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ACC NEWS

President's Page: Quality of Care: A Moving Target Worthy of Pursuit

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If I were to informally survey 100 prospective medical students, asking all of them the same question, "Why do you want to be a doctor?" I suspect that at least 90 would reply with some variation on "I want to help people." A similar study of seasoned physicians, asked why they chose medicine and why they spent a dozen or more years in training, would probably yield similar answers. The desire to "help people"—to make them well or ease their suffering—is the common thread running through the community of physicians. It is what most of us do all day long.

I suspect that, among physicians, there are other common traits as well. We are a hard-working, ambitious group, driven to succeed, willing to give up time for ourselves and, in some circumstances, even for our families, for the good of our patients. We are quick thinking and confident in our instincts and our abilities. These attributes are the products of our training—the long hours we logged as fellows, the pressure we felt to deliver the right answer while on hospital rounds, and the burden of knowing that the decisions we made might save or end a life. No doubt, it takes a great deal of self-assurance to deal in life and death.

So, it's hardly surprising that many physicians are distressed, offended, even angered by the "quality assurance" movement that is making headlines these days. Since the early days of medicine, physicians have worked autonomously. Yes, we have relied on nurses and technicians, but there has still been a certain mystique about being the doctor. And, now, we find at every turn someone questioning our judgment…payers, government agencies, hospital committees, even our patients. And some of these parties don't stop at just asking questions; some seem to threaten us—with "profiling," report cards, outcomes monitoring, analysis of practice variation…the list of ways they want to "measure" our work seems endless.

Making the situation worse is that the "quality" that these parties are demanding that we demonstrate often appears to be a moving target. The "best practice" that I learned during my training more than 30 years ago (although it wasn't called that) is a far cry from today's "state-of-the-art" care. And I wouldn't be surprised to hear some of the physicians I trained in the past decade say something similar. It's not that any of us was poorly trained. That excellence, and our achievements, have made possible the extraordinary progress we have realized in the management of cardiovascular disease. Ironically, those achievements are what have made much of what we learned back then history already. As Blumenthal (1) has noted: "A hundred years ago, everything physicians needed to treat their patients was found between their own two ears or in a small black bag." We have moved light years from that capability. Today, it is not humanly possible for any individual to keep up with what Chassin and Galvin (2) call the "avalanche of efficacy data" that should be informing how each of us delivers care. Compounding this dilemma is the fact that it is impossible for any physician to care for patients with complete autonomy. Because we now realize the complexity of most diseases and because every scientific discipline has grown more and more specialized, the simple biology we relied on to make clinical judgments in the past has metamorphosed into biochemistry, biophysics, bioethics, bioenergetics, and biogenetics—to name only a few. Clinical care of a single patient often becomes so complex that it must be expanded to include many other health care experts, which means that systems and processes often determine outcomes. I can be the best cardiologist around, but if I do not work in an efficient and expert system that includes nurses, technicians, and others, my expertise may become lost. In short, the target all of us were shooting for when we started treating patients has moved.

These are just some of the reasons that the quality-of-care concept represents frustration for many physicians. But, here's the kicker—I would argue that each of these reasons is exactly why it behooves us as physicians to embrace the quality-of-care movement. And, more important is that this movement will help us to do a better job of what all of us set out to do when we became doctors: help people.

"QUALITY" DEFINED

If we, as a community of physicians, can agree that it is in the best interests of both our patients and our profession to embrace the quality-of-care initiatives now being undertaken in so many sectors of society, then a logical place to start is to examine what "quality" is and what it is not. As Blumenthal (1) has pointed out, the struggle to define this term has led to varied definitions, from descriptions set forth by the American Medical Association to characteristics outlined by individual patient groups, managed-care organizations, public agencies, and insurance programs. In 1994, the Institute of Medicine convened a roundtable representing these and other perspectives, including academia, business, consumers, federal programs, the private

sector, and the media. The group agreed on the following definition:

> "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (2).

The College is not entirely sure that this is the right definition, but it is a good place to begin. Chassin and Galvin (2) have also investigated problems indicative of poor quality. Noting that, "At its best, health care in the United States is superb," these researchers added that there are three categories into which problems detracting from quality can be grouped: underuse, overuse, and misuse.

