Cooperative Cardiovascular Project

NATIONAL Perspective

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Introducing *National Perspective*: A New CCP Report

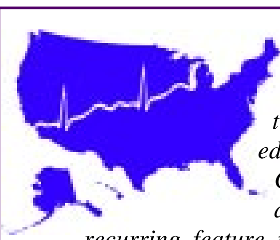
This issue of *National Perspective* is the first in a series devoted to the Cooperative Cardiovascular Project (CCP). The publication highlights current CCP issues of interest to hospitals, physicians, peer review organizations (PROs), and the health-care community.

Until now, CCP lacked a national reporting tool to communicate PRO efforts and publish data analyses and improvement activities. By sharing such information through *National Perspective*, the Health Care Financing Administration (HCFA) and the PRO community hope to promote broad-based improvement in care for patients with acute myocardial infarctions (AMIs).

National Perspective is published on behalf of the PRO community by Florida Medical Quality Assurance, Inc. (FMQAI) and Texas Medical Foundation (TMF) in collaboration with HCFA.

In addition to *National Perspective,* the CCP Reporting team plans to publish a comprehensive annual report. This report will compile current CCP data analyses, continuous quality improvement activities by the health-care community, PRO highlights, and CCP special project updates. CCP special reports may be published as needed to present information that requires a timely release or targets a specific audience.

First Issue Highlights



National Perspective *showcases national and state CCP efforts. In this edition, Thomas Marciniak, MD, HCFA Central Office, addresses future CCP activities. "Regional Perspectives," a recurring feature that focuses on state accomplishments, spotlights California, Georgia, and New Jersey. Other articles update HCFA/PRO special studies involving North Carolina, Pennsylvania, and Texas.*

Focus on AMI Care

CCP is the first national effort of the Health Care Quality Improvement Program (HCQIP) developed by HCFA. HCFA initiated HCQIP in 1992 to shift emphasis from random chart audits of Medicare patients to a more effective approach based on continuous quality improvement techniques.

HCFA selected AMI as the first national focus for three reasons:

- AMI is a common cause of hospitalization with a high rate of mortality in the Medicare population;
- An abundance of information is available on specific interventions that can improve the quality of care and reduce mortality;
- The American College of Cardiology (ACC) and the American Heart Association (AHA) publish nationally recognized AMI clinical practice guidelines.

The ACC/AHA 1990 guidelines formed the basis for CCP quality indicators – measurable aspects of care to determine areas for improvement. The guidelines were adapted into quality indicators by the CCP National Steering Committee coordinated by the American Medical Association and convened by HCFA.

CCP's pilot program started in 1992 with four states: Alabama, Connecticut, Iowa, and Wisconsin. The pilot project abstracted over 16,000 medical records for Medicare AMI patients discharged between June 1, 1992, and February 28, 1993.

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Aggregate Statistics Establish National Baseline Data

HCFA recently released aggregate data results from two CCP national random samples. These statistics provide baseline data for AMI care that HCFA and PROs can use to evaluate the impact of future CCP analyses.

The first national random sample collected records from 2,500 AMI patients admitted between September 1993 and August 1994. HCFA distributed these results to PROs as part of their national CCP data analysis packages. PROs shared these statistics with hospitals and physicians during feedback so hospitals could compare facility-specific data to national findings.

The second sample collected an additional 2,500 records for patients admitted between September 1994 and August 1995. HCFA is currently establishing a method to send PROs the new database.

The CCP Internal Steering Committee plans to develop a strategy for future remeasurement. Remeasurement data will be collected from the medical records of AMI patients hospitalized after the national hospital-specific data collection, feedback, and implementation of hospitals' CCP improvement plans.

Table 1
Summary Statistics

AMI Admissions	National Baseline
Total AMI Admissions	4896
Confirmed AMIs	4271
% Confirmed	87
% Direct admissions, not transfer	74
Demographics	
Median Age	75
% White	89
% Male	54
Procedures	
% Cardiac Catheterizations	34
% PTCAs	13
% CABGs	8
Risk Factors	
% Anterior MIs	46
% Q wave MIs	60
% Age > 75	48
% Respirations > 20/min	41
% Pulse > 100/min	27
% SBP < 90 mmHg	4
% Albumin < 3 gm/dl	4
% BUN > 30 mg/dl	19

Table 2
Quality Indicator Results
(Ideal Candidates)*

Quality Indicator	National Baseline
Aspirin during stay	86%
Reperfusion	59%
ACE inhibitors (low LVEF)	59%
Aspirin at discharge	78%
Beta blockers at discharge	50%
Avoidance of calcium channel blockers (low LVEF)	83%
Smoking advice/counseling	38%

** After all exclusions have been applied.*

Table 3
Quality Indicator Results
(Eligible Candidates)

Quality Indicator	National Baseline
Aspirin during stay	78%
Reperfusion	21%
ACE inhibitors (low LVEF)	57%
Aspirin at discharge	67%
Beta blockers at discharge	37%
Avoidance of calcium channel blockers (low LVEF)	74%
Aspirin on day 1	57%
Thrombolytics in 1 hour	53%
Median time to thrombolytics	59 min.
Median time to PTCA	144.5 min.

