

## Mortality Data and Quality Improvement

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*Quality Matters* is a newsletter from The Commonwealth Fund. Published bimonthly, the newsletter explores issues of quality and efficiency in health care.

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*“We have a very supportive organizational approach to looking at what we do for patients, understanding it, and looking and what we need to do to make it better. We’re never satisfied.”*  
– Sheila J. Namm, J.D., R.N., M.A., Vice President of Professional Affairs, Maimonides Medical Center

Welcome to *Quality Matters*, a bimonthly roundup of news and opinion on quality and efficiency, information technology, performance improvement initiatives, and policy innovations.

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### In Focus: Making Mortality Data More Meaningful

**Summary:** *After a 14-year hiatus, the federal government resumed publication of mortality data on Medicare patients, this time in a more limited fashion. Its effort to avoid the criticisms that felled the previous program has left some questioning whether the data, released in June, have any value at all. This article examines those complaints and looks at ways mortality data may be—and are already being—modified to make them more useful as quality improvement tools.*

**By Sarah Klein**

Publishing mortality data is a bit like grabbing the third rail on a train track. Few things agitate and mobilize hospitals more quickly than publicly comparing the rate at which patients die after receiving care in their institutions. The first time the federal government attempted it, in the mid-1980s, the backlash was so intense the government scrapped the program.

That release, which examined death rates at hospitals nationwide related to nine conditions and surgical procedures, was arguably premature—forced upon the government by a flurry of Freedom of Information Act requests before statisticians had a chance to make a full set of risk adjustments. Hospitals nationwide pounced on the data,

claiming they unfairly prejudiced patients against their hospitals, while pointing out a some legitimate explanations for their low rankings. Even a concession from top officials that the information was not yet ready for public consumption failed to stop the criticism.

### **A Second Try**

The Centers for Medicare and Medicaid Services (CMS), which recently has made value-based purchasing a priority, was understandably cautious when it decided to release some data on hospital mortality rates for Medicare beneficiaries. The agency chose only two measures to make public—death rates within 30 days of admission with a diagnosis of heart failure or acute myocardial infarction—and did so under the most generous of terms. (Next year, CMS will release data on rates of mortality among Medicare beneficiaries hospitalized for pneumonia.) Instead of comparing hospitals to top performers, CMS ranked them according to how their performance compared to an average hospital. The public learned only whether a participating hospital's results were better than expected from an average institution, as expected, or worse than expected. The actual mortality rates weren't released to the public, unless hospitals chose to disclose the numbers themselves.

"The feds were trying to come up with a statistic that would be as close to unassailable as possible," says David Schulke, executive vice president of the [American Health Quality Association](#), the group representing Quality Improvement Organizations, which are charged with helping those deemed poor performers to improve.

Partly as a function of these changes, the results seem improbable to many. More than 98 percent of the nation's hospitals were

deemed to perform as expected in treating heart attack and heart failure. For heart attack, only 17 performed better than expected, while seven performed worse than expected. In treating heart failure, 38 hospitals performed better than expected, while 35 performed worse than expected. Even the most unsophisticated observers assume, "there are more good hospitals and probably more bad hospitals," says Denise Love, M.B.A., executive director of the [National Association of Health Data Organizations](#), which represents public and private data agencies.

The method served a valuable purpose, says Harlan Krumholz, M.D., professor of medicine, epidemiology, and public health at Yale University, who together with colleagues from Harvard and Yale universities developed the analytical methodology. It helped to reacquaint hospitals with the public reporting of health outcomes and encouraged quality improvement and self-examination, rather than embarrassment. "We want to get people engaged in a culture of quality improvement and a focus on outcomes from the patient's perspective," rather than arguing about the data, Krumholz says. "We were very conservative."

But many observers say that engagement hasn't happened. Some hospitals are still disputing the validity of the data, arguing they aren't properly adjusted to take into account palliative care cases and patients with do-not-resuscitate orders. At the same time, some data experts are arguing the methodology has not gone far enough in identifying problem hospitals.

