prasugrel.

Although ischemic stroke is defined as a permanent infarction (symptomatic or asymptomatic) of the central nervous system, TIA is defined as a transient neurologic dysfunction caused by focal ischemia without ensuing infarction. Hemorrhagic strokes result from either subarachnoid or intracerebral bleeding, and usually represent 20% of all stroke events.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. Prasugrel should not be administered to patients with a history of prior stroke or transient ischemic attack (116). (Class III, Level of Evidence: B)

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. Prasugrel should not be administered to patients with a prior history of stroke or transient ischemic attack (116). (Class III, Level of Evidence: B)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI acute myocardial infarction; and TIA, transient ischemic attack.

APPENDIX A. CONTINUED

SHORT TITLE: QM-7 Inappropriate High-Dose Aspirin With Ticagrelor at Discharge**QM-7: AMI: Inappropriate Prescription of High-Dose Aspirin With Ticagrelor at Discharge****Measure Description:** Percentage of patients, age ≥ 18 y, hospitalized with AMI who are prescribed ticagrelor and high-dose aspirin at discharge.

| | |
|------------------------|---|
| Numerator | Patients with AMI who are prescribed ticagrelor and high-dose aspirin at discharge Note: The recommended maintenance dose of aspirin is 81 mg daily in patients treated with ticagrelor. A high-dose aspirin is defined as a daily maintenance dose >100 mg. In the United States, a high-dose aspirin for thromboprophylaxis is usually a 162 mg or a 325-mg regimen. |
| Denominator | All patients with AMI who are prescribed ticagrelor at discharge |
| Denominator Exclusions | <ul style="list-style-type: none"> • Patients age <18 y • Patients who leave against medical advice • Patients who die during hospitalization • Patients who are on comfort care measures only or hospice • Patients who are transferred to another hospital for inpatient acute care |
| Denominator Exceptions | None |
| Measurement Period | Encounter |
| Sources of Data | Medical record or other database (e.g., administrative, clinical, registry) |
| Attribution | Measure reportable at the facility or provider level |
| Care Setting | Inpatient |

Rationale

In the PLATO (Platelet Inhibition and Patient Outcomes) trial, a prespecified subgroup analysis showed a significant regional variation in the comparative efficacy of ticagrelor with diminished benefits in North America compared with the rest of the world. Subsequent analyses demonstrated that the lowest risk of the composite ischemic outcome with ticagrelor compared with clopidogrel is associated with a low-maintenance dose of concomitant aspirin. (7,12,40). Overall, a high-dose aspirin (>100 mg) is associated with increased bleeding hazard without an improved antiplatelet efficacy. The FDA also issued a boxed warning indicating that aspirin daily maintenance doses of >100 mg decrease the effectiveness of ticagrelor.

Clinical Recommendation(s)**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (12)**

1. P2Y₁₂ inhibitor therapy should be given for 1 year to patients with STEMI who receive a stent (bare-metal or drug-eluting) during primary PCI using the following maintenance doses:
 - a. Clopidogrel 75 mg daily (115,116) (Class I, Level of Evidence: B); or
 - b. Prasugrel 10 mg daily (115) (Class I, Level of Evidence: B); or
 - c. Ticagrelor 90 mg twice a day* (117) (Class I, Level of Evidence: B)

*The recommended maintenance dose of aspirin to be used with ticagrelor is 81 mg daily.

2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes (11)

1. Aspirin should be continued indefinitely. The maintenance dose should be 81 mg daily in patients treated with ticagrelor and 81 mg to 325 mg daily in all other patients (39,40,42). (Class I, Level of Evidence: A)

ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; AHA, American Heart Association; AMI, acute myocardial infarction; FDA, U.S. Food and Drug Administration; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

APPENDIX B. AUTHOR LISTING OF RELATIONSHIPS WITH INDUSTRY AND OTHER ENTITIES (RELEVANT)—2017 AHA/ACC CLINICAL PERFORMANCE AND QUALITY MEASURES FOR ADULTS WITH ST-ELEVATION AND NON-ST-ELEVATION MYOCARDIAL INFARCTION