"PRO" Defined for *National Perspective*

The term ***peer review organization (PRO)*** appears throughout *National Perspective*. It refers to organizations that are responsible for Medicare quality improvement and program oversight activities as designated by HCFA contracts.

The Social Security Act refers to these organizations as "utilization and quality control peer review organizations" in an amendment created by the Peer Review Improvement Act of 1982. For general use, HCFA has shortened this term to "peer review organizations."

In the past few years, HCFA has changed its approach to Medicare program oversight. PROs have shifted their primary focus from reviewing individual cases to promoting broad-based improvement in care. PROs provide hospitals and physicians with data related to management of specific illnesses, thus forming a basis for improvement initiatives.

To reflect this change in their relationships with the health-care community, some PROs now refer to themselves as quality improvement organizations (QIOs). For the first edition of *National Perspective*, the term **PRO** includes all such organizations, whether known as QIOs or PROs.

CCP Quality Indicators: An Overview

Many articles in *National Perspective* refer to quality indicators, the backbone of the Cooperative Cardiovascular Project (CCP).

Quality indicators are measurable aspects of patient care based on scientific evidence and research. Studies demonstrate that attention to quality indicators improves outcomes, including thirty-day mortality rates.

CCP's quality indicators were developed by the CCP National Steering Committee, a panel of experts that represented a variety of national medical organizations. This committee was convened by HCFA and coordinated by the American Medical Association in 1992. The committee based the majority of the CCP quality indicators on guidelines for AMI care published in 1990 by the American College of Cardiology and the American Heart Association.

These are the national CCP quality indicators for patients with confirmed AMIs:

During hospitalization:

- Aspirin;
- Timing of aspirin;
- Reperfusion, either by administering thrombolytics or performing primary percutaneous transluminal coronary angioplasty (PTCA);
- Timing of thrombolytics (minutes from arrival until administration);
- Timing of primary PTCA (minutes from arrival until PTCA is begun).

At or prior to discharge from the hospital:

- Aspirin;
- Beta blockers;
- Smoking cessation advice and counseling.

For patients with low left ventricular ejection fraction (LVEF):

- Use of angiotensin converting enzyme (ACE) inhibitors;
- Avoidance of calcium channel blockers.

Ideal vs. Eligible Patients

To give hospitals additional information, data analysts classified AMI patients into two categories for each quality indicator: eligible and ideal.

The *eligible* category is the broader group. It includes all patients who meet basic eligibility requirements for the aspect of care measured by a specific quality indicator. For instance, to be included as an eligible patient for the "aspirin at discharge" indicator, a patient had to be discharged alive from that hospital, and not transferred to another hospital. Eligible patients form a pool from which ideal patients are identified.

The *ideal* category is a subgroup of eligible patients. Ideal patients qualify for a specific indicator and have no documented contraindications. They fit the national profile of patients who benefit from care associated with specific quality indicators. For instance, to be included as an ideal patient for the "aspirin at discharge" indicator, a patient could not be allergic to aspirin.

Because the ideal category is clearly defined, many physicians and other health-care professionals consider the statistics for this group to be more significant than the eligible category for quality improvement activities.

CCP National Advisory Group*

Members of the 1992 CCP National Steering Committee included representatives from these organizations:

- Agency for Health Care Policy and Research
- American Academy of Family Physicians
- American Association of Retired Persons
- American College of Cardiology
- American College of Physicians
- American Health Quality Association (formerly known as the American Medical Peer Review Association)
- American Hospital Association
- American Medical Association
- American Nurses Association
- American Society of Internal Medicine
- Boston University
- Duke University, IHD PORT
- Harvard Medical School, AMI PORT
- Joint Commission on Accreditation of Healthcare Organizations
- National Heart, Lung, and Blood Institute
- State University of New York
- Veterans Administration

** The CCP National Advisory Group will convene in the near future. The group will expand to include additional appropriate representatives.*

Did you know...

HCFA, in collaboration with the General Accounting Office, is expanding CCP to include beneficiaries enrolled in managed-care plans. *National Perspective* will profile this project in a future issue.

CCP Timeline

1992

HCFA proposes HCQIP.

1993

CCP National Steering Committee develops quality indicators.

1994

Pilot states abstract records, provide feedback.

1995

Two CDACs begin data collection for national CCP effort.

Pilot baseline results are published.

PROs begin feedback of national data.

1996

CDACs complete abstraction of 224,377 records for hospital-specific national sample.

PROs continue feedback of national data.

Pilot PROs remeasure 8,040 records.

1997

PROs complete feedback of national data.

Pilot PROs report remeasurement.

CDACs abstract managed-care AMI records.

HCFA initiates national remeasurement.

Introducing… cont'd from page 1

Data from the four original CCP states continue to be analyzed and discussed as a separate "pilot" group.