### **Methodology Examined**

CMS used a method to adjust the data that was designed to ensure hospitals with low volumes would not be disproportionately

affected by those results. In those instances, the agency factored in the results of all hospitals. It is a statistical method that allows CMS to increase its confidence in the reliability of the data, but it lessens the likelihood that that low-performing hospitals will stand out, says Edward Hannan, Ph.D., a professor of health policy, management, and behavior at the University of Albany School of Public Health, who helped create the model New York State uses to determine mortality rates for coronary artery bypass graft surgery in New York hospitals.

The method can be problematic when analyzing procedures for which volume affects outcomes. Because there is a tendency for hospitals that perform fewer procedures to get inferior results, relying on data from other hospitals to judge them may distort that. "You're disguising the result," Hannan says. It may also enhance the performance of high-volume hospitals relative to others. The reason is statisticians have a higher degree of confidence in those results and therefore don't blend them with outcomes from other hospitals.

But Krumholz argues that the adjustment is not only important, it is essential to avoid overstating problems in hospital outcomes. When declaring a hospital an outlier, "You need to be very, very confident," he says.

The hospitals haven't criticized this aspect of the data analysis, perhaps because the method favors them. Instead, many institutions have voiced concerns that the data were not adjusted to take into account hospice patients and do-not-resuscitate orders, which they claim would add to hospitals' overall mortality figures. Another objection is that CMS relied on administrative claims data, rather than clinical data from medical records.

There's a rationale for not using clinical data, experts say. "Acquiring detailed clinical

information is incredibly expensive," says Lisa Iezzoni, M.D., M.Sc., associate director of the Institute for Health Policy at Massachusetts General Hospital and professor of medicine at Harvard Medical School.

Some states have begun to incorporate clinical information into mortality data, including Pennsylvania. One important benefit of doing this is the impact it has on providers. "I don't think we would have the support of the physician community [if we didn't]," says Joe Martin, communications director for the Pennsylvania Health Care Cost Containment Council. Others are watching Maine to see how its database, which combines administrative and clinical data from all payers in the state, is used.

In the meantime, there may be cost-efficient alternatives to collecting clinical data. A study by Michael Pine, M.D., M.B.A., president of Michael Pine & Associates Inc., a consulting firm, demonstrated that combining administrative data with lab results comes very close to approximating the medical record. "What's really wonderful about this is that more than 80 percent of the hospitals in the U.S. have lab data electronically," says Anne Elixhauser, Ph.D., a senior research scientist in the Agency for Healthcare Research and Quality (AHRQ) who worked on the study. AHRQ is currently funding projects at hospitals to develop a means of linking lab results to administrative claims for this purpose.

### Future Reports

In the meantime, other observers are hoping CMS will make subsequent iterations of the mortality reports more meaningful to consumers by focusing on conditions for which patients shop for medical care. Patients who are suffering from a heart attack will be hard pressed to research hospitals before going to them for treatment. But a

woman who has nine months lead time will put a lot of research into the hospital where she will give birth, says Judith Hibbard, Ph.D., professor of health policy at the University of Oregon. Patients also prefer measures that are more intelligible, such as infection rates and drug errors. "The measures themselves don't lend themselves to thoughtful choice," Hibbard says.

One change to Medicare data that is already under way is the addition of present-on-admission indicators, which help to distinguish conditions that arise during the hospital stay (such as hospital-acquired infections) from those that patients have at admission. Such indicators have been used in state programs in California and Pennsylvania for more than a decade. CMS plans to add them in 2008, to avoid paying for avoidable complications in care.

Using present-on-admission indicators is not as straightforward as it seems. "The examples of states have shown it is hard to make it happen in a way that is consistent across hospitals," Dr. Iezzoni says. Another risk is that hospitals will use that coding to game the system, by making their care appear more flawless than it is.

