Despite the significant reimbursement problems we are encountering and our continuing focus on establishing fair and equitable reimbursements for cardiology, the College's efforts as a professional society to improve quality and provide better care continue. This month, Drs. Cacchione and Kovacs, two of our American College of Cardiology (ACC) leaders in quality, have summarized the ongoing obstacles to quality cardiovascular care.

—Alfred A. Bove

Once upon a time, an FACC could demonstrate the quality of his or her care by credentials and a good reputation in the community. Formal measurement of quality did not exist, and only care that deviated from community standards was subject to scrutiny. It was assumed that a competent cardiologist provided quality care. Now, the individual FACC and the College as an organization are challenged with redefining, measuring, and reporting quality in the hospital and in the outpatient arena. How do we meet this challenge as individuals and as a profession? How do we advocate for quality care for our patients?

Every current debate in health care reform places quality reform front and center. Practicing cardiologists have different answers to the question “what is quality care?” Other stakeholders—patients, insurance companies, professional organizations, state and federal government, employers, and health delivery researchers—all have nuanced views of quality. It seems as if every organization and agency has an agenda to produce, measure, or regulate quality in medical care. To many, the landscape has become a confusing jargon and “alphabet soup” of letters indicating this agency or that foundation (Table 1). The quality landscape is as dynamic and political as the rest of the health care reform debate. This paper is an attempt to define the quality landscape at present and the role of the ACC, on behalf of the individual cardiologist and the profession, in quality reform.

The Stand for Quality (SFQ) document, created by members of the Quality Alliance Steering Committee and endorsed by numerous organizations including the ACC, has been incorporated into many versions of reform proposals. The SFQ document has numerous recommendations, which are well grounded and difficult to refute as key elements in any health care reform (1). The SFQ deals with issues from a high-level view, but it would serve all cardiologists to be familiar with these basic principles. The SFQ steering committee recently sent an open letter to congressional leadership urging incorporation of those principles into the final consolidated health care legislation.

The key foundational principles for building high quality, affordable health care as proposed by the SFQ document include performance measurement, reporting, and improvement to drive quality and reduce cost. The core building blocks to effect this reform include: stakeholder participation, endorsed priorities and measures by constituents, technology and data to provide the information for improvement and reporting, and
well-designed solutions for providers. To that end, the SFQ document has identified 6 key functions of the performance measurement, reporting, and improvement enterprise:

1. Set national priorities.
2. Endorse and maintain national standard measures.
3. Develop measures to fill gaps in priority areas.
4. Establish consultative processes so that stakeholders can inform policy makers on use of measures.
5. Collect, analyze, and make performance information available and abundant.
6. Support a sustainable information structure for quality improvement.

The key principles espoused in the SFQ have led to a myriad of initiatives, public and private, to move quality reform forward. The ACC is well positioned to support these initiatives on behalf of its members. A number of external organizations, such as the National Quality Forum and the Physician Consortium for Performance Improvement, have ACC representation. The ACC/American Heart Association Task Force on Performance Measures has been instrumental in developing measures that set national standards for quality cardiovascular care. In addition, initiatives such as Door to Balloon: An Alliance for Quality and Hospital to Home: Excellence in Transitions assist in operationalizing the quality improvement process and support certain measures as surrogates for quality. Last, but by no means least, the National Cardiovascular Data Registry, a suite of registries, such as CathPCI and PINNACLE, provides the information infrastructure to track, improve, and report the process and outcomes of care. It is key for ACC members to recognize the impending changes and use the existing tools to meet these changes at the local level. Equally critical, the ACC as an organization must stay strategically involved at many points on the Quality Cycle (Fig. 1) (2) that drives the quality agenda. This wheel was proposed by the Quality Alliance Steering Committee and represents the framework for stakeholder interaction in the quality enterprise.

Clinical quality improvement viewed as this cycle, or wheel, allows for priority setting, measure development, and endorsement. Measurement strategies are then tested, implemented, and validated. Data are gathered, and projects are developed to improve the care reflected in the measures. The entire process is re-evaluated, and the cycle begins again.

The concept of “measure, improve, and report” will also likely lead to structural changes in reimbursement and the movement toward value-based purchasing. Integrated care delivery models that ensure evidence-based practice and include longitudinal tracking of both clinical outcomes and patient experience may be a larger part of the value equation. The reimbursement models will then track these changes and possibly modify the vehicle of reimbursement and the incentives. The often-cited goal of paying for quality and not just quantity of services could be in reach (3).

The last element of this reform will be “reporting” in an effort to support transparency and consumerism. The key aspects of public reporting are well outlined in the Ambulatory Quality Alliance principles of public reporting (4). The College’s position is expressed in a recent principles document as well (5). The ACC inpatient and outpatient registries will provide credible clinical data sources and can populate these public reports with intrinsic benchmarking to allow targeted improvement and comparison. Reports on outcomes, performance, and patient experience may then be utilized by consumers to make informed decisions about where they can seek care. Short-term outcomes, such as hospital survival after myocardial infarction or 30-day readmission rates following a heart failure admission, will be easier
to track. Long-term outcomes, such as stroke prevention or improvement in longevity, that are achieved by consistent management of cardiovascular risk factors will be more challenging to track. Longitudinal data from the registries will be key to the latter.

The mission of the ACC is to promote science, quality, advocacy, and lifelong learning. Strategic and tactical initiatives of the College provide the foundation necessary for members to meet these impending changes in health care. The College is positioned to advise other organizations on quality cardiovascular care. Clinical practice guidelines and appropriate use criteria define quality care across the spectrum of cardiovascular disease. The ACC can provide subject experts from its ranks to serve other organizations positioned at the various stages of the quality wheel. The ACC can provide demonstration projects and pilot data to support the testing of care models. The ACC, through the Board of Governors and the Chapters, can rapidly disseminate and implement strategies to improve quality of care, such as the D2B Alliance, H2H, and the recently launched FOCUS (Formation of Optimal CV Imaging Strategies): A Quality Improvement Campaign.

There is yet much to be done before the quality wheel turns smoothly. There are ideas to be vetted, data to be

Figure 1 The Quality Cycle
American College of Cardiology (ACC) annotations were added by the authors as to where they see the organization best fits. **List of all involved partners available. Nursing academic communities, etc. Adapted, with permission, from The Engelberg Center for Health Care Reform at the Brookings Institution (2). NCDR = National Cardiovascular Data Registry; PFMT = Performance Member Task Force.
gathered, and projects to be piloted. The ACC can drive the wheel at multiple points. By driving the process, the ACC will be well positioned to provide its individual members the tools to promote quality at the level of the individual patient, to measure the improvement in outcome, and to reap the benefits that will come from a professional and national culture of continuous quality improvement.

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REFERENCES