Breaking National Ground

Based on the results of the pilot study, HCFA introduced CCP to other states in 1994, making it a national effort. Using Medicare claims data, HCFA identified patients with AMIs who were admitted to acute-care hospitals in the United States, except for the four pilot states and Minnesota, where a federally funded AMI project took place. Hospitals submitted medical records for AMI patients hospitalized during designated eight-month periods between March 1, 1994 and June 30, 1995. Two Clinical Data Abstraction Centers (CDACs) requested and abstracted the medical records.

CDACs abstracted data from the records of more than 224,000 AMI patients. The clinical data were collected under HCFA confidentiality guidelines so specific patient and physician identifiers were not included in the results. Data collection and analysis focused on ten quality indicators related to AMI care (*see page 3*).

PROs analyzed the data and used a variety of methods to provide feedback to hospitals and medical staffs. Most hospitals received a data analysis package containing statistics from two groups of patients – the hospital's own patients and, for comparison, a national random sample of Medicare patients hospitalized between September 1993 and August 1994.

To aid in data comparison, HCFA placed hospitals into one of four peer groups, categorized by number of licensed beds and geographic region:

- *rural* – less than 200 beds;
- *urban* – less than 200 beds;
- *mid-size* – between 200 and 400 beds;
- *large* – more than 400 beds.

Currently, PROs around the country are working with hospitals and physicians to foster excellence in the care of Medicare AMI patients. Among other efforts, PROs collaborate with key physicians and quality improvement leaders in hospitals to review existing quality improvement efforts, or to develop new improvement plans. On a statewide level, PROs have enlisted the support of leaders in AMI care.

*The CCP Reporting team encourages PROs to submit CCP success stories to **National Perspective**. For details on submission, PROs should read the request for information on page 12. PRO input is vital to the success of **National Perspective**.*

What is a CDAC?

PROs contract with national *Clinical Data Abstraction Centers* (CDACs) designated for each state by HCFA to obtain medical records and abstract the necessary data for Medicare quality improvement projects such as CCP. Each PRO works with one of two CDACs: DynKePRO, located in York, Pennsylvania; or FMAS Corp. located in Columbia, Maryland.

When HCFA and/or PROs prepare for CCP data abstraction, they notify their designated CDACs to request selected medical records from hospitals. Abstractors from CDACs enter information from medical records into a data-entry collection software package that contains online definitions and edit checks for each data field.

All CDAC abstractors receive substantial training regarding applicable medical terms and procedures. In addition, CDACs periodically perform blinded reabstraction on a random sample of medical records to measure the quality of the abstraction process.

After data abstraction is completed, the CDACs send raw data back to HCFA and the appropriate PROs for analysis.

Revised AMI Guidelines Mailed to Hospitals Nationwide

Recently revised guidelines for AMI care reached hospitals across the country as PROs worked together under a HCFA special study, "CCP AMI Guidelines Intervention."

In 1996, the American College of Cardiology (ACC) and the American Heart Association (AHA) updated their ***Guidelines for the Management of Patients with Acute Myocardial Infarction***. The guidelines, originally printed in 1990, provided the basis for the quality indicators developed by the CCP National Steering Committee.

HCFA wanted to ensure that the revised guidelines were available for review by hospital personnel responsible for AMI care and continuous quality improvement activities. HCFA therefore awarded a special project to ***Medical Review of North Carolina, Inc. (MRNC)*** to coordinate a focused distribution plan.

The 1996 revisions emphasize early recognition and prompt treatment of patients with AMIs by emergency personnel, and incorporate the most recent advances in diagnosis and treatment.

MRNC asked PROs about their plans for guideline distribution and the number of copies needed for mailing. As a result, 92 percent of PROs agreed to work with MRNC on guideline distribution.

PROs could decide whether to mail the new guidelines to hospitals or have MRNC mail them directly. Each PRO could choose whether hospitals would receive a packet with both the unabridged document (100 pages) and the executive summary (10 pages), or a packet with just the executive summary.

MRNC mailed packets to hospitals in 36 states, while other PROs mailed to hospitals in 13 states. The term "states" refers to the United States, its territories, and the District of Columbia.

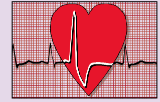
Together, MRNC and other PROs mailed 12,000 packets of guidelines to hospitals nationwide. More than 75 percent of these hospitals received both the unabridged guidelines and the executive summary.

To assist MRNC's analysis of the project, each hospital received a postcard in its guideline packet asking for comments about how effective both the guidelines and the distribution method proved to be. Sixteen percent have returned the postcards to date.

In addition, MRNC will send a follow-up questionnaire to hospitals at random in May. MRNC will report its findings to HCFA and the PRO community, who can use these results to plan for future distribution of important materials.

Special Study in Brief

CCP AMI Guidelines Intervention



Lead PRO:

Medical Review of North Carolina, Inc. (MRNC)

Main Contact:

Randa Hall, Project Coordinator, MRNC, Raleigh, North Carolina

Summary:

MRNC worked with PROs nationwide to coordinate distribution of the 1996 revised ***Guidelines for the Management of Patients with Acute Myocardial Infarction*** to hospitals, to ensure that the revisions were available to hospital personnel responsible for AMI care.