Despite the challenges to Medicare's recent release, many are happy to see the government return to outcomes reporting, which represents the next frontier. The majority of U.S. hospitals have been reporting data on adherence to processes of evidence-based care for acute myocardial infarction, congestive heart failure, and pneumonia to CMS via the Hospital Quality Alliance since 2003. The notion that someone is reporting death rates tends to focus providers' attention on their quality, even when they disagree with the methodology, Love says. "They may be defensive, but they do deploy," she says. Pennsylvania officials believe so, too. When the state's mortality program began 10 years ago, "mortality rates were statistically significantly higher [than they are today]," Martin says.

It's also important that information makes providers a little nervous, Love says. "Nothing happens unless people are a little uncomfortable," she says.

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## Case Study: Looking Behind the Top Heart Failure Mortality Rating at Maimonides Medical Center

By Vida Foubister

### Issue

In June 2007, the Centers for Medicare and Medicaid Services (CMS) released mortality rates among Medicare beneficiaries hospitalized for heart attack or heart failure, ranking hospitals across the country as "better than the U.S. national rate," "no

different than the U.S. national rate," and "worse than the U.S. national rate." Our analysis of the data on the Hospital Compare Web site led us to identify three, out of the nearly 5,000 hospitals participating, that ranked better than the national average for the treatment of both heart attack and heart failure: Cleveland Clinic's Hillcrest Hospital, Maimonides Medical Center in Brooklyn, N.Y., and New York–Presbyterian Hospital.

This case study examines the quality improvement efforts behind Maimonides' ranking, in particular a Congestive Heart

Failure (CHF) Program implemented in 1999. Through this analysis, we explore what influence public reporting of hospital mortality rates is likely to have on patient outcomes.

## Organization

[Maimonides Medical Center](#) is a 705-bed, tertiary care hospital that serves a diverse community in southern Brooklyn, N.Y. Almost 50 percent of patients seen at the hospital were born outside of the U.S.; patients speak many different languages and represent many different cultures. Founded in 1911, Maimonides was later named after Rabbi Moshe Ben Maimon, a 12th-century philosopher committed to cultural tolerance and humane care.

The nonprofit, independent hospital includes Maimonides Cancer Center, Maimonides Infants & Children's Hospital of Brooklyn, Stella and Joseph Payson Birthing Center, ACE (Acute Care for Elderly) Unit, Stroke Center, and Cardiac Institute. It is a teaching hospital affiliated with Mount Sinai School of Medicine, SUNY-Brooklyn, the New York College of Osteopathic Medicine, and St. George's University.

## Target Population

Maimonides serves a community with a large elderly population. Patients who come through its emergency department, for example, are a decade older on average than those seen in other urban hospitals. Heart failure is a common diagnosis among this population and, each year, the hospital has more than one thousand discharges for primary heart failure and several thousand for secondary heart failure. Nearly 5 million people in the United States suffer from heart failure, the leading cause of hospitalization among older Americans.

## Key Measures

Hospital Compare reports participating hospitals' comparative performance on 30-day, risk-adjusted mortality rates for Medicare patients hospitalized for either heart attack or heart failure, and will do so next year for pneumonia as well. CMS bases these mortality rates on a complex statistical model that relies on Medicare claims and enrollment information to predict patient deaths for any cause within 30 days of hospital admission (see the [Hospital Compare Web site](#) for further details).

Prior to the release of the CMS data in June, Maimonides had been benchmarking its outcomes among physicians in the hospital and with other hospitals. As part of the CHF program, the hospital has tracked heart failure patients' readmission rates since 1999. Also, Maimonides has been following its mortality rates in this area and others through [HealthGrades](#), a private health care ratings organization, and the [New York State Hospital Report Card](#). HealthGrades' rating methodology is proprietary, but it is based on the most current three-year data set available from CMS and states that make such data available. The N.Y. Report Card, released by the Alliance for Quality Health Care and the Niagara Health Quality Coalition, uses a risk-adjustment methodology developed by the 3M Corporation to analyze administrative data.

Maimonides gathers information on these mortality rates and has long gathered information on the hospital's processes of care—both internally and from external sources including CMS, New York State, Hospital Quality Alliance, Joint Commission, and [IPRO](#), the Medicare quality improvement organization for New York State—to create an internal report for use in hospital-wide performance initiatives. This report is available to Maimonides leadership,

physicians, and staff, through the second quarter of 2007, on its internal Web site.