Underuse occurs when therapies proven to be effective are not provided. Chassin and Galvin (2) cited several efficacious drug therapies for acute myocardial infarction (AMI) patients that are underused. They suggested that 18,000 deaths might be prevented each year in the U.S. if physicians more routinely prescribed thrombolytics, beta-blockers, and ACE inhibitors to AMI patients. In contrast, *overuse* occurs when a procedure or service is provided for clearly inappropriate indications. I suspect that when insurance companies or managed-care organizations try to dictate to physicians which procedures are necessary, they are relying on overuse statistics as their justification. And, finally, *misuse* occurs when an appropriate service is delivered but preventable complications develop and the patient fails to fully benefit from the care.

QUALITY: PROGRESS AND TOOLS

The group also agreed that it is possible to measure quality, although doing so is a daunting task. They noted that some tools are already available but that many are being developed. In accordance with its mission, the American College of Cardiology (ACC) has been participating in quality-of-care efforts for approximately 20 years, beginning with the development of practice guidelines. In more recent years, we have expanded our efforts significantly in pursuit of means to help our members hit the target of delivering optimal care.

I believe that one of the most important facts to keep in mind when thinking about the College and quality is this: The ACC is a member-led and member-driven organization. This means that there are physicians—not payers, not government agencies, not administrators, and not even patients—driving all of our activities, including quality. This fact will serve us well in many regards:

- First, we physicians have the best likelihood of being effective. Who understands the day-to-day rigors of practicing medicine better than doctors?
- Second, leading the way in quality-of-care initiatives is an excellent way for us to demonstrate to our patients and their families that we are looking out for them, that we are "reforming" health care and not in need of reform ourselves.
- Third, as Chassin (3) has written, "By specifying what quality means and how it should be measured, physicians will specify how medicine should be practiced." In other words, by tackling the problems in health care delivery, we are taking important steps toward maintaining our autonomy.

The College's investment in quality-of-care efforts is already significant, and our initiatives are numerous and diverse. These efforts have arisen based on opportunities, and the time has come for us to be more strategic. I have charged the newly created Task Force on Science and Quality of Care to help the College develop an overall strategy and objectives that will direct our movement forward and ensure that we have recognized and seized the best opportunities for the College's programs in quality. The task force will complete its work by March 2002, and I look forward to sharing its recommendations with you. In the meantime, here is a brief overview of where we are today:

Practice guidelines. The Institute of Medicine (4) defines practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." The College has a long history in practice guidelines. With the American Heart Association (AHA), the College undertook its first practice guideline in 1980, when a number of organizations were just breaking into this area. In subsequent years, dozens of guidelines have been published, and 16 are currently in print and available for download from the ACC Web site. A discussion of these guidelines and their enormous potential to beneficially influence the care of cardiovascular patients will be the subject of a future President's Page. In the meantime, I want simply to emphasize that practice guidelines are developed through a rigorous process conducted by expert physicians. The writing groups spend months culling through all of the literature about the subject condition or procedure and filtering out findings that are not yet supported by professional experience. These guidelines are a major help to practicing physicians, who do not have the time to synthesize the extensive evidence derived from population-based studies and apply it to individual patients.

Performance measures. A relatively new undertaking for the ACC and the AHA, performance measures translate the key recommendations from the guidelines into measures that we clinicians can use to assess and improve quality of care. The first two sets of ACC/AHA performance measures—on AMI and heart failure—will be published early next year. Although performance measures, like many other quality initiatives, are based on practice guidelines, they are usually a small set of *measurable* items that individual cardiovascular care providers can use. For example, once completed, the AMI performance measures might be six to ten questions, including: "Did you prescribe aspirin to

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patients with AMI who did not have major contraindications?" The key here is to be able to track back to the guideline, which in this case recommends the use of aspirin for all patients except those with a true aspirin allergy and to be careful with those who have a history of upper gastrointestinal bleeding. This way, the behavior being measured is one that the best available evidence suggests bears an important relationship to patient outcome. During a given week, I would look at all of the AMI patients I encountered and measure which of the items I did or did not do. At the end of the week, I could see how I measure up to the ideal. And the best things about performance measures are that the "ideal" is the recommendation of my peers and other cardiovascular care providers who are as interested as I am in quality care and that I do the measuring myself, for myself.