Future Actions:

MRNC will follow up with hospitals to determine the effectiveness of the distribution method. MRNC will share its findings with HCFA and the PRO community.

Internal Steering Committee Focuses on PRO Concerns

The CCP Internal Steering Committee recently met for the first time to identify CCP-related issues needing national attention.

This committee, created earlier this year, will provide a national forum for the PRO community to share ideas and resolve issues related to CCP. Members include representatives from 17 states and the District of Columbia as well as from HCFA regional offices and HCFA Central Office.

The CCP Internal Steering Committee met via teleconference on April 10. Committee members approved a draft charter, handled administrative details, and discussed the CCP issues on which they will focus.

The mission of the CCP Internal Steering Committee is to address four main areas of concern to the PROs regarding CCP: future direction, publication, resampling, and abstraction changes.

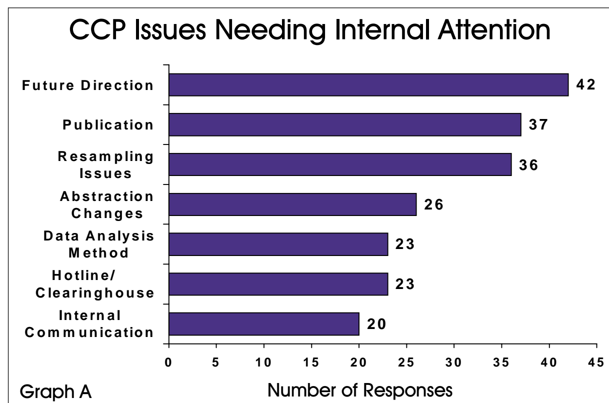
Committee members will hold monthly conference calls with non-represented PROs in their regions, then take any issues raised in these calls to the committee meetings for discussion.

KePRO is managing the CCP Internal Steering Committee and will provide updates of future activities.

PRO Survey Identifies CCP Efforts, Reveals Issues PROs Want Committees to Address

A CCP internal steering committee made up of PRO and HCFA representatives will provide nationwide leadership and a forum for innovative ideas and effective strategies. In addition, an external committee may be convened this year to collaborate on future direction for CCP.

Keystone Peer Review Organization (KePRO), the peer review organization for Pennsylvania, will oversee the development of these committees as part of a HCFA special project.



KePRO surveyed the PRO community in December 1996 to ascertain interest in and to discover methods for developing these two committees. The survey also asked PROs about their progress in CCP efforts, including feedback, improvement plans, and post-project monitoring. KePRO received responses from 96 percent of PROs from the 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico. PROs received the results of this survey earlier this year.

Survey Results:

Internal Communication

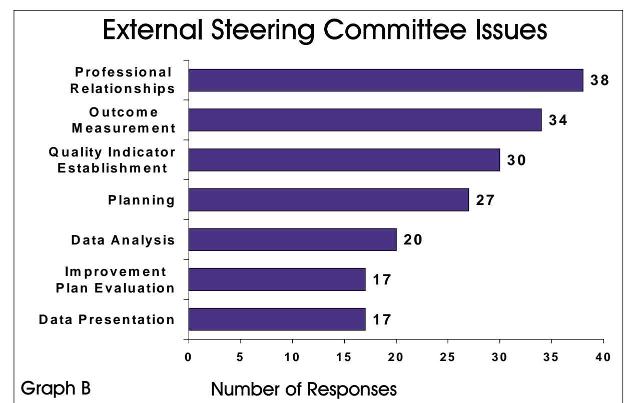
Sixty-nine percent of the responding PROs agreed with the need for an internal committee. The CCP Internal Steering Committee will be responsible for making specific recommendations about CCP's continuing efforts.

KePRO will manage the CCP Internal Steering Committee and will update participating PROs regarding committee activities and meeting dates. The committee's members include PRO physicians and administrative staff members as well as representatives from HCFA regional offices and HCFA Central Office.

In the survey, PROs indicated the CCP issues they would like HCFA and the PRO community to address (*see Graph A*). The mission of the CCP Internal Steering Committee will be to focus on four of these issues: future direction, publication, resampling, and abstraction changes.

External Communication

The CCP National Steering Committee originally convened in 1992 to develop the quality indicators used in CCP measurement and feedback. HCFA and the PROs may convene another external steering committee this year. The KePRO survey asked PROs to determine the most important ways this committee could help PROs succeed in future CCP efforts (*see Graph B*).



Feedback to Hospitals and Others

PRO feedback to hospitals is an important part of the CCP process. Of the 4,394 hospitals participating in CCP, 4,202 (95.6 percent) received feedback. Mailing was the most common method used in distributing feedback and analyses to hospitals (*see Graph C*).

