

New CMS Report Publicizes Mortality Rates for MI and HF

Evaluation and transparent reporting of patient outcomes is an essential component of efforts to improve the quality of patient care. In June 2007, the Centers for Medicare & Medicaid Services (CMS) and Hospital Quality Alliance (HQA) will begin annual reporting of 30-day mortality measures for acute myocardial infarction (MI) and heart failure (HF) on the *Hospital Compare* Web site (www.hospitalcompare.hhs.gov). The mortality rates will be derived from administrative data using new measures, methods and ratings. The American Heart Association (AHA) and the American College of Cardiology (ACC) are committed to improving public health by supporting quality improvement, education and science in heart disease and stroke. In order to help physicians, hospitals and communities understand the results and to take full advantage of this opportunity to improve patient outcomes, important information regarding the process and best use of these new data are summarized here.

A different approach to mortality measures:

The CMS report is based upon administrative data, rather than chart-abstracted information. The methods used by CMS in this effort have been validated against clinical, chart-abstracted data, and the output of the CMS approach has been shown to be a reasonable surrogate for chart-based methods with respect to profiling hospital performance.

The risk-standardized mortality rates provided by the CMS report will be derived from administrative data for Medicare patients with a principal discharge diagnosis of MI and HF from all acute care and critical access hospitals in the nation. The intent of these measures is to draw attention to the outcome of hospitalization in an effort to recognize quality improvement efforts made by hospitals. CMS will provide all hospitals detailed reports (with numerical rates) that describe their performance, the performance of other hospitals in their state, and patient-level data for use in quality improvement. For the public, CMS will describe hospital performance - relative to U.S. national rates on Hospital Compare, as “better than ...”, “no different than ...”, and “worse than ...” those national rates. Actual numerical rates will not be released. Almost all hospitals will fall in the middle category—“no different than.”

In early 2007, “dry run” reports based on data from 2003 data were made available to hospitals in preparation for the formal 2005 and 2006 reports to be publicly released in June, 2007.

A Call to Action: Responding to the CMS report

The hospital and public CMS reports will display the levels of hospital success in achieving good patient outcomes to professional and lay audiences, and hopefully serve as a driving force for improvement. However, it is important to understand what these reports are not. These ratings should not be an invitation to complacency. The benchmark of the national rate for MI and HF mortality is not the same as the best possible outcome for which we all must strive. Even hospitals with a “better than” rating will continue to have significant opportunity to improve, and these outcomes results can serve as a catalyst and indicator for those efforts. We should all strive to improve to

achieve and keep pace with a rising benchmark for national cardiovascular care performance.

These ratings are based on national Medicare data, and must not be viewed as a head-to-head comparison between hospital systems. While these methods are robust, they do not reflect patients in HMOs or those younger than 65.

It is also important for patients and communities to understand that these ratings should not be used to differentiate regional options for emergency cardiac care, where rapid access is foremost in importance.

These reports emphasize the need for providers to recognize improved patient outcome as the “end game” of all efforts to improve quality of care. Institutions which have limited their scope of quality improvement efforts to the narrow spectrum of performance metrics set forth by CMS or Joint Commission will see a need to broaden their scope of interest. While certainly performing well on these test indicators is important, it likely that more fundamental changes are needed to truly affect outcomes.

We encourage all hospitals to carefully review and respond to the CMS report. It can be anticipated that patients and communities will also expect a local plan of action. In order to effectively respond, it is suggested that hospitals create a multidisciplinary team to review the data and develop plans to improve outcomes for patients with MI and HF. The designated team should:

- Perform an ongoing review of the causes of deaths for MI and HF patients and determine how many deaths were fully anticipated (patients admitted with comfort measures only orders) versus predictable but perhaps preventable (e.g., severely ill on admission), versus unanticipated (generally well but suffered complications or sudden death).
- Review current available care process information. All hospitals should have process performance measures required by CMS/JCAHO and many others will have more detailed clinical information available from participation in other clinical data registries.
- The team should broadly consider all means to improve outcomes, including structure and process, as well as culture and interpersonal interactions. Many factors may influence effectiveness and safety (e.g. clear communication and coordination between departments and caregivers, infection control, accurate medication administration, early and appropriate interventions for signs of a change in clinical condition, and systems which foster quality control and a spirit of commitment to the patient).
- For each opportunity for optimization, the team should develop an action plan for improvement (including defined clinician champions, an intervention plan, and a timeline). Action plans need downstream monitoring to determine whether they were implemented, whether the intervention was successful and the outcomes improved.

This cycle of review, reflection, quality improvements and monitoring should be continuous and carried out with an ambitious end-goal in mind such as “we are committed to having no preventable deaths related to our institution’s care.” Several programs aimed at improving compliance with evidence-based treatments

and improving care are available, including the AHA's Get with the Guidelines™ programs for coronary artery disease, heart failure and stroke; as well as participation in the D2B Alliance for Quality initiative and the NCDR ACTION registry. These programs not only can provide institutions with in-depth feedback on care processes but also have ongoing efforts to assist sites in their quality improvement efforts.

References:

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