## FACT SHEET
## AMI-10:  Statin Prescribed at Discharge
### (Specifications Manual addendum for 10/1/2010 Discharges)

### Why is this measure important?

Multiple randomized clinical trials have proven that statin drugs reduce the risk of death and recurrent cardiovascular events in patients with prior myocardial infarction (MI).  The use of statins for patients hospitalized with acute MI is strongly supported by current American College of Cardiology/American Heart Association (ACC/AHA) clinical guidelines.  The magnitude of benefit with statins matches or exceeds benefits with other secondary prevention medications such as aspirin, beta-blockers, and angiotensin-converting enzyme inhibitors (ACEIs) in patients after MI.

### When does data collection begin?  What does the bigger picture look like?

This is a CMS/Joint Commission measure that received full National Quality Form (NQF) endorsement in June 2010.  It is NOT a test measure.  Data collection is required to start with **January 1, 2011 discharges** but providers may opt to begin submitting AMI-10 data during the interim time period (October 1, 2010 - December 31, 2010 discharges).  CMS will implement this measure for Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU).

The current CMS test measures "LDL-Cholesterol Assessment" (AMI-T1a) and "Lipid-Lowering Therapy at Discharge" (AMI-T2) will remain optional for October 1, 2010 - March 31, 2011 discharges, in the event providers choose to continue to collect this information.

### Which patients are included in this measure?

The AMI statin measure specifications are concordant with the ACC/AHA AMI statin performance measure.

As in the case with all the other acute myocardial infarction (AMI) measures, patients with an ICD-9-CM principal diagnosis code of AMI (appendix A, table 1.1) are included in this measure.

The following types of patients are EXCLUDED from this measure:

- Patients less than 18 years of age*
- Patients who have a length of stay > 120 days*
- Patients with comfort measures only documented*
- Patients enrolled in an AMI clinical trial*
- Patients discharged/transferred to another hospital for inpatient care*
- Patients who left against medical advice or discontinued care*
- Patients who expired*

- Patients discharged/transferred to a federal health care facility*
- Patients discharged/transferred to hospice*
- Patients with a low-density lipoprotein (LDL) less than 100 within the first 24 hours after hospital arrival AND not discharged on a statin
- Patients with a reason for not prescribing statin medication at discharge documented by a physician/APN/PA/pharmacist

\* Common across all AMI discharge medication measures (ASA, beta-blockers, ACEI/ARB)

### What's behind the LDL-c less than 100 exclusion?

This measure is modeled after the published ACC/AHA performance measure for patients with AMI, which excludes patients with LDL-c levels below 100 mg/dL. This performance measure is derived from the ACC/AHA guidelines for STEMI and NSTEMI, which support the use of statins for patients with AMI in the absence of contraindications regardless of baseline LDL, and recommend that patients with LDL-cholesterol levels greater than 100 mg/dL should receive lipid-lowering therapy to reach this target. In excluding patients with an LDL less than 100 only if they are **not** discharged on a statin, this construct enables hospitals to get credit where credit is due - specifically those cases where a patient's LDL is less than 100 and the clinician chooses to prescribe a statin anyway (as supported in the guidelines).

### Why does the exclusion focus on LDL measurements within 24 hours of arrival?

The first 24 hours timeframe stems from guideline recommendations that lipids be measured within 24 hours on all AMI patients. This recommendation results from evidence that shows that after longer periods of time, patients with AMI can have transiently depressed LDL levels that do not reflect their typical level.

### Why doesn't this measure automatically include patients on a lipid-lowering agent prior to arrival, like the Joint Commission's Stroke statin measure?

The measure does not factor in previous lipid-lowering therapy consistent with the ACC/AHA performance measures for AMI. Whether or not the patient was on a lipid-lowering agent on admission does not matter, in terms of the AMI statin measure. LDL levels should be measured on AMI patients and statins prescribed if warranted, as supported in the guidelines.

### What can we expect in terms of abstraction for this measure?

This measure requires only three additional data elements on top of the usual AMI abstraction workload:

- *Statin Medication Prescribed at Discharge*
  This element is being adopted from the Stroke data element set. Because their abstraction guidelines were built from the guidelines developed in *Aspirin Prescribed at Discharge*, *Beta-Blocker Prescribed at Discharge*, etc., abstraction of *Statin Medication Prescribed at Discharge* will work the same way. Notes for Abstraction cover all of the same scenarios - conflicting documentation, documented holds or plans to start a statin after discharge, etc. A look-up list of statin medications is provided in appendix C, table 8.1.

- *LDL-c Less Than 100 Within 24 Hours After Arrival*

  The abstractor will first determine the lowest LDL-c from all LDL-c testing done within the first 24 hours after hospital arrival.  If that lowest value is less than 100 mg/dL, the abstractor will answer "Yes."  If that lowest value is greater than or equal to 100, or if LDL-c testing was not done within 24 hours after arrival (or results are not available), the abstractor will answer "No."

- *Reason for Not Prescribing Statin Medication at Discharge*

  Again, this element is being adopted from the Stroke data element set, and because their abstraction guidelines were built from the guidelines developed in *Reason for No Aspirin at Discharge, Reason for No Beta-Blocker at Discharge*, etc, abstraction of *Reason for Not Prescribing Statin Medication at Discharge* will work the same way. Notes for Abstraction cover the same scenarios - allergies, holds/discontinuations of statins during the stay, examples of acceptable reason documentation, deferral of statins to another physician, documented plans to start a statin after discharge, etc.

  Note:  Unlike the other AMI reason for no medication elements, an Inclusion list exists in the *Reason for Not Prescribing Statin Medication at Discharge* element, which lists such terms as arrhythmias, hepatic failure, hypoglycemia, etc.  This was added by the Stroke team in an attempt to help abstractors in locating reasons for not prescribing statins - In cases where such conditions are present, the abstractor may wish to pay more attention to physician/APN/PA/pharmacist documentation, given the increased likelihood that a reason for not prescribing statins may be present.  This Inclusion list does NOT change the way the abstractor will collect *Reason for Not Prescribing Statin Medication at Discharge* compared to the other AMI reason elements.  In a hepatic failure case, for example, the physician must still link the hepatic failure to the non-use of statins, in order for the documentation to count as a reason for not prescribing a statin at discharge (e.g., "Patient in hepatic failure.  No statins.").

### Where can I find more information on this measure?

Refer to the Specifications Manual for National Hospital Quality Measures for discharges 10/1/2010, addendum version 3.2c.  The manual can be found at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2F QnetTier4&cid=1228754600169

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