In addition to hospitals, PROs also distributed CCP information to other appropriate groups. Many of the surveyed PROs shared aggregate data with state chapters of medical and specialty

PRO Survey... cont'd on next page

Special Study in Brief

CCP Committee Collaborations

Lead PRO:

Keystone Peer Review Organization (KePRO)

Main Contact:

Sharon Kessler, Project Coordinator, KePRO, Harrisburg, Pennsylvania

Summary:

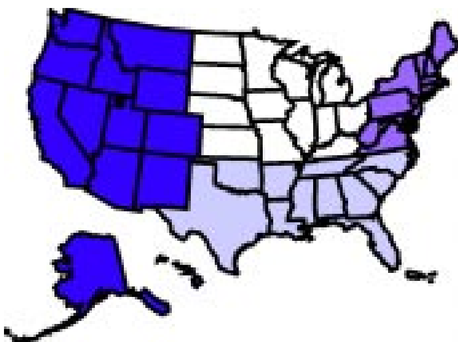
KePRO surveyed PROs nationwide to gather and analyze their opinions about CCP issues and PRO approaches to CCP. KePRO used these responses from PROs to create the CCP Internal Steering Committee.

Future Actions:

KePRO may use the survey results to convene an external steering committee.

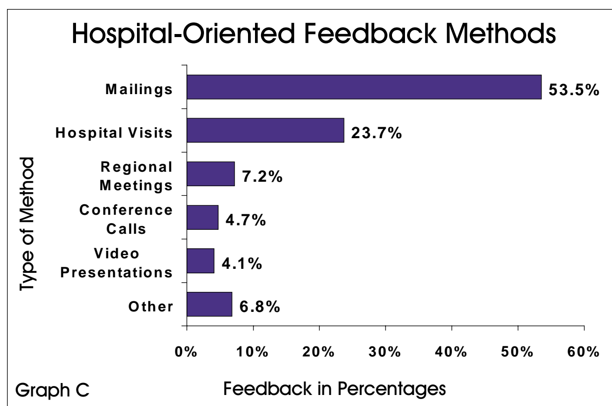
CCP Feedback Approaches Differ by Region

In addition to reporting PRO information on a national level, KePRO's survey evaluated data by geographic region. The four PRO regions shown on the map are consolidations of HCFA regions and retain their original titles (e.g., Region VII). The chart at right demonstrates regional variations in CCP feedback methods.



Regional Variations in Feedback Methods (percentages)				
	Region I Boston	Region VI Dallas	Region VII Kansas City	Region X Seattle
Mailings	56.4	45.0	38.7	80.5
Individual Hospital Visits	14.0	24.1	34.6	8.5
Conference Calls	10.7	2.0	5.8	0.2
Regional Meetings	6.4	11.2	4.4	6.5
Video Presentations	0.0	5.2	6.5	1.2
Other	12.5	12.5	10.0	3.1
TOTAL	100.0	100.0	100.0	100.0

PRO Survey... cont'd from previous page



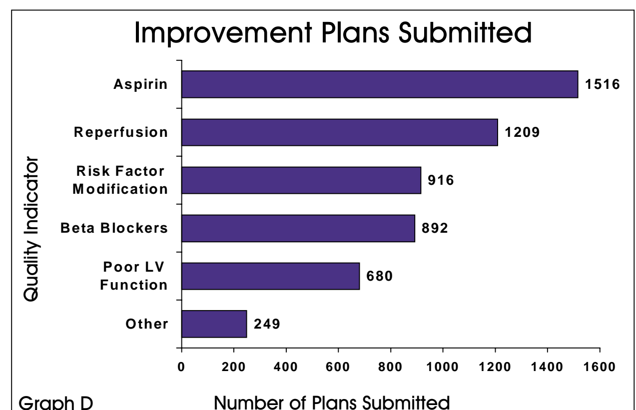
Graph C

societies, in meetings with cardiology group practices, and through CCP newsletters and public service announcements.

Hospital Improvement Plans

After PROs shared feedback with hospitals and physicians, hospitals developed improvement plans. These plans focused on one or more of the CCP quality indicators (*see page 3*). For the purpose of this survey, one improvement plan represents a hospital's focus on one quality indicator. Some hospitals selected more than one quality indicator for improvement; some did not submit any improvement plans. The KePRO survey showed hospitals submitted 5,462 improvement plans (*see Graph D*). Of these, 45 percent had been implemented at the time of the survey.

Fourteen percent of the responding PROs reported that all improvement plans for their states had been implemented. For those plans not implemented at the time of the survey, the expected dates ranged from January 1997 through January 1998.



Graph D

Post-Project Monitoring

Additionally, the survey asked PROs about their post-project monitoring plans for CCP. Post-project monitoring is the process of remeasuring quality indicator performance after hospitals have implemented improvement plans.

Thirty-nine of the responding PROs (76 percent) developed CCP post-project monitoring plans. Of these PROs, 12 started their plans in 1996, 14 more will implement their plans by June 1997, and eight will begin post-project monitoring between July 1997 and January 1998.

Regional Perspectives: States Share Individual Approaches to CCP

"Regional Perspectives" is a recurring feature in *National Perspective*. Each issue will profile several PROs to illustrate various approaches to CCP.

