

Change in Composition of the National Hospital Quality Acute Myocardial Infarction Set

This communication is to notify you of a change in composition of the Acute Myocardial Infarction (AMI) Set for one AMI measure common to the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission. These changes are pursuant to changes in the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines for ST-segment elevation myocardial infarction and non-ST segment elevation myocardial infarction and the evolving science for the care of patients with AMI. The measure to be retired is AMI-6: Acute myocardial infarction patients without beta-blocker contraindications who received a beta-blocker within 24 hours after hospital arrival.

AMI- 6 Beta-blocker at arrival: Will be retired effective with discharges after March 31, 2009.

Rationale for Retirement

In 2005, CMS initiated the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program using the ten “starter set” of measures. One of the ten starter set measures was Beta-Blocker at Arrival, which is specific to patients presenting to the hospitals with ST-elevation AMI. The Joint Commission implemented this measure as part of their ORYX core measure requirements in July 2002. This measure was based on clinical guidelines set forth by the ACC/AHA. The measure’s intention is to collect data on the percentage of AMI patients receiving beta-blocker therapy within the first 24 hours of hospitalization compared to all AMI patients. The AMI-6 measure that focuses on early delivery of beta-blockers to AMI patients has always included an exclusion data element “Reason for No Beta-Blocker on Arrival,” (previously, “Contraindications to Beta-Blocker on Arrival”) which allows for patient exclusion from the measure denominator with appropriate documentation of contraindications to beta-blocker therapy.

In late 2005, more recent evidence reported in the Clopidogrel and Metoprolol in Myocardial Infarction Trial (COMMIT) raised questions about all AMI patients needing early beta-blocker therapy. This trial’s investigators found that while beta-blockers reduced the risk of death from arrhythmia and reinfarction, they also can significantly increase the risk of cardiogenic shock within the first 24 hours of admission in some patients with a previous history of heart failure.

In response to the COMMIT results, a joint practice advisory was issued by the ACC/AHA/AHRQ/CMS/Joint Commission acknowledging the new evidence, but reiterating the flexibility in the current measure as follows: “The measures have been constructed to allow for clinical judgment and documentation of reasons for not prescribing beta blockers. As such, the specifications are meant to encourage evidence-based care and to help clinicians avoid care oversights, but do not mandate that everyone is treated in exactly the same way.”

In December 2007, the ACC/AHA in their updated guidelines on care of patients with ST-Elevation Acute Myocardial Infarction (STEMI) acknowledged that some patients presenting to the hospital are not appropriate for early beta-blocker therapy. Additionally the guideline stated that the current evidence base for the administration of oral versus intravenous (IV) beta-

blockers differs. The new guideline recommends that early intravenous beta blockers should specifically be avoided in some patient populations. Balancing and integrating these factors into clinical decision making produces a complexity for performance measurement which would make a revised AMI-6 measure a burden to collect. Based on these new studies, the ACC/AHA Task Force on Performance Measures has removed this measure from their list of supported performance measures as of November 10, 2008.

Although performance measures are not intended to be used as practice standards, many end-users interpret them in this manner. For AMI-6, there is a potential unintended consequence that clinicians or providers may attempt to treat patients with beta blockers despite the presence of clinical contraindications and despite the ability to exclude these cases from the current measure through appropriate documentation.

Having been apprised of this, CMS and the Joint Commission have reviewed this issue with stakeholders including the National Quality Forum, the Hospital Quality Alliance, ACC and AHA. Due to changes in and interpretation of the evidence base, we are concerned that the current requirement to submit this measure for the RHQDAPU and other reporting initiatives may adversely affect the way physicians practice medicine and ultimately harm patients. Under section 1886(b)(3)(B)(viii)(VI) of the Social Security Act, CMS has the authority to suspend an indicator if it is “subsequently shown not to represent the best clinical practice,” which is believed to be the case with AMI-6. In adherence to the process mentioned in the FY 2008 final rule (72 Fed. Reg. 47,359) regarding retiring or replacing a measure, CMS will utilize the Measure Management System and initiate an ad-hoc review of the measure.

It is also noteworthy that the retirement of this performance measure does not reflect a disagreement with existing guidelines, which support the use of beta blockers in many patients with coronary artery disease, including those with myocardial infarction. Specifically, the ACC/AHA guidelines still include class I indications for beta blockers for many such patients (note, class I indications are those conditions for which there is evidence and/or general agreement that a given procedure or treatment is beneficial, useful, and effective).

