and now he is on the transplant list after normalization of pulmonary pressures.

CONFLICTS OF INTEREST

S. Schueler has received consulting and proctor honorarium from HeartWare Inc.

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Initiatives to Achieve Excellence in the Care of Acute Coronary Syndrome

Iniciativas para conseguir una atención excelente en el síndrome coronario agudo

To the Editor,

We read with interest the article by de Lorenzo-Pinto et al.[1] reporting a program to reduce bleeding in acute coronary syndrome patients. We would like to congratulate the authors for their initiative, which, through proper use of the extensive battery of antithrombotic therapies, will help to improve the care of patients with a highly prevalent and complex condition that represents a substantial part of our activity.

The introduction of coronary units, improvements in antithrombotic therapy, and the use of interventional procedures in the acute phase has helped to produce a spectacular improvement in the care of coronary patients. This is particularly evident in the decreased 30-day mortality rate, which, in the case of ST-elevation acute coronary syndromes, dropped from 16.6% in 1978 to 4.7% in 2007.[2]

Nonetheless, despite these advances, programs such as the one reported by Lorenzo-Pinto et al.[1] show that the task is not over and there is still room for improvement to reach desirable results. The program described by these authors can be added to 2 other initiatives also aimed at improving care, which could be complementary. One of them has not been tested in Spain and the other, in our opinion, could be further perfected. The first involves the recently described programs to effectively reduce readmission rates following percutaneous revascularization. The incidence of repeat hospitalizations is around 15% in the first month and these are rarely due to a procedure-related problem or an acute coronary syndrome.[3,4] The second is the RECALCAR project, launched in Spain in 2011 with the aim of gaining information related to the infrastructure and results of cardiology units within the Spanish health care system. This initiative should be applauded because of its aim of improving knowledge about our activity, but we believe that it could and should undergo some changes. The origin of the data is 2-fold: first, the department heads provide data about the infrastructure and activity of each cardiology unit recorded for a particular year, and second, the outcome data are obtained from the Minimum Basic Data Set of the Ministry of Health, Social Services and Equality, derived from the coded discharge reports of the previous year.

Since its inception, this structure has received criticism, as errors in the coding and administrative processes have resulted in complaints from some of the participating centers. This same road was travelled by the New York system and led to a temporary interruption until the current modification was applied, in which the data are based on individual risk, estimated through the use of risk scales. The scores on these scales are recorded by the physician at the time of the procedure, and the accuracy of the data is verified by strict external auditing through random selection of the patients' clinical records, with consequencies for both the center and the physician if there are errors.[5] Following the use of this model, there was a 41% decrease in mortality from 1989 to 1992. Furthermore, since 1992 the data per each physician and center have been published online so that patients can check them and choose a physician according to outcomes. Although it may seem distant or utopian, achieving this level of transparency in the results for centers and physicians in our setting would be a resounding success. In this line, the Spanish Society of Cardiology has launched an effort to monitor quality indicators and improve the results in individual centers.[6]

It is likely that there will be the usual impediment, a lack of infrastructure to carry out this activity, but our current mission is to demonstrate its effectiveness. In this way, the administration

will be encouraged to offer the commitment and resources required to continue on the path to a level of health care excellence we all desire.

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Initiatives to Achieve Excellence in the Care of Acute Coronary Syndrome. Response

Iniciativas para conseguir una atención excelente en el síndrome coronario agudo. Respuesta

To the Editor:

We appreciate the interest shown in our article[1] published in *Revista Española de Cardiología* and the comments made. We agree with Lozano et al. that our intervention is only one option and that it could complement other ways to improve quality of care. Undoubtedly, the 2 strategies suggested by the authors could enhance our proposed model.

In our case, we realized the need to reduce the incidence of bleeding events in patients with acute coronary syndrome due to an exhaustive coding of diagnoses. In addition to participating in the RECALCAR program, the cardiology service of *Hospital General Universitario Gregorio Marañón* also participates in the Cardiac Section of the Benchmarking Club, which publishes an annual series of data comparing the participating hospitals. In 2009, patients (most with acute coronary syndromes) who underwent a percutaneous coronary intervention and who were admitted to the cardiology service of our hospital had a crude bleeding rate of 12.5%, higher than the mean of the hospitals in the Benchmarking Club (9.5%) and the national average (8.6%).[2] However, the bleeding rate reported by each center is entirely reliant on the degree of hospital coding (because the analyses are based on the Spanish Minimum Basic Data Set), as correctly noted by the authors of the letter, and our hospital performed one of the most exhaustive coding of diagnoses and complications of all participating in the Benchmarking Club.

Despite the limitations inherent to these voluntary programs, our results were key to the identification of improvement opportunities and guided us toward the need to develop a multidisciplinary strategy to reduce bleeding events and assess their economic and health effects.

Adequate monitoring of health care quality requires measurement of both activity and outcomes.[3] While acknowledging the limitations noted in the measurement tools and the different monitoring systems, we believe that incomplete or imperfect information is still better than no information at all. This knowledge should be the starting point for the development of strategies to improve quality of care or, in the worst case scenario, of measurement instruments or systems. Declaring that instruments do not work without doing anything to change them is not a responsible approach.

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CONFLICTS OF INTEREST

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