### **Implementation Timeline**

Norbert Moskovits, M.D., associate director of clinical cardiology, led the implementation of the Congestive Heart Failure Program in 1999 and serves as its director.

### **Process of Change**

Maimonides' performance improvement committee, which includes the CEO, COO, vice president, clinical department chairs, nursing directors, and representatives from clinical support departments including respiratory and pharmacy, meets monthly to review performance across the hospital and choose areas for improvement. The Maimonides CHF program was established to create a new treatment protocol that provides heart failure patients with prompt and appropriate treatment in the hospital, and includes follow-up care after discharge. Its goal is for every patient with a primary or secondary diagnosis of heart failure to be seen by the CHF team. This team includes two staff physicians, three to four nurse practitioners, and two registered nurses. Each team member has specific duties, and together they assess and create an individualized treatment plan for each patient.

The program's first goal is to identify all patients with heart failure within a few hours of their arrival to the emergency department. Nurse practitioners review patients referred to the program by their physicians and use the hospital's computer system to search for additional patients admitted with heart failure or a related diagnosis code. Each patient who is identified receives a visit from the nurse practitioner, who assesses whether further attention from other team members is

necessary. Patients are also identified through emergency department visits, based on heart failure symptoms in cases where a diagnosis is lacking. Echocardiology staff collaborate with the CHF team, alerting nurse practitioners to patients with fluid accumulating around the heart.

"In the past, that was the biggest problem," says Moskovits. "Some of these patients slipped through. We spent a lot of time putting into place procedures where we can reliably identify all the patients with heart failure."

A second goal is to provide heart failure patients with evidence-based medical treatments and interventions to improve their outcomes. Nurse practitioners see patients for an initial evaluation in the hospital; CHF team physicians then consult with patients, referring them for further interventions as necessary. A significant aspect of their inpatient care is ensuring that heart failure patients are taking the right medications, at the right doses.

"There are several medications available that improve symptoms, decrease rehospitalization, and improve survival," says Moskovits. These include ACE (angiotensin converting enzyme) inhibitors, angiotensin receptor blockers (ARBs), beta blockers, aldosterone antagonists, and diuretics. The provision of the first two are appropriate care measures tracked by IPRO.

The third goal grew out of the realization that patients were having difficulties understanding their discharge instructions and complying with their medication regimens once they left the hospital. A standardized, patient-focused instruction sheet was created to provide patients with clear information on their disease and continuing treatment. This sheet can be customized, reflecting the individual health

status of each patient (accounting for disease severity, comorbidities, and other medications). Nursing team members also work to educate patients and their caregivers, both in the hospital and after discharge. The CHF team follows up with patients by telephone once they are home to make sure they are complying with their medications and maintaining an appropriate diet. If necessary, changes in their treatment plan—such as switching to a more affordable medication—are made. (As heart failure is a chronic disease, many patients continue to follow up with Maimonides physicians, both in the hospital and their private offices, for the rest of their lives.) Patients can also participate in a monthly support group.

## Results

Maimonides' rehospitalization rates for heart failure patients had been between 18 to 20 percent for many years prior to the implementation of the CHF program in 1999. The following year, that rate decreased to 6.75 percent and has remained between 6 and 8 percent (see [Chart 1](#)).

CMS, which together with the Hospital Quality Alliance ranked 4,807 hospitals for the treatment of heart failure, found the U.S. national 30-day risk standardized mortality rate was 11 percent. Maimonides' was 8.5 percent, placing it among the 38 hospitals that had an adjusted mortality rate lower than the U.S. rate in the 12-month period from July 2005 through June 2006. The agency also ranked Maimonides better than the national average for all U.S. hospitals reporting process of care measures for heart failure patients, based on discharges from October 2005 through September 2006. These measures show, in percentage form or as a rate, how often a health care provider gives recommended care. Specifically, at Maimonides: 92 percent of heart failure patients were given ACE inhibitor or ARB

for left ventricular systolic dysfunction (vs. 83 percent nationally); 95 percent of heart failure patients were given an evaluation of left ventricular systolic function, if appropriate (vs. 83 percent nationally); 83 percent of heart failure patients were given discharge instructions, if appropriate (vs. 61 percent nationally); and 89 percent of heart failure patients were given smoking cessation advice/counseling, if appropriate (vs. 82 percent nationally). Although Maimonides performed better than the national average, it did not rank in the "Top Hospitals" category—the top 10 percent of hospitals nationwide—for these process of care measures.

