**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 0505

**Measure Title**: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 11/2/2020

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name what is being measured

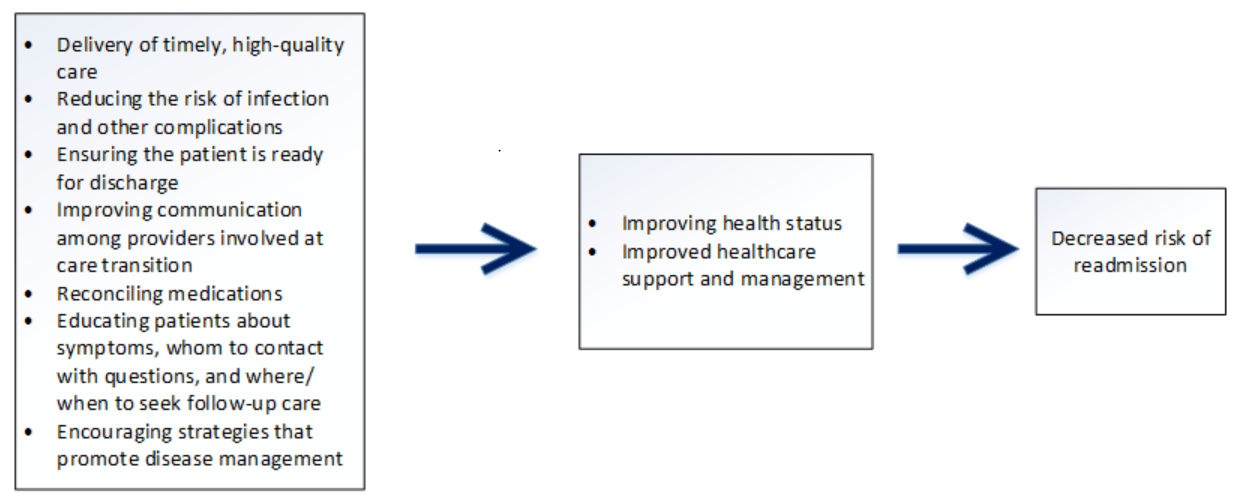
Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

Figure 1: AMI Logic Model



The goal of this measure is to improve patient outcomes by providing patients, physicians, and hospitals with information about hospital-level, risk-standardized readmission rates following hospitalization for AMI. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of, and response to, complications, patient safety and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk-adjust for patients’ conditions at the time of hospital admission and then evaluate patient outcomes. This readmission measure was developed to identify institutions, whose performance is better or worse than would be expected based on their patient case-mix, and therefore promote hospital quality improvement and better inform consumers about care quality.

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A. This measure is not an intermediate outcome, process, or structure performance measure.

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

AMI is among the most common principal hospital discharge diagnoses among Medicare beneficiaries, and, in 2013, it was the fifth most expensive condition treated in US hospitals, accounting for 3.5% of national healthcare costs (Torio et al., 2016). Readmission rates following discharge for AMI are high and variable across hospitals in the United States (Krumholz et al., 2009; Bernheim et al., 2010). For example, for the time period of July 2015-June 2018, publicly reported 30-day risk-standardized readmission rates ranged from 12.0% to 21.9% for patients admitted with AMI (Wallace et al., 2019).

The diagram above indicates some of the many care processes that can influence readmission risk. In general, randomized controlled trials have shown that improvement in the following areas can directly reduce readmission rates: quality of care during the initial admission; improvement in communication with patients, their caregivers and their clinicians; patient education; predischarge assessment; and coordination of care after discharge. Evidence that hospitals have been able to reduce readmission rates through these quality-of-care initiatives illustrates the degree to which hospital practices can affect readmission rates. Successful randomized trials have reduced 30-day readmission rates by 20-40% (Coleman et al., 2004; Courtney et al., 2009; Garasen et al., 2007; Koehler et al., 2009; Mistiaen et al., 2007; Weiss et al., 2010; Krumholz et al., 2002), and trends over the last 20 years show marked improvement in AMI readmissions among older adults (Krumholz et al., 2019). The Project RED (Re-Engineered Discharge) intervention, in which a nurse was assigned to each patient as a discharge advocate, responsible for patient education, follow-up, medication reconciliation, and preparing individualized discharge instructions sent to the patient’s primary care provider and there was a follow-up phone call from a pharmacist within 4 days of discharge demonstrated a 30% reduction in 30-day readmissions (Jack et al., 2009, Patel et al., 2018). Another study found that transitional care models prioritizing effective collaboration across providers/facilities, through follow-up calls, patient tracking through medical charts, and team communication within and across facilities/providers, may reduce readmissions after AMI and other conditions (Radhakrishnan et al., 2018). Other specific interventions among patients with AMI that have been shown to significantly reduce the rate of readmission include disease management programs that involved home visits by cardiac-trained nurses, standardized checklists, communication with physicians, and patient education. Similarly, in observational studies, enrollment in cardiac rehabilitation programs has been found to be associated with significant reductions in readmission after AMI (Mudrick et al., 2013).

References:

Bernheim SM, Grady JN, Lin Z, Wang Y, Savage SV, Bhat KR, et al. National patterns of risk-standardized mortality and readmission for acute myocardial infarction and heart failure. Update on publicly reported outcomes measures based on the 2010 release. Circ Cardiovasc Qual Outcomes 2010;3:459-67.

Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriatr Soc 2004;52(11):1817-25.

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Torio CM, Moore BJ. National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2013. HCUP Statistical Brief # 204. Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb204-Most-Expensive-Hospital-Conditions.pdf>. Published May 2016. Accessed May 23, 2020.

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**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** |  |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. |  |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade |  |
| Provide all other grades and definitions from the evidence grading system |  |
| Grade assigned to the **recommendation** with definition of the grade |  |
| Provide all other grades and definitions from the recommendation grading system |  |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? |  |
| Estimates of benefit and consistency across studies |  |
| What harms were identified? |  |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? |  |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

N/A

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

N/A

**1a.4.2 What process was used to identify the evidence?**

N/A

**1a.4.3.** **Provide the citation(s) for the evidence.**

N/A