All of us aspire to provide our best medical care to every patient, every day. This driving desire comes from within us and is our professional responsibility. It is also a critical factor to our patients, who are entrusting us with their health and well being. However, how do we really know what is “best”? And does “knowing” automatically translate into “doing”?

Just a few years ago, medical journal editorialists and practitioners alike decried a potentially unsavory reduction of care to “cook-book medicine” (1). Detractors believed the best doctors’ wisdom and experience could not be adequately distilled into guidelines, and that those guidelines implied an inappropriate “one-size-fits-all” approach to care. Perhaps worse, such a prescriptive approach would restrict freedom of decision. Rather, they argued that good training, board certification, and conscientious attention to continuing medical education (CME) should be more than enough.

Today, however, we recognize the magnitude and growing complexity of cardiovascular knowledge and the best practices, and we realize that we need help. A significant component of the bench-to-bedside gap lies beyond translating fundamental discovery into clinical research. We must take that research one step further to connect what we know (the evidence) with what we do (the care). We must recognize our obligation to intentionally address this gap as fundamental to our unspoken contract with society and patients to provide optimal cardiovascular care.

Another recent shift is transforming the concept of quality away from something that is done to us by regulators, to something we are actively controlling, even leading. Quality is expanding from a binary goal of present or absent to a journey along a continuous cycle of learning, processes of care, and measurement of outcomes, adjustment, and improvement. It is informed by our clinical judgment while it provides the supportive tools needed to assess—and improve—performance. Unfortunately, because this process may be cumbersome, costly, and even adversarial, there are significant barriers to implementation.

A fundamental problem is that quality is extraordinarily difficult to define and measure. Health services research often focuses on hospital-based dimensions of structure, process, and outcomes (2). All are important; most are difficult to quantify. Surrogates, such as credentialing or procedural volumes, are ultimately inadequate. Mandated outcomes reporting, such as New York State’s coronary artery bypass graft and angioplasty mortality (3), present an incomplete picture and drive physicians to manage numbers rather than patients. Furthermore, many existing quality metrics do not fit physicians’ practice patterns as well as performance measures designed for this purpose.

At the same time, organizations such as CMS and Leapfrog are redefining their roles as payers by requiring quality of care for reimbursement, whereas the Food and Drug Administration is mandating that manufacturers continue to prove the value of their devices and medications by post-market surveillance (4). Regardless of the difficulties, we cannot ignore the issue nor can we afford to let others set this agenda. We must set quality standards and be willing—and able—to enforce them.

The American College of Cardiology (ACC) can help us complete this daunting task with a robust portfolio of quality-related activities and tools. Available today are such quality supports as 17 ACC/American Heart Association (AHA) guidelines published over the last 25 years, training and competency statements, cardiologist-specific performance standards, registries, laboratory accreditation programs, and quality improvement tools. The College also is partnering with many national organizations to develop useful standards and tools.

However, all this is not enough. Quality is so important and so difficult to achieve, that it requires every one of us to personally adopt this as our mission and rethink our daily work. We must recommit to consciously measuring and improving our care with every patient encounter. Given the pace of our lives, this sounds impossible—but there is help.

The ACC has been a leader in developing point-of-care tools such as order sets, checklists, and patient information sheets through the Guidelines Applied in Practice (GAP) initiative. Think of these as memory aids, or concentrations of guideline recommendations into practical nuggets of actionable information. The ACC has also led in developing tools that measure performance and provide specific feedback to improve it. The most widely known of these is the
ACC-National Cardiovascular Data Registry (NCDR), which is currently used by about 40% of the catheterization laboratories in the country and soon will be expanded to include carotid stenting and electrophysiology devices (5).

Some of the most exciting quality improvement efforts are happening at the local level. The ACC chapters are serving as a key “distribution channel” to translate national guidelines into local practice. In North Carolina, for example, the ACC chapter is partnering with Blue Cross and Blue Shield of North Carolina and five local care networks to improve care for patients with acute myocardial infarction. This Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments (RACE) program will enhance systems of care delivery and teamwork by linking ambulance systems, emergency departments, smaller hospitals and referral hospitals, and many departments within hospitals. The RACE program provides emergency department guideline tools backed by a 24-h hotline staffed by senior cardiologists. It also funds educational nursing and physician educational programs.

Other local successes include the Virginia ACC chapter’s “GAP-Virginia Using Get With the Guidelines” project. In this initiative, the chapter has partnered with the AHA and the Virginia Health Quality Center, Virginia’s Quality Improvement Organization that includes 32 hospitals across the state. This collaboration has already improved statewide discharge measures for acute myocardial infarction and congestive heart failure.

Although we cannot—and will not—abdicate our responsibility to tackle quality from the big-picture view, it remains that true quality depends on each of us. We must be proactive in removing barriers to implementing guidelines-based medicine. What are you doing today to start or enhance quality improvement programs in your practice? Why not take this opportunity to identify then take advantage of those routines, short cuts, and check lists that help you prevent errors and omissions and provide better care?

Better yet, are you functionally informed about quality? Have you made it more than an abstract word in the dictionary? Look up your hospital’s ratings on the CMS website (6) or other public, consumer-oriented websites and, if they are not outstanding, take it upon yourself to launch a doctor-led movement to implement system-wide tools for improvement.

Do you participate in registries such as ACC-NCDR that objectively measure your performance against your peers, and do you use this straightforward, unbiased feedback to recalibrate your work? Why not consider employing such process improvement initiatives like the ACC’s CathKit to help your entire cardiac care team to do better? Or, seek out other methods to double-check your work so you are educated about your performance before the government or an anonymous payer makes it their business.

Resolve to become a physician champion and get involved with your local ACC chapter. You can catalyze the development of quality-oriented programs and projects on topics from clinical strategies to pay for performance. Remember: quality is not a destination, it is a continuous journey, a unique approach to clinical care, and it depends on you to succeed. Welcome to the all-FACC quality family.

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REFERENCES


