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

**Measure Number** (*if previously endorsed*)**:** 2473

**Measure Title**: Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Acute Myocardial Infarction (AMI)

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** n/a

**Date of Submission**: 4/9/2018

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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: Hospital 30-day mortality

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.



The goal of this measure is to improve patient outcomes by providing patients, physicians, and hospitals with information about hospital-level, risk-standardized mortality rates following hospitalization for acute myocardial infarction (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 mortality 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.

Because it is developed for use in EHRs, this measure can utilize detailed clinical data without requiring the investment of resources currently needed to collect registry or medical record-abstracted data. This Hybrid measure of AMI mortality responds to stakeholders’ interest in using clinical data from medical records for risk adjustment in outcome measures. This measure will provide critical insight into AMI outcomes across hospitals, using clinical data for risk adjustment without undue burden on hospitals

**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.)

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

**1a.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.**

The measures assess mortality within a 30-day period from the date of the index admission. From a patient perspective, death is a critical outcome regardless of cause. The measures use a 30-day time frame because older adult patients are more vulnerable to adverse health outcomes occurring during this time. Death within 30 days of the start of the admission can be influenced by hospital care and the early transition to the non-acute care setting. The 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce mortality.

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.

Reference:

1. 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.

2. Dharmarajan K, Hsieh AF, Kulkarni VT, et al. Trajectories of risk after hospitalization for heart failure, acute myocardial infarction, or pneumonia: retrospective cohort study. BMJ (Clinical research ed). 2015;350:h411.

3. 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.

4. Drye E, Normand S, Wang Y, et al. Comparison of hospital risk-standardized mortality rates calculated by using in-hospital and 30-day models: an observational study with implications for hospital profiling. Annals of internal medicine. 2012;156(1 Pt 1):19-26.

**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.*

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

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

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