State data released as part of the New York State Hospital Report Card show Maimonides' mortality rate for heart failure patients (3.1 percent) was below the risk-adjusted state average (4.3 percent) in 2005.

Maimonides also monitors its heart failure mortality rates using HealthGrades data. Since 2002, it has performed "better than expected" for both in-hospital and 180-day mortality, with the exception of an "as expected" in-hospital mortality ranking in 2006 (see [Chart 2](#)).

## Implications

Maimonides, which has both an organization-wide and a department-specific approach to quality, began tracking process measures, quality indicators, and core measures "long before public reporting became the norm," says Sheila J. Namm, J.D., R.N., M.A., vice president of professional affairs. "All that we do as an organization, to treat patients and support the people that take care of patients, is focused on the outcomes that are appropriate for each patient." The hospital has been working with IPRO on its appropriate care measures, including some related to acute

myocardial infarction and heart failure, and with the Institute for Healthcare Improvement on reducing ventilator-associated pneumonia and central line infections.

Public reporting of outcome measures can serve as an incentive for physicians and other caregivers to provide evidence-based medicine within established guidelines and document their provision of this care, says Moskovits. “It all comes down to something that’s been known for many years: if you practice evidence based medicine, your outcomes will be better.”

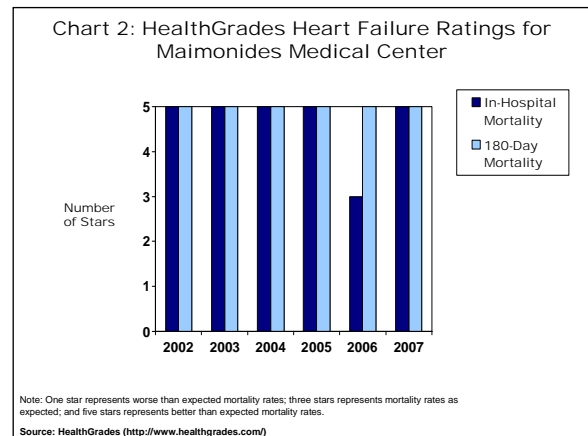
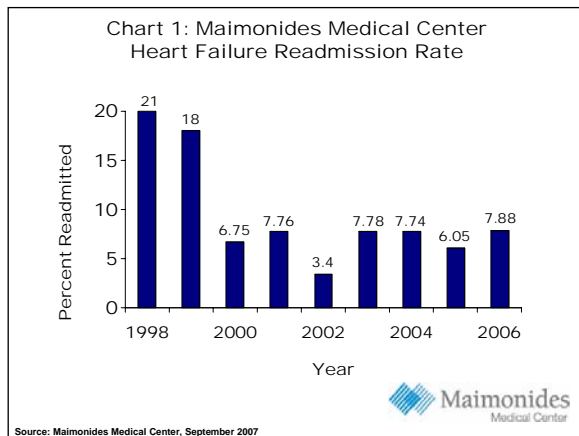
Maimonides works to support its clinical staff and provides physicians with valid and valuable data to promote quality

improvement throughout the hospital, says Namm. These efforts receive a “tremendous amount of support” from the CEO and COO, as well as an active board of trustees “that is very interested in clinical care and outcomes.”

“We have a very supportive organizational approach to looking at what we do for patients, understanding it, and looking at what we need to do to make it better,” she says. “We’re never satisfied.”

