

## NATIONAL QUALITY FORUM—Evidence (subcriterion 1a)

**Measure Title:** [Hospital 30-Day Risk-Standardized Acute Myocardial Infarction \(AMI\) Mortality eMeasure](#)

**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:** [12/23/2013](#)

### Instructions

- 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.
- Respond to all questions as instructed with answers immediately following the question. 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.
- Maximum of 10 pages (*includes questions/instructions*; minimum font size 11 pt; do not change margins).  
**Contact NQF staff if more pages are needed.**
- Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](#).

**Note:** The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF's evaluation criteria.

### Subcriterion 1a. Evidence to Support the Measure Focus

The measure focus is a health outcome or is evidence-based, demonstrated as follows:

- Health outcome:<sup>3</sup> a rationale supports the relationship of the health outcome to processes or structures of care.
- Intermediate clinical outcome, Process,<sup>4</sup> or Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence<sup>5</sup> that the measure focus leads to a desired health outcome.
- Patient experience with care: evidence that the measured aspects of care are those valued by patients and for which the patient is the best and/or only source of information OR that patient experience with care is correlated with desired outcomes.
- Efficiency:<sup>6</sup> evidence for the quality component as noted above.

### 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.** 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.

**5.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](#) and [methods](#), or Grading of Recommendations, Assessment, Development and Evaluation ([GRADE guidelines](#)).

**6.** Measures of efficiency combine the concepts of resource use and quality (NQF's [Measurement Framework: Evaluating Efficiency Across Episodes of Care](#); [AQA Principles of Efficiency Measures](#)).

**1a.1. This is a measure of:**

Outcome

☒ Health outcome: [30-day mortality](#)

*Health outcome includes patient-reported outcomes (PRO, i.e., HRQoL/functional status, symptom/burden, experience with care, health-related behaviors)*

☐ Intermediate clinical outcome: [Click here to name the intermediate outcome](#)

☐ Process: [Click here to name the process](#)

☐ Structure: [Click here to name the structure](#)

☐ Other: [Click here to name what is being measured](#)

**HEALTH OUTCOME PERFORMANCE MEASURE** *If not a health outcome, skip to [1a.3](#)*

**1a.2. Briefly state or diagram the linkage between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

The goal of this measure is to directly affect patient outcomes by measuring risk-standardized rates of mortality. Measurement of patient outcomes, including mortality, allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. As described below, mortality is likely to be influenced by a broad range of clinical activities such as the prevention of complications and the provision of evidenced-based care.

**1a.2.1. State the rationale supporting the relationship between the health outcome (or PRO) and at least one healthcare structure, process, intervention, or service.**

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. Furthermore, recent work has identified specific strategies utilized by hospitals that achieve low AMI mortality rates (Bradley et al., 2012; Curry et al., 2011). These strategies include having cardiologists on site, the presence of physician and nurse champions, and promoting strong communication and coordination across disciplines and departments. This work demonstrates the relationship between hospital organizational factors and performance on the AMI mortality measures and supports the ability of hospitals to impact these rates.

References:

Bradley EH, Curry LA, Spatz ES, Herrin J, Cherlin EJ, Curtis JP, Thompson JW, Ting HH, Wang Y, Krumholz HM. Hospital strategies for reducing risk-standardized mortality rates in acute myocardial infarction. *Ann Intern Med.* 2012 May 1;156(9):618-26.

Curry LA, Spatz E, Cherlin E, Thompson JW, Berg D, Ting HH, Decker C, Krumholz HM, Bradley EH. What distinguishes top-performing hospitals in acute myocardial infarction mortality rates? A qualitative study. *Ann Intern Med.* 2011 Mar 15;154(6):384-90.

*Note: For health outcome performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

## INTERMEDIATE OUTCOME, PROCESS, OR STRUCTURE PERFORMANCE MEASURE

**1a.3.** Briefly state or diagram the linkages between structure, process, intermediate outcome, and health outcomes. Include all the steps between the measure focus and the health outcome.

**1a.3.1.** What is the source of the systematic review of the body of evidence that supports the performance measure?

- ☐ Clinical Practice Guideline recommendation – *complete sections [1a.4](#), and [1a.7](#)*
- ☐ US Preventive Services Task Force Recommendation – *complete sections [1a.5](#) and [1a.7](#)*
- ☐ Other systematic review and grading of the body of evidence (e.g., *Cochrane Collaboration, AHRQ Evidence Practice Center*) – *complete sections [1a.6](#) and [1a.7](#)*
- ☐ Other – *complete section [1a.8](#)*

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

## 1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION

**1a.4.1.** Guideline citation (including date) and URL for guideline (if available online):

**1a.4.2.** Identify guideline recommendation number and/or page number and quote verbatim, the specific guideline recommendation.

**1a.4.3.** Grade assigned to the quoted recommendation with definition of the grade:

**1a.4.4.** Provide all other grades and associated definitions for recommendations in the grading system. (Note: If separate grades for the strength of the evidence, report them in section 1a.7.)

**1a.4.5.** Citation and URL for methodology for grading recommendations (if different from 1a.4.1):

**1a.4.6.** If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?

- ☐ Yes → *complete section [1a.7](#)*
- ☐ No → *report on another systematic review of the evidence in sections [1a.6](#) and [1a.7](#); if another review does not exist, provide what is known from the guideline review of evidence in [1a.7](#)*

## 1a.5. UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

**1a.5.1.** Recommendation citation (including date) and URL for recommendation (if available online):

**1a.5.2.** Identify recommendation number and/or page number and quote verbatim, the specific recommendation.

**1a.5.3.** Grade assigned to the quoted recommendation with definition of the grade:

**1a.5.4.** Provide all other grades and associated definitions for recommendations in the grading system. (Note: the grading system for the evidence should be reported in section 1a.7.)

**1a.5.5.** Citation and URL for methodology for grading recommendations (if different from 1a.5.1):

Complete section [1a.7](#)

#### **1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** Citation (including date) and URL (if available online):

**1a.6.2.** Citation and URL for methodology for evidence review and grading (if different from 1a.6.1):

Complete section [1a.7](#)

#### **1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE SUPPORTING THE MEASURE**

**1a.7.1.** What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?

**1a.7.2.** Grade assigned for the quality of the quoted evidence with definition of the grade:

**1a.7.3.** Provide all other grades and associated definitions for strength of the evidence in the grading system.

**1a.7.4.** What is the time period covered by the body of evidence? (provide the date range, e.g., 1990-2010). Date range: [Click here to enter date range](#)

#### **QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.** How many and what type of study designs are included in the body of evidence? (e.g., 3 randomized controlled trials and 1 observational study)

**1a.7.6.** What is the overall quality of evidence across studies in the body of evidence? (discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population)

#### **ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence? (e.g., ranges of percentages or odds ratios for improvement/decline across studies, results of meta-analysis, and statistical significance)

**1a.7.8.** What harms were studied and how do they affect the net benefit (benefits over harms)?

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review.

**1a.8 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.*

**1a.8.1** What process was used to identify the evidence?

**1a.8.2.** Provide the citation and summary for each piece of evidence.