CMS Mortality Reporting and Your Hospital

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Coming in July to you, your hospital and your patients: 2008 annual CMS report on 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) began annual reporting of 30-day mortality measures for acute myocardial infarction (MI) and heart failure (HF) on the Hospital Compare Web site. A similar 30-day risk standardized mortality for pneumonia (PN) will be introduced this year. The mortality rates are derived from administrative claims data. In July of 2008, results will again be posted to the Hospital Compare Web site.

The American College of Cardiology (ACC) and American Heart Association (AHA) are committed to improving public health by supporting quality improvement, education and science in cardiovascular disease. 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 data are summarized here.

A different approach to mortality measures:

The CMS report is based on administrative data, rather than chart-abstracted information. The methods used by CMS in this effort have been reasonably well validated against clinical data abstracted from chart reviews. It is generally agreed that the output of the CMS approach represents an acceptable surrogate for chart-based models with respect to profiling hospital performance.

The risk-standardized mortality rates provided by the CMS report have been derived from administrative data for Medicare patients with a principal discharge diagnosis of MI, HF, and PN 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. The ability to vary 30 day event rates varies by disease with more certainty established for 30 day outcomes after acute myocardial infarction than heart failure. However, it is widely accepted that the best way to lower 30 day event rates is through rigorous adherence to ACC/AHA guideline recommendations for AMI and HF and through effective transitions of care from the in-patient to out-patient arena. Thus an overall focus on quality of care is suggested as the best practice.

CMS will provide all hospitals detailed reports (with numerical rates) that describe their performance, the performance of other hospitals in the state, and patient-level data for use in quality improvement. In response to the request for more transparency in the healthcare system, CMS will display the risk-standardized mortality rates, interval estimates, the number of cases from each hospital, and a summary statement of the results as one of three categories – "better than U.S. national rate," "no different than U.S. national rate," or "worse than U.S. national rate."

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 show how a hospital performs given the patients it has. The metric should not be viewed as providing a head-to-head comparison between hospitals. While these methods are robust, the data did not include patients in HMOs or those younger than 65.

New for this 2008

This year, the measures were updated to exclude patients with any history of Medicare hospice enrollment in the 12 months prior to hospitalization. This affected less than one percent of the patients included in the measures but led to several facilities having unexpectedly poor outcomes in the 2007 database. Also, the quantitative data for all facilities will now be publicly available—not just to the indicated facility but to all who view the data. This is again done in the spirit of transparency and all should be aware that previously confidential hospital data will be in the public domain.

How to use these ratings

It is important for patients and communities to understand that these ratings should not be used to choose regional options for emergency cardiac care where rapid access is foremost in importance. A patient should always be taken to the nearest available emergency medical center in a critical situation.

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 that have limited their scope of quality improvement efforts to the narrow spectrum of performance metrics set forth by CMS or The Joint Commission (TJC) will see a need to broaden their scope

of interest. While certainly performing well on these test indicators is important, it is likely that more fundamental changes are needed to truly improve 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. Suggestions for elements of an effective response include:

- Create a multidisciplinary team to review the data and develop plans to improve outcomes for patients with MI and HF. The designated team should:

    1. 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 but not already on hospice) versus predictable but perhaps preventable (e.g., severely ill on admission) versus unanticipated (generally well but suffered complications or sudden death).
    2. Review current available care process information. All hospitals should have process performance measures required by CMS/TJC and many others will have more detailed clinical information available from participation in other clinical data registries.

- These teams 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 that 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 are aimed at improving compliance with evidence-based treatments and improving care; these include the AHA's Get With The Guidelines™ programs for heart failure and stroke, joint ACC-AHA ACTION Registry®-GWTG™, and ACC's NCDR CathPCI Registry and their associated ACC Continuous Quality Improvement educational tools. 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 and may result directly in improved outcomes through greater adherence to guideline recommended therapies.

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