#### For Further Information

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## News Briefs

### CMS Will No Longer Pay for Hospital-Acquired Infections

The Centers for Medicare and Medicaid Services (CMS) [announced](#) last month that Medicare will no longer reimburse health care providers for the extra costs incurred

when beneficiaries contract certain hospital-acquired infections (HAIs).

Each year, some 2 million hospital patients acquire an infection during their stay, and nearly 100,000 patients die from these infections, according to the Centers for Disease Control and Prevention. Treating HAIs adds an average \$15,000 to patient bills, totaling about \$30 billion annually.

According to the most recent [Leapfrog Hospital Quality and Safety Survey](#), 87 percent of U.S. hospitals do not follow all of the recommended practices to prevent most HAIs, including hand-washing—the first line of defense against many infections.

Beginning in October 2008, Medicare will end payments to hospitals for treating common HAIs, including catheter-associated urinary infections, bloodstream infections, and surgical site infections. CMS also will withhold payment for other complications considered preventable, including injuries resulting from falls, bed sores, and objects left in patients during surgery. To implement this policy, hospitals will be required to report secondary diagnoses present during admission, making it possible to detect what conditions were acquired during hospital stays. The new rules are part of several payment reforms intended to improve the quality and efficiency of Medicare.

### **QIOs Target Prescription Drug Therapy**

The Medicare Modernization Act of 2003 gave Quality Improvement Organizations (QIOs) a new line of work: improving the quality and safety of drug prescribing and use among Medicare beneficiaries. It also gave them wide latitude in pursuing this goal.

According to a recent *Journal of Managed Care Pharmacy* [supplement](#), QIOs across the nation have taken various approaches to improve prescribing, including: working to promote safer alternatives to the use of drugs known to produce adverse effects among elderly patients; improving medication use among diabetics; educating providers and beneficiaries who have high medication use about medication therapy programs; reporting comparative performance information among different health plans; and creating systems in which health care

professionals can work together to improve medication reconciliation.

### **UnitedHealth to Test Medical Home Concept**

Last month, UnitedHealth Group, one of the nation's largest commercial insurers, [announced](#) that it will test the efficacy of the "medical home" concept. This is the first time this model—centered on primary care practices that provide accessible, continuous, and coordinated care—will be put into practice by a private health plan. Medical homes have been advocated by several medical professional societies and linked to better-quality care in a recent Commonwealth Fund [report](#).

UnitedHealth Group will partner with six primary care practices in Florida to test the model, and patients will be offered the option of choosing to register with a medical home. UnitedHealth will then offer enhanced reimbursement to physicians who offer medical homes, and who can demonstrate measurable improvement in the overall health of their patients.

To improve access to care, the insurer will offer round-the-clock triage services by nurses, and provide educational tools to patients. They will also work to identify and reach out to patients who need care, and provide assistance to help patients manage their conditions.

### **Leapfrog Group Names 41 "Top Hospitals"**

Based on the results of its annual Hospital Quality and Safety Survey, the Leapfrog Group has named 41 hospitals high performers for 2007. The results, released Sept. 18, are based on responses from 44 percent of the urban, general acute-care hospitals in the 33 regions targeted by the survey, or 1,285 hospitals.

Leapfrog collects data from hospitals on their progress in four areas: implementation of computerized physician order entry; ICU physician staffing; evidence-based hospital referral; and adherence to Leapfrog's designated safe practices. Seventy-four percent of participating hospitals have fully implemented the practices in at least one of these four categories.

"Top Hospitals" fully meet Leapfrog's standards for ICU physician staffing and safe practices and follow either 1) two or more of

the eight evidence-based hospital referral (EBHR) practices or 2) have computerized physician order entry plus one of the eight EBHR practices. Thirty-three general hospitals meet these criteria. "Top Children's Hospitals" fully meet the standard for ICU physician staffing, safe practices, and the EBHR Neonatal ICU standard for high-risk newborns. Eight children's hospitals meet these criteria. The complete list and a detailed explanation of the methodology can be found at the [Leapfrog Group Web site](#).