Although CCP is a national project, PROs tailor project guidelines and methods to best serve Medicare beneficiaries in their states. The PROs featured in this issue represent different stages of CCP.

- Data analysis: **Georgia Medical Care Foundation** (GMCF) used cardiovascular peer groups to organize the state's data.
- Feedback: **California Medical Review, Inc.** (CMRI) enlisted cardiologists across the state to work with them in sharing feedback with hospitals.
- Improvement plans: **The Peer Review Organization of New Jersey** (The PRO) showcased hospitals that demonstrated early, promising results in their improvement plans.

Georgia Adapts Alternative Method to Compare Data

Georgia Medical Care Foundation (GMCF) used an alternative approach for its CCP data analysis and comparison. The Georgia PRO adapted a hospital peer-group structure used during the CCP pilot study. Hospitals were categorized by the number and type of AMI procedures instead of by bed size.

These peer groups allowed for data analysis that related directly to invasive cardiac procedures. Hospitals and GMCF could compare CCP data with other facilities that had similar cardiovascular departments.

GMCF divided 143 hospitals into three peer groups based on the use of invasive cardiac procedures during a selected time frame. Category 1 included hospitals that billed for less than five cardiac catheterizations and no PTCAs or CABGs. Category 2 consisted of hospitals that billed for five or more cardiac catheterizations but only one PTCA or CABG. Category 3 included hospitals that billed for more than one PTCA or CABG.

DynKePRO, one of two Clinical Data Abstraction Centers (CDACs), abstracted 5,910 Georgia Medicare AMI patient admission records from 1994 and 1995. The Georgia PRO shared individual data analyses with hospitals, who could compare their numbers with their peer group as well as with statewide and national data.

Of the 143 hospitals, 43 collaborated with GMCF. GMCF received improvement plans from 100 percent of the collaborating hospitals. Regardless of peer group, most hospitals' plans focused on the use and timing of aspirin, and documentation of smoking cessation counseling. Statewide remeasurement is scheduled to be completed by December 1997.

GMCF established a CCP Hotline to provide additional information to Georgia hospitals: (404) 982-7561.

Collaboration Spells Success In California

California Medical Review, Inc. (CMRI) invited cardiologists to work with hospitals in sharing feedback and developing improvement plans. The California PRO collaborated with the American College of Cardiology (ACC) to reach community cardiologists. CMRI used mailings to initiate feedback, then targeted groups for follow-up communication.

After analyzing data, CMRI and the California chapter of ACC co-wrote a letter to cardiologists requesting their involvement in CCP. The letters encouraged cardiologists to act as catalysts for improvement by working with hospitals' quality improvement staffs. The letter suggested that cardiologists review CCP quality indicators and California aggregate data. This information could be used to

Collaboration… cont'd on next page

Collaboration… cont'd from previous page

help hospitals evaluate facility-specific data to identify opportunities for measurable improvement in the care of AMI patients. ACC leaders signed these letters, which CMRI then mailed in ACC envelopes to 2,100 ACC members in California.

The California data set included 17,095 cases of AMI from 383 hospitals. CMRI shared CCP data with these hospitals. The PRO sent the CCP data to the hospital chiefs of staff by registered mail. In addition, hospital quality improvement staff received packets that included CCP data, copies of the ACC letter, and cover letters that described CCP, elements of improvement plans, and requests for response.

CMRI followed these mailings with phone calls to hospitals. The PRO divided CCP hospitals into two groups to determine how effective these calls would be. Half of the hospitals received follow-up phone calls to see if they received the materials and needed more information, and the other half received no phone calls. CMRI is still analyzing this data, but early results indicate that follow-up phone calls did not increase hospital participation.

As another follow-up method, CMRI studied hospitals in the top 10 percent and the bottom 10 percent of state CCP quality indicator performance. CMRI called all hospitals in these two groups, told them into which category they fell, and offered to visit each hospital for a presentation. Hospitals in the top percentile group shared their views on why they thought they were so successful. CMRI offered to assist hospitals in the lower percentile group with improvement plan implementation and development.

Changes by New Jersey Hospitals Lead to Measurable Improvement

The Peer Review Organization of New Jersey, Inc.

The Peer Review Organization of New Jersey (The PRO) focused its attention on successful methods of improvement designed by individual hospitals. Earlier this year, The PRO and the New Jersey Hospital Association sponsored a statewide conference that showcased three hospitals. The hospitals implemented changes that directly impacted patient care and led to significant, measurable improvement.

Of the 87 New Jersey hospitals participating in CCP, most concentrated on two to four quality indicators for their improvement plans. Quality indicators related to aspirin usage, thrombolytics, and smoking cessation advice and counseling were most frequently selected by hospitals.

In one hospital, the number of AMI patients receiving aspirin increased from 63 to 83 percent over several months. The hospital attributed its success not only to staff education focusing on the CCP quality indicators, but to simple process changes that made it easier for physicians to prescribe and nurses to administer aspirin to AMI patients.