Thus, although the ACC/AHA have recommended the retirement of the performance measure assessing rates of use of beta blockers within 24 hours of presentation for patients with AMI, there remain many clinical circumstances where beta blockers are recommended therapy for patients with both acute and chronic coronary artery disease, including early use in some patients with AMI.

It is important to note that this evidence in no way affects the SCIP-Card-2 measure, Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period.

Effective immediately, mechanisms are being put in place to suppress public reporting of the measure and cease submission of data elements unique to this measure. As these mechanisms are initiated and to ensure best practices, CMS and The Joint Commission encourage providers to use the “Reason for No Beta-Blocker on Arrival” exclusion in order to remove high risk

patients from the measure. Beginning with April 1, 2009 discharges, the data elements unique to this measure will no longer be required for submission by CMS or the Joint Commission.

CMS and THE JOINT COMMISSION

*Mechanisms and Continuing Requirements for Hospitals Applicable **Starting with April 1, 2009 Discharges:***

CMS and The Joint Commission will issue an addendum to Version 2.6 of *The CMS/Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures* to delete the AMI-6 measure from the manual. Version 2.6 is the manual version applicable for April 1, 2009 through Sept. 30, 2009 discharges. AMI-6 will not be included in Version 2.6 and future updates to the manual.

CMS ONLY

*Mechanisms and Continuing Requirements for Hospitals Applicable **Before April 1, 2009 Discharges:***

RHQDAPU Program Requirements

- Hospitals choosing to participate in the RHQDAPU “pay–for-reporting” program must continue to submit AMI-6 measure data through 1st quarter 2009 discharges as part of their RHQDAPU program requirements. The following current deadlines will apply to AMI-6 and other AMI, Heart Failure, Pneumonia, and Surgical Care Improvement Project chart abstracted measures:
 - 3rd quarter 2008 discharges: February 15, 2009
 - 4th quarter 2008 discharges: May 15, 2009
 - 1st quarter 2009 discharges: August 15, 2009
- CMS will continue to validate AMI-6 abstracted elements for the RHQDAPU program through 1st quarter 2009 discharges as part of the RHQDAPU program requirements. As noted above, the “Reason for No Beta Blocker” exclusion should be used by hospitals to remove high risk patients from the measure.

Hospital Compare Public Reporting Mechanisms

- CMS will begin suppressing the AMI-6 measure from public reporting and all relevant reports beginning with the March 2009 release of Hospital Compare (or sooner, if possible).

Quality Improvement Organization (QIO) Education and Technical Assistance to Hospitals

- CMS, through its Quality Improvement Organization (QIO) contractors, will communicate and educate hospitals about this change to the RHQDAPU data submission and validation requirements for participating IPPS hospitals. QIOs are required under current their 9th Statement of Work contracts to actively promote and support hospitals with submission of quality data for reporting and Annual Payment Update (APU) purposes.
- QIOs and hospitals should notify their internal point of contact for any questions. They may contact the Hospital Reporting Program QIOSC at hrpqiosc@iaqio.sdps.org if information and/or assistance are needed.

Mechanisms and Continuing Requirements for Hospitals Applicable Starting with April 1, 2009 Discharges:

RHQDAPU Program Requirements

- Data submission and validation of the AMI-6 measure will not be required for IPPS hospitals participating in the RHQDAPU “pay-for-reporting” program beginning with April 1, 2009 discharges and forward. The two elements that are required only for AMI-6 and will not be validated or scored on discharges beginning with April 1, 2009 discharges are: 1) Contraindication to Beta Blocker on Arrival, and 2) Beta Blocker Received Within 24 Hours After Hospital Arrival.

Hospital Compare Public Reporting Mechanisms

- The AMI-6 measure will be deleted from the list of available measures for voluntary Hospital Quality Alliance (HQA) reporting initiative beginning with April 1, 2009 discharges. Acute care hospitals (both Critical Access Hospitals and Prospective Payment System hospitals) will no longer be able to submit AMI-6 data to the QIO Clinical Warehouse for quality improvement and public reporting purposes.

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JOINT COMMISSION ONLY

Joint Commission will suppress the measure from Quality Check starting with the posting of 3Q08 data in April 2009.

Additional technical details will be forthcoming to ORYX performance measurement systems.