| Committee Member | Employment | Consultant | Speaker | Ownership/ Partnership/ Principal | Research | Institutional, Organizational, or Other Financial Benefit | Expert Witness |
|-----------------------|--|---|---------|-----------------------------------|--|--|----------------|
| Hani Jneid (Chair) | Baylor College of Medicine — Associate Professor of Medicine; Director of Interventional Cardiology Research The Michael DeBakey VA Medical Center—Director of Interventional Cardiology | None | None | None | None | None | None |
| Daniel Addison | Fellow at Massachusetts General Hospital | None | None | None | None | None | None |
| Deepak L. Bhatt | Executive Director of Interventional Cardiovascular Programs, Brigham and Women's Hospital Heart & Vascular Center; Harvard Medical School — Professor of Medicine | <ul style="list-style-type: none"> Duke Clinical Research Institute: Ferring Pharmaceuticals Duke Clinical Research Institute: Novartis Duke Clinical Research Institute: Bristol-Myers Squibb/Pfizer Duke Clinical Research Institute: Eli Lilly | None | None | <ul style="list-style-type: none"> Amarin† Amgen Inc.† AstraZeneca† BIOFLOW-V (Bio-tronik)-clinical trial Bristol Myers Squibb† Eisai† Ethicon† EVOLVE Short DAPT Study (Boston Scientific) Flowco* Forest Laboratories† Ischemix† Medtronic† Merck and Co, Inc* Pfizer† PLxPharma* Roche† Sanofi Aventis† Takeda* The Medicines Company† | <ul style="list-style-type: none"> Cardax* Duke Clinical Research Institute Data Safety Monitoring Board Harvard Clinical Research Institute: Boehringer Ingelheim Harvard Clinical Research Institute: St. Jude Data Safety Monitoring Board Harvard Clinical Research Institute (St. Jude) Data Safety Monitoring Board Merck & Co., Inc. Planning Committee for Clinical Study* Novartis | None |
| Gregg C. Fonarow | Ahmanson-UCLA Cardiomyopathy Center Division of Cardiology — Director of UCLA's Cardiology Fellowship Program | <ul style="list-style-type: none"> Amgen Boston Scientific Janssen Johnson&Johnson Medtronic Novartis† St. Jude Medical Takeda The Medicines Company ZS Pharma | None | None | <ul style="list-style-type: none"> Medtronic Novartis† | None | None |
| Sana Gokak | ACC/AHA | None | None | None | None | None | None |
| Kathleen L. Grady | Northwestern University Feinberg School of Medicine — Professor of Surgery and Medicine; and Administrative Director for Heart Failure | None | None | None | None | None | None |
| Lee A. Green | University of Michigan — Professor Emeritus | None | None | None | None | None | None |
| Paul A. Heidenreich | Stanford VA Palo Alto Health Care System — Professor of Medicine | None | None | None | None | None | None |
| P. Michael Ho | VA Eastern Colorado Health Care System University of Colorado School of Medicine — Associate Professor of Medicine | <ul style="list-style-type: none"> Anthem, Inc.† Janssen Pharmaceuticals, Inc.† Premier, Inc.† Telligen* | None | None | None | None | None |

Continued on the next page

APPENDIX B. CONTINUED

| Committee Member | Employment | Consultant | Speaker | Ownership/ Partnership/ Principal | Research | Institutional, Organizational, or Other Financial Benefit | Expert Witness |
|--------------------|--|------------|--|---|----------|--|-------------------|
| Corrine Y. Jurgens | Stony Brook University – Associate Professor | None | None | None | None | None | None |
| Marjorie L. King | Helen Hayes Hospital | None | None | None | None | None | None |
| Dharam J. Kumbhani | UT Southwestern Medical Center – Assistant Professor of Medicine | None | None | None | None | None | None |
| Samir Pancholy | The Wright Center for Graduate Medical Education | None | <ul style="list-style-type: none">• Medtronic• Pfizer†• Terumo Medical | <ul style="list-style-type: none">• Duke Clinical Research Institute Odyssey Outcomes Trial | None | None | |

This table represents the relationships of committee members with industry and other entities that were reported by authors to be relevant to this document. These relationships were reviewed and updated in conjunction with all meetings and/or conference calls of the writing committee during the document development process. The table does not necessarily reflect relationships with industry at the time of publication. A person is deemed to have a significant interest in a business if the interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of \$5,000 or more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be modest if it is less than significant under the preceding definition. Relationships in this table are modest unless otherwise noted. According to the ACC/AHA, a person has a *relevant* relationship IF: a) the relationship or interest relates to the same or similar subject matter, intellectual property or asset, topic, or issue addressed in the document; or b) the company/entity (with whom the relationship exists) makes a drug, drug class, or device addressed in the document, or makes a competing drug or device addressed in the document; or c) the person or a member of the person's household has a reasonable potential for financial, professional, or other personal gain or loss as a result of the issues/content addressed in the document.

*No financial relationship.

†Significant (greater than \$5,000) relationship.

