JCAHO Measures Boost Heart Failure Survival

BY MITCHEL L. ZOLER
Philadelphia Bureau

MADRID — The four criteria now used to measure hospitals' performance in treating patients with heart failure also have a significant impact on patient survival, based on a review of more than 2,000 patients.

In 2002, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) set four core measures for assessing the quality of heart failure management. "To our knowledge, this is the first report showing that adherence to the JCAHO heart failure core measures improves 1-year survival following hospitalization for heart failure," Dr. A.G. Kfoury said at the annual meeting of the International Society for Heart and Lung Transplantation.

"The data show that these four cheap interventions can have an impact on patient outcomes," said Dr. Kfoury, medical director of the Utah Transplantation Affiliated Hospitals cardiac transplant program, and associate director of the heart failure prevention and treatment program at LDS Hospital in Salt Lake City.

The four performance measures are: discharge instructions to patients on heart failure management, including medications, diet, and weight control; assessment of left ventricular function or scheduling an assessment at discharge; treatment with an ACE inhibitor or angiotensin receptor blocker (ARB) at discharge; and instructions on smoking cessation at discharge.

To determine how the application of these four measures correlated with patient survival, Dr. Kfoury and his associates reviewed the records of 2,144 patients who were discharged with a primary diagnosis of heart failure and left ventricular dysfunction from 20 hospitals within the Intermountain Healthcare system from January 2003 to May 2005. The primary end point of the analysis was death during the 12 months following hospital discharge.

Because 90% of the patients were nonsmokers, one analysis excluded the smoking cessation measure and focused on the application of the other three criteria.

About 43% of patients received all three interventions, and another 39% received two of the interventions. Some 3% of patients received none of the interventions.

Patients who received all four interventions at discharge had a 5% mortality rate over the next 12 months. Those who received none had a 25% mortality rate.

When only one intervention was used, it was most often prescription of an ACE inhibitor or ARB. The second-most-commonly used intervention was assessment of left ventricular function. Patient education was applied less often.

According to an analysis that adjusted for patients' age, gender, and severity of illness, patients who received none of these three interventions had about a 25% mortality rate during the 12 months following hospital discharge.

Patients who received one or two interventions had about a 15% mortality rate, and patients who received all three interventions had about a 10% mortality rate.

When differences between these subgroups were analyzed statistically, patients who received two or three of the JCAHO-prescribed interventions had a significantly improved 12-month survival, compared with the patients who did not, Dr. Kfoury said.

A second analysis looked at the impact of all four interventions, including counseling on smoking cessation. The pattern was quite similar to the prior analysis: Patients who received all four interventions at discharge had a 5% mortality rate over the next 12 months. Those who received none of the interventions had a 25% mortality rate.

"These results should be an impetus to implement these simple but effective measures," said Dr. Kfoury. "Most patients get one or more of the interventions, but patients do not always get all of them."

Treatment with an ACE inhibitor or ARB at discharge has become standard practice, but patient education at discharge is a strategy that's been used only for a few years and needs to become more widely used, he added. ■

Pages 54a—54b