## Recent Publications of Note

Selected articles on quality improvement from a number of journals, including the *American Journal of Medicine*, *Annals of Internal Medicine*, *Archives of Pediatric and Adolescent Medicine*, *BMJ*, *Health Affairs*, *Health Services Research*, *International Journal for Quality in Health Care*, *Joint Commission Journal on Quality and Safety*, *Journal of the American Medical Association*, *Journal of General Internal Medicine*, *Journal of Patient Safety*, *Journal of Safety and Quality in Health Care*, *Medical Care*, *The Milbank Quarterly*, *The New England Journal of Medicine*, and *Pediatrics*. The articles are nominated by Editorial Advisory Board members from a preselected list.

### *Health Care System Performance*

#### **Managing Surgical Wait Times**

The authors compared strategies to manage surgical waiting times in Australia, Canada, England, New Zealand, and Wales. Most of these countries have allocated dedicated funding and set explicit waiting time targets in this area, and the most effective policies are highlighted. S. Willcox et al. (2007) [Measuring and Reducing Waiting Times: A Cross-National Comparison of Strategies](#). *Health Affairs* 26, 1078–1087.

#### **Insurer-Motivated Redesign Lowers Costs**

An integrated delivery system's response to a threatened exclusion from an insurer's high-performance network is reviewed, including its attempt to reduce costs through a fundamental care process redesign. Although some features of this transformation are organization- and market-specific, other elements could be replicated. However, the authors conclude that making the business case for sustaining desirable provider behavior may require that purchasers and plans make equally fundamental changes in payment policy. H.H. Pham et al. (2007) [Redesigning Care Delivery in Response to a High-Performance Network: The Virginia Mason Medical Center](#). *Health Affairs* 26, w532–w544.

### *Quality Reporting*

#### **HQA Indicators and Mortality**

The authors examined the relationship between a hospital's performance on Hospital Quality Alliance (HQA) quality indicators and mortality for Medicare enrollees admitted for acute myocardial infarction, congestive heart failure, and pneumonia. They found that higher, condition-specific performance on the HQA indicators is

associated with lower risk-adjusted mortality for each of the three conditions, validating the importance of this national hospital quality rating program. A.K. Jha et al. (2007) [The Inverse Relationship between Mortality Rates and Performance in the Hospital Quality Alliance Measures](#). *Health Affairs* 26, 1104–1110.

### **Mortality Measures and End-of-Life Care**

A commentary responding to the public release by CMS of hospital mortality rates concludes that mortality is a good quality measure for individuals with acute illness who are not supposed to die. But, according to the authors, it is a poor quality measure for most patients with multiple chronic diseases who are near the end of their life, as it treats death as a medical failure and reinforces avoiding death at all costs. R.G. Holloway and T.E. Quill. (2007) [Mortality as a Measure of Quality: Implications for Palliative and End-of-Life Care](#). *Journal of the American Medical Association* 298, 802–804.

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### **Quality Tools in Practice**

#### **QI: Evidence Needed**

Increased interest in patient safety and health care quality has led to the implementation of innovative but unproven quality improvement (QI) strategies. The authors argue that these initiatives run counter to the principle of following the evidence in selecting interventions that meet quality and safety goals, as well as the idea that interventions should be tailored to local needs and resources. Thus, they recommend holding safety and quality interventions to the same standards that are applied to the adoption of all medical technologies. A.D. Auebach et al. (2007) [The Tension between Needing to Improve Care and Knowing How to Do It](#). *New England Journal of Medicine* 357, 608–613.

### **National Initiative Improves HF Care**

This study examined the effect of a national initiative to improve the care of patients hospitalized with heart failure, called the Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients With Heart Failure (OPTIMIZE-HF). Based on data from 259 U.S. hospitals (from March 1, 2003, to Dec. 31, 2004), the study found that OPTIMIZE-HF participation was associated with an increase in the use of evidence-based therapy, adherence to performance measures, and shorter lengths of stay for heart failure patients. G.C. Fonarow et al. (2007) [Influence of a Performance-Improvement Initiative on Quality of Care for Patients Hospitalized With Heart Failure; Results of the Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients With Heart Failure \(OPTIMIZE-HF\)](#). *Archives of Internal Medicine* 167, 1493–1502.