Brightly colored stickers placed on patient charts reminded physicians to order aspirin during a patient's hospitalization and at discharge. Pharmacy staff added aspirin to the medication stock in various hospital units, including the emergency department. The pharmacy newsletter for that hospital featured an article educating hospital staff members on the importance of aspirin use.

Another New Jersey hospital reduced the "door to drug" waiting time for thrombolytic administration by 23 percent in less than a year. The emergency room instituted "clot boxes" to permit rapid administration of thrombolytic drugs. A mandatory thrombolytic order sheet was included with the clot box. Emergency room physicians received the necessary training and credentials to order thrombolytics without waiting for an on-site cardiology consultation.

Smoking cessation advice and counseling took precedence at a third hospital. This hospital decided to improve its smoking cessation efforts through a standardized counseling program for all eligible patients, not just those treated for AMI. The hospital identified all patients eligible for counseling, made the counseling part of its respiratory treatment plan, and standardized all smoking cessation education materials.

The New Jersey PRO will continue to focus on hospitals this year with "The CCP Breakthrough Cooperative Project" – a special project for hospitals that want to accelerate improvement in AMI care. Hospitals will work collaboratively on changes in their facilities, share successful improvement strategies, and receive coaching from leading hospitals in the state.

HCFA has encouraged PROs to develop and use effective methods for organizing data, sharing feedback, and helping hospitals with their individual improvement plan development, implementation, and remeasurement.

These three PROs show only a few of the ways that PROs nationwide developed innovations in CCP efforts. Their various approaches produced positive, concrete results.

New CCP Abstraction Tool Simplifies Data Collection

The CCP Abbreviated Abstraction Tool (AAT) is a new, free software package that hospitals can request from their PROs. ***Texas Medical Foundation (TMF)*** developed this user-friendly tool as part of a HCFA-funded project.

HCFA wanted to provide an abstraction tool that hospitals could use to remeasure their own CCP data. With the AAT, hospitals can continually monitor the impact of their CCP quality improvement efforts. The AAT software package includes a data collection program as well as an analysis program that allows hospitals to view and print immediate abstraction results.

AAT versions are available for MS-DOS or Windows 3.1 operating systems. Both versions use public domain software programs. The DOS-compatible version of the AAT uses Epi Info, a program developed by the Centers for Disease Control and Prevention, for data entry and analysis. The Windows-compatible program uses MedQuest, a program distributed by HCFA, for data entry, and Epi Info for data analysis.

Texas hospitals received the Epi Info AAT Version 1.0 in August 1996 to test the product. TMF used the hospitals' comments and suggestions to develop the software for nationwide distribution. Overall, Texas hospitals reported that the AAT contained clear instructions and was easy to install and use.

Sample of Abbreviated Abstraction Tool: Monitoring Questionnaire

Reperfusion

If the patient received both thrombolytics and PTCA, record only the first procedure.

18. Did the patient receive thrombolytics during this admission?
    [Y] [N]

If the answer is "N", go to #20.

19. Date of first thrombolytic dose: ____/____/____
    Time of first thrombolytic dose (24-hour clock):

20. Did the patient undergo a PTCA during this admission?
    [Y] [N]

21. Date of PTCA: ____/____/____
    Time of PTCA (24-hour clock):

The AAT Application

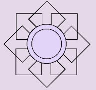
The AAT evaluates CCP quality indicators in six categories: use of aspirin, reperfusion, use of beta blockers at discharge, use of ACE inhibitors at discharge for patients with low LVEF, avoidance of calcium channel blockers for low LVEF, and smoking cessation counseling. Hospitals may use the AAT to obtain quick data for any of the six quality indicators they choose.

The AAT identifies key elements similar to those in HCFA's data collection tool used by CDACs. Many elements used in the CDAC tool have been omitted or differently defined. For instance, when confirming AMI diagnosis, the CDAC abstraction tool relies on the evaluation of laboratory values, but the AAT relies on physician documentation of the diagnosis.

Because the AAT collects fewer data elements than the CDAC tool, it limits the categories of patients used in data analysis. Since the number of data elements required to identify *ideal* patients is too large for quick abstraction, the AAT captures data for *eligible* patients only. (*Page 3 explains ideal vs. eligible patients.*)

Special Study in Brief

CCP Abbreviated Abstraction Tool



Lead PRO:

Texas Medical Foundation (TMF)

Main Contact:

Karen Sabharwal, Clinical Statistician, TMF, Austin, Texas

Summary:

TMF developed the Abbreviated Abstraction Tool (AAT) so hospitals could easily collect and analyze CCP follow-up data. In April, TMF sent PROs samples of the latest software package for the AAT.

Future Actions:

After hospitals nationwide have the opportunity to use the AAT, TMF will seek feedback from users to determine the AAT's contribution to AMI improvement efforts.

Publications/Applications:

Hospitals may contact PROs to obtain a free software package that includes instruction manuals and disks for both DOS- and Windows-based applications.