ACC indicates American College of Cardiology; AHA, American Heart Association; BIOFLOW-V, A Prospective Randomized Multicenter Study to Assess the SaFety and Effectiveness of the Orsiro SiroLimus Eluting Coronary Stent System in the Treatment Of Subjects With up to Three De Novo or Restenotic Coronary Artery Lesions - V; EVOLVE DAPT, A Prospective, Multicenter, Single-arm Study Designed to Assess the Safety of 3-month Dual Antiplatelet Therapy in Subjects at High Risk for Bleeding Undergoing Percutaneous Coronary Intervention With the SYNERGY Everolimus-Eluting Platinum Chromium Coronary Stent System; and UT, University of Texas.

APPENDIX C. PEER REVIEWER RELATIONSHIPS WITH INDUSTRY AND OTHER ENTITIES—2017 AHA/ACC CLINICAL PERFORMANCE AND QUALITY MEASURES FOR ADULTS WITH ST-ELEVATION AND NON-ST-ELEVATION MYOCARDIAL INFARCTION

| Peer Reviewer | Representation | Consultant | Speakers Bureau | Ownership/ Partnership/ Principal | Personal Research | Institutional, Organizational, or Other Financial Benefit | Expert Witness |
|---------------------|------------------------------------|--|-----------------|-----------------------------------|---|---|----------------|
| Randal Thomas | Official TFPM Lead | None | None | None | None | None | None |
| Timothy A. Dewhurst | Official ACC BOG | None | None | None | <ul style="list-style-type: none"> Biotronik- Protoge Phase IV registry clinical trial enroller | None | None |
| Fredrick A. Masoudi | Official AHA | None | None | None | None | None | None |
| Hitinder Gurm | Official SCAI | <ul style="list-style-type: none"> Osprey Medical† | None | None | None | None | None |
| Michael Kontos | Content: ACTION Steering Committee | <ul style="list-style-type: none"> Astra Zeneca† Medicure Roche Diagnostics | None | None | None | <ul style="list-style-type: none"> Astellas Novartis* | None |
| Matthew Roe | Content: NCDR SQOC | <ul style="list-style-type: none"> AstraZeneca† Boehringer Ingelheim Pharmaceuticals, Inc Quest Diagnostics | None | None | <ul style="list-style-type: none"> Daiichi-Sankyo Ely Lilly† Janssen Pharmaceuticals† Merck† Sanofi-Aventis† | <ul style="list-style-type: none"> Bristol-Myers Squibb Company Eli Lilly and Company | None |
| Claire Duvernoy | Content: AUCTF | None | None | None | None | None | None |
| H. Vernon Anderson | Content: ACC/AHA TFDS | None | None | None | <ul style="list-style-type: none"> Capricor: ALLSTAR (Clinical Trial Enroller) | <ul style="list-style-type: none"> DSMB: MedPace Medical Devices | None |
| Fredrick G. Kushner | Content: ACC/AHA TFPG | None | None | None | None | None | None |
| Ezra Amsterdam | Content: ACC/AHA TFPG | None | None | None | None | None | None |

This table represents the relationships of reviewers with industry and other entities that were disclosed at the time of peer review and determined to be relevant. It does not necessarily reflect relationships with industry at the time of publication. A person is deemed to have a significant interest in a business if the interest represents ownership of $\geq 5\%$ of the voting stock or share of the business entity, or ownership of $\geq \$5,000$ of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be modest if it is less than significant under the preceding definition. Relationships that exist with no financial benefit are also included for the purpose of transparency. Relationships in this table are modest unless otherwise noted. According to the ACC/AHA, a person has a *relevant* relationship IF: a) the *relationship or interest* relates to the same or similar subject matter, intellectual property or asset, topic, or issue addressed in the *document*; or b) the *company/ entity* (with whom the relationship exists) makes a drug, drug class, or device addressed in the *document*, or makes a competing drug or device addressed in the *document*; or c) the *person or a member of the person's household* has a reasonable potential for financial, professional, or other personal gain or loss as a result of the issues/content addressed in the *document*.

*No financial relationship.

†Significant (greater than \$5,000) relationship.

ACC indicates American College of Cardiology; AHA, American Heart Association; ALLSTAR, The Allogeneic Heart Stem Cells to Achieve Myocardial Regeneration clinical trial; AUCTF, Appropriate Use Criteria Task Force; BOG, Board of Governors; DSMB, Data and Safety Monitoring Board; MER, Medical Education Resources; NCDR, National Cardiovascular Data Registry; NIH, National Institutes of Health; SCAI, Society for Cardiovascular Angiography and Interventions; SQOC, Science and Quality Oversight Committee; TFDS, Task Force on Data Standards; TFPG, Task Force on Practice Guidelines; TFPM, Task Force on Performance Measures; VA, U.S. Department of Veterans Affairs; and VHAC, Virginia Heart Attack Coalition.