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### **Pay-for-Performance**

#### **Proposal: New Payment Model for Medicare**

This article proposes a new, blended payment strategy for Medicare that would combine fee-for-service payments with payments based on episodes of care. Transitioning to this payment model could take place in two stages, beginning with a pay-for-performance (P4P) payment system that rewards quality and efficiency and moving to a blended fee-for-service and case-rate system. Such a system, the authors conclude, would create incentives for providers to deliver both high-quality and efficient care. K. Davis and S. Guterman. (2007) [Rewarding Excellence and Efficiency in Medicare Payments](#). *The Milbank Quarterly* 85, 449–468.

### UK: P4P Led to "Modest" Improvements

Family practitioners' achievement under a P4P contract implemented in the United Kingdom three years ago exceeded the government's expectations, with an average of 83.4 percent of the available incentive payments claimed. This article reviews whether the 2004 contract or prior quality initiatives led to improvements in three conditions: asthma, coronary heart disease, and type 2 diabetes. Although care for these conditions was improving, the authors conclude that the introduction of P4P was associated with a modest acceleration in improvement for diabetes and asthma. S. Campbell et al. (2007) [Quality of Primary Care in England with the Introduction of Pay for Performance](#). *New England Journal of Medicine* 357, 181–190.

### Case-Rate Payment for CABG

Geisinger Health System's new approach to elective coronary-artery bypass grafting (CABG) promises that 40 key processes, agreed to by the seven cardiac surgeons in its delivery system, will be completed for every patient who undergoes elective CABG. According to the author, a member of Geisinger's board of directors, "the real question for Geisinger and for the rest of the health care system is whether this case-rate approach might emerge as a new form of pay for performance." T.H. Lee et al. (2007) [Pay for Performance, Version 2.0?](#) *New England Journal of Medicine* 357, 531–533.

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### *Patient Safety*

#### Pharmacies and Non-English Communication

A cross-sectional, mixed-methods survey of Milwaukee County, Wis., pharmacies was used to evaluate their ability to provide non-English-language prescription labels, information packets, and verbal communication. The authors found that

about half of Milwaukee pharmacies never/only sometimes can provide non-English-language prescription labels or information packets, and about two-thirds never/only sometimes can verbally communicate in non-English languages. Also, only 55 percent of pharmacies said they were satisfied with their communication with patients who have limited English proficiency. M. Bradshaw et al. (2007) [Language Barriers to Prescriptions for Patients with Limited English Proficiency: A Survey of Pharmacies](#). *Pediatrics* 120, e225–e235.

#### Study: Work Hour Limits Improve Outcomes

A retrospective cohort study was used to examine changes in internal medicine patient outcomes after resident work-hour regulations were implemented at an urban, academic medical center. It found that the teaching service had net improvements in three of the seven assessed outcomes: decreased intensive care unit utilization, improved rate of discharge to home or rehabilitation facility versus elsewhere, and reduced pharmacist interventions to prevent errors. L. I. Horwitz et al. (2007) [Changes in Outcomes for Internal Medicine Inpatients after Work-Hour Regulations](#). *Annals of Internal Medicine* 147, 97–103.

#### Errors Increase Physician Anxiety

A survey, completed by 3,171 internal medicine, pediatrics, family medicine, and surgery physicians, examined the impact of medical errors on five work and life domains. After being involved in an error, physicians reported increased anxiety about future errors (61 percent), loss of confidence (44 percent), sleeping difficulties (42 percent), reduced job satisfaction (42 percent), and harm to their reputation (13 percent). Their job-related stress increased with involvement in serious errors, but this effect was less dramatic with near misses. The authors

conclude that organizational resources to support physicians after errors should be improved. A.D. Waterman et al. (2007) [The Emotional Impact of Medical Errors on](#)

[Practicing Physicians in the United States and Canada](#). *Joint Commission Journal on Quality and Patient Safety* 33, 467–476.

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### **Editorial Advisory Board 2007**

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