Clinical data standards. An important task the ACC has set for itself is to promote consistency among data-collection efforts, whether they are clinical studies, registries of clinical data, or published articles related to patient care. By identifying the best definitions and standards for clinical care and research, data standards will go a long way toward this goal. Just this fall, the College published its first set of data standards. This document focuses on acute coronary syndromes (ACS) and provides a common terminology for describing the care and outcomes of patients with ACS. The group that drafted these standards invested more than three years in getting them right, including a period when the draft document was posted on the ACC Web site and comments from physicians, researchers, hospitals, payers, and others were welcomed. Standards for heart failure and atrial fibrillation are in progress.

GAP program. The Guidelines Applied in Practice, or GAP, program is one of the College's most exciting and rewarding projects. The GAP program takes guidelines off the shelf, where they too often go unheeded, and puts them into practice. The first GAP Project was conducted in Southeast Michigan in collaboration with the Greater Detroit Area Health Council and the state's peer review organization. Concentrating on AMI, this GAP Project spanned just 12 months and achieved significant results in that short time. Using a kit full of tools designed to help physicians and other health care providers, as well as patients and their families, the project yielded what its principal investigator, Dr. Kim Eagle, calls "striking" results. The GAP team assessed the impact of the tools, including checklists, standing orders, chart stickers, and a flight plan for patients being treated after an AMI, on more than 800 patients in 10 hospitals in the Detroit area.

For virtually every key quality indicator, GAP resulted in either a positive trend or a significant improvement in adherence to the recommendations in the guideline. Following the GAP initiative, more AMI sufferers were being advised to kick the smoking habit. The most impressive results were seen in Medicare patients. In addition to the fact that more of these patients received beta-blockers in the first 24 h after hospital admission, these patients were significantly more likely to be given aspirin during the first day of their hospital stay and on discharge from the hospital.

Following the enormous success of the first project, the College has launched two new GAP initiatives. Alabama is the site for a GAP Project on stable angina, and Oregon will host a project focused on heart failure. In the meantime, the College is working with the AHA to develop a program that unites the GAP program with the AHA's "Get With the Guidelines" program, which has similar aims and approaches.

National Cardiovascular Data Registry™. A critical requirement for quality improvement is the ability to measure performance and to compare your performance with others like you. Such measurement permits opportunities for improvement to be identified, and the impact of intervention on performance then can be monitored. The ACC has made a considerable investment in supporting the efforts of catheterization laboratories to measure the quality of care they provide to patients undergoing diagnostic catheterizations and percutaneous coronary interventions. The ACC-National Cardiovascular Data Registry™ (NCDR) service currently provides comparative reports to assist its more than 300 subscribers in understanding and improving the quality of their results. The ACC-NCDR™ database is also an incredible resource for ACC members, many of whom have begun to use it to answer important research questions and to produce a stream of abstracts and papers that I expect will be a river before long.

The cath lab "Continous Quality Improvement" (CQI) tool kit. Although the ACC-NCDR™ is a first step toward improving quality in this arena, performance information alone—without tools that lead to improvement—creates frustration rather than higher-quality care. So, the College's next step is to develop a broad-based "tool kit" that will provide the recommendations, guides, and templates needed to translate identified opportunities for improvement into the delivery of better care. The tool kit is in an early stage of development, and we expect that a prototype will be ready for testing in 2002.

CONCLUSION

In previous President's Pages, I have discussed issues related to education and advocacy. Recently, I outlined ACCardio, the College's endeavor to provide a knowledge management system that will help cardiovascular specialists and other health care providers to stay current in the field and to access information on an as-needed basis. In other issues of the *Journal of the American College of Cardiology*, I have discussed our advocacy efforts and the important step we are taking by establishing a political action committee and creating new resources for our chapters and grassroots lobbying. These

and other initiatives in education and advocacy are crucial to quality care. When we can easily obtain the latest research findings, we will be in a better position to give our patients state-of-the-art care. Likewise, maintaining an environment in which we are able to provide the care our patients need, unrestrained by unnecessary regulations or payer protocols, will serve our patients.

The issue of quality is pertinent for everyone at the ACC and for all of its members. The notion of "continuous quality improvement" is driving all of our efforts. We all weather the frustrations that sometimes accompany progress, realizing that achieving quality is not a destination but rather a journey toward a constantly moving target. We will never "get there," but we must keep striving to move in that direction.

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