

## EDITORIAL COMMENT

# Coming Together to Achieve Quality Cardiovascular Care

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Agreement on the processes of health care that are necessary to achieve health care quality goals is the foundation of performance measurement. In addition, standardization of performance measures themselves is essential to avoid confusion and undue burden among those whose performance is being measured. Recent work on cardiovascular performance measures establishes a new standard for how those agreements can be achieved and maintained among multiple stakeholders. The collaboration among the American College of Cardiology (ACC), the American Heart Association (AHA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Healthcare Research and Quality (AHRQ) serves as a useful model for how to reduce the burden of measure development, endorsement for public reporting, and implementation for quality improvement and accountability.

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The collaboration started in 1993 when the ACC lent its support to an effort by CMS (then the Health Care Financing Administration) to develop objective performance measures based on the ACC/AHA Guideline on the Early Management of Patients With Acute Myocardial Infarction. Those measures were used to track inpatient care, first at the state level (1) and then at the national level (2,3). The ACC and AHA also supported measure development efforts by the JCAHO for its new requirement that hospitals measure performance.

In 2000, as the ACC was developing the Guideline Applied in Practice (GAP) program and the AHA was developing Get With the Guidelines (GWTG), both organizations recognized the need for a common set of measures to accompany those quality improvement activities. The steps for the development of these common measures have

been outlined by the ACC/AHA and recently published (4).

With the initiation of public reporting in 2003, the CMS and JCAHO recognized that small discrepancies between their measures were creating major data abstraction burdens for providers and distractions to quality improvement initiatives. As a result, the CMS and JCAHO joined together to publish consolidated measure specifications in 2004. When the ACC and AHA published their draft joint measures a few months later, the four organizations recognized a need and an opportunity. The CMS and JCAHO reached out to the ACC/AHA Task Force on Performance Measures to establish a dialogue about how the joint expertise of all four organizations could be leveraged to achieve national standardization of measurement for cardiovascular care.

The first tangible result of this collaboration was demonstrated in 2004 in the response by all organizations to the changing use of angiotensin-converting enzyme inhibitors (ACEI) and angiotensin receptor blockers (ARB). We realized if all four organizations could agree on how to modify this measure, then such agreement could be used as a model that would allow each organization to contribute its strengths toward measurement development and would synchronize measure updates. The AHRQ supported these efforts by bringing together the stakeholders for a one-day summit. The National Quality Forum (NQF) provided additional focus for this collaboration by highlighting the need to re-examine these NQF-endorsed measures. Within months of the first communication, the ACC, AHA, CMS, and JCAHO agreed that clinicians should be given credit for the initiation of ACEI or ARB therapy at discharge for acute myocardial infarction (AMI) and heart failure patients (5). The measurement specifications for both AMI and heart failure were modified by all four organizations simultaneously. Resolving the ACEI/ARB issue provided an opportunity to build trust among all parties. The clinical expertise of the ACC/AHA in evidence review and guideline/measurement development was leveraged, while the CMS and JCAHO contributed their expertise in the development, specification, and implementation of the measures. The AHRQ and NQF served as important supporters through their convening efforts.

The organizations collaborated again in 2005 when the Clopidogrel and Metoprolol in Myocardial Infarction (COMMIT/CCS-2) trial (6) raised questions about the current acute beta-blocker measure for AMI. Within seven weeks, the organizations jointly issued a practice advisory to the health care community providing information on how the data from the trial should be interpreted when implementing the current beta-blocker measure (7).

The publication of the ACC/AHA Clinical Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction (STEMI/NSTEMI) (8) signals another step in the evolution of this national collaboration. All organizations have committed to impor-

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tant revisions to the current CMS/JCAHO AMI measurement set based on recommendations within the ACC/AHA STEMI/NSTEMI Clinical Performance Measures. These suggestions will be implemented in two phases by the CMS/JCAHO.

The first phase will change the method of reporting for the time-to-reperfusion measures (both thrombolytic and percutaneous coronary intervention [PCI]) from a report of the mean time to a report of the median time. The median time more closely reflects the overall pattern of care and better portrays the central tendency of the data, because the mean time is more heavily influenced by outlier cases. All organizations agreed that a change to a median time could be accomplished without significant changes to data collection.

Additional changes during a second phase will refine the measures specifications to determine the time to primary PCI (rather than all PCI procedures done during the first day), to take into account medical and patient-specific reasons for delay in primary PCI, and to modify the threshold time to PCI to 90 min in concordance with guideline recommendations. A measure to assess the number of patients who are eligible for reperfusion who receive such therapy also will be developed over the next year as all organizations work jointly to integrate such changes into specifications and data collection protocols.

All organizations want to assure the practicing community that each organization is dedicated to a collaborative process to achieve a single national measurement standard. The ACC/AHA, CMS, JCAHO, and AHRQ plan to continue their close communication to ensure that information that may impact inpatient measures is discussed promptly among all organizations and conveyed to the health care community. In addition, these organizations will work with the Physician Consortium for Performance Improvement to align inpatient and outpatient measures as necessary and appropriate. Lastly, measures that are ready for national adoption will continue to be submitted to the NQF, confirming the commitment by all organizations involved to provide various stakeholders with an opportunity to review and endorse the measures as national standards.

Issues with performance measures will undoubtedly arise, whether from the results of new evidence or from feedback

after the implementation of the measures by the health care community. To retain credibility with professionals, any established system of performance measurement must be nimble enough to be able to respond appropriately to a changing evidence base. The physician community should be assured that the ACC, AHA, CMS, JCAHO, and AHRQ are committed to continuing to help the measures evolve in a joint and collaborative way. That may be as much of a contribution to health care quality improvement as the measures themselves.

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