Obtaining a Copy of the AAT

TMF shipped demonstration samples of the AAT software package to all PROs in April. Hospitals should contact the PROs from their states to request AAT software packages containing instruction manuals and diskettes for both the DOS- and Windows-based software as well as an evaluation form. TMF will provide a toll-free number that user hospitals can call for technical support through September 30, 1997. There is no charge to hospitals for the software, shipping, or technical support.

Dr. Marciniak Outlines Future for CCP in 1997 and Beyond

"We will have things to celebrate about CCP in 1997, but before we celebrate, we have some work to do," Thomas Marciniak, MD, told American Health Quality Association (AHQA) members during their annual technical conference in January.

Dr. Marciniak, a physician consultant for HCFA, coordinates CCP data analyses and special studies from HCFA's Central Office. During his presentation at the AHQA conference in Albuquerque on January 24, he outlined CCP plans for 1997 and beyond.

AHQA, a trade association for PROs, conducted a forum for PRO-related issues attended by physicians, technical experts, and administrative staff from PROs across the country. Dr. Marciniak delivered his speech during the CCP segment of the conference.

The four issues that will affect CCP in 1997 are future direction, publication, resampling, and abstraction changes, Dr. Marciniak said.

"We hope 1997 will be the year we can collaborate with medical societies as a whole," Dr. Marciniak predicted, describing CCP future direction. "We can promote CCP not just by going through individual hospitals but by working with some of these other professional organizations."

Current CCP activities involve collaboration with medical organizations such as the American Heart Association and the American College of Cardiology. Dr. Marciniak hopes that future collaborations include other groups which focus on cardiac care. For example, he noted that the American Academy of Family Physicians (AAFP) is focusing its 1997 educational efforts on cardiovascular disease.

Another collaborative effort identified by Dr. Marciniak was the convening of an external steering committee, which will provide a panel of experts and promote CCP. Additionally, PROs are uniting this year to create the CCP Internal Steering Committee. This internal committee will address the four CCP issues outlined by Dr. Marciniak.

In addition to future direction, CCP efforts will also concentrate on publication in 1997. Data from national and pilot-state

Thomas Marciniak, MD

Four issues that will affect CCP in the next year are future direction, publication, resampling, and abstraction changes.

studies, reports from PROs on state accomplishments, and special project updates are all slated for publication.

"We are very interested in getting out the message on CCP," Dr. Marciniak said. The pilot-state remeasurement data and the national CCP database are currently being analyzed. Pilot baseline follow-up comparisons and national trends will be released by the end of this year, he said.

A third major issue that will affect CCP in 1997 will be resampling, Dr. Marciniak told the AHQA audience.

"Quality improvement is one goal of resampling," he said. Most PROs should be finishing their baseline feedback to hospitals, and by the end of 1997, planning to remeasure or resample. Not all PROs will handle resampling in the same ways. PROs can develop individual plans based on what has worked best in their states.

Data abstraction changes are another consideration for 1997 and future years, Dr. Marciniak said. Changes will depend on factors such as documented use, compatibility with past data samples, and the need to keep the CCP data set manageable. HCFA and the CCP Internal Steering Committee will consider adding areas to the data set such as the use of stents and Swan-Ganz catheters, and measurement of serum cholesterol levels.

By 1998, CCP could diffuse its focus and turn to cardiovascular issues other than AMI, Dr. Marciniak predicted.

"People accuse me of being CCP-centric, but that's not true," he joked. "CCP is the center of the universe, but it's not the only thing in the universe. We're looking toward related activities for the next few years."

For 1998 and future years, Dr. Marciniak mentioned a number of CCP-related opportunities aimed at improving health care for the Medicare population: congestive heart failure, ischemic heart disease, invasive procedures, lipid management, and thrombolysis in stroke management.

Dr. Marciniak also anticipated continued expansion of collaborative efforts in 1998. One potential cooperative endeavor could be a collaboration with the AAFP, whose educational focus for 1998 will be diabetes. Dr. Marciniak noted that roughly 30 percent of AMI patients in a typical CCP data set are diabetic.

In addition, HCFA is planning another national random sample of 2,500 medical records for early 1998.

"Globally, it's a very complicated picture," Dr. Marciniak said. "But I have the same simple goal for 1998 as I did for 1997, 1996, and 1995: to reduce mortality.

"I think if we all try to do these things, we can really accomplish that goal."

CCP on the Web

For information on the Cooperative Cardiovascular Project, please visit our CCP Reporting Web site at www.usccp.org.

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Attention Peer Review Organizations: CCP Publishing Opportunity

National Perspective seeks input from PROs around the country. Appropriate submissions by PROs for upcoming issues include:

- Stories/data related to successful CCP improvement plans;
- Updates on CCP special projects awarded to PROs by HCFA;
- CCP analyses performed on a statewide or regional basis.

Reports or text about CCP success stories can be sent on a 3.5" floppy diskette, or emailed to a project leader, in WordPerfect format. Data can be sent in Excel spreadsheet format. If these software applications are not available, an ASCII text file is acceptable. Please include a contact name and phone number in case further information is needed.

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