JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 71, NO. 20, 2018

PUBLISHED BY ELSEVIER

LEADERSHIP PAGE

Helping ACC Members Deliver Higher-Quality Care

C. Michael Valentine, MD, FACC, *President, American College of Cardiology*

We have come a long way since the concept of "pay-for-performance" first emerged on the scene nearly 2 decades ago. Faced with both increasing cuts in Medicare reimbursement and rising overhead costs, it was difficult for practices at the time to make a business case for, let alone invest in, long-term system improvements. Payers, lawmakers, and others saw pay-for-performance as a clear solution.

Seeing the writing on the wall, the American College of Cardiology (ACC) was an early supporter of the pay-for-performance concept but with reservations, given the rapid rate it was evolving at the time and little direct evidence that it could achieve the desired short- or long-term outcomes. Speaking before Congress on behalf of the ACC in 2006, John Brush, MD, FACC, noted: "Currently, there are about 100 pay-for-performance systems in place in the private sector, but very few studies have evaluated the utility of these systems. Pay-for-performance must be based on evidence, and a one-size-fits-all approach may not be wise" (1).

To help guide pay-for-performance discussions given the lack of research and solid supporting evidence, the ACC developed formal pay-for-performance principles to guide its members and payers through the transition to novel payment mechanisms (2). In addition, the College embarked on efforts to: systematically measure and provide feedback on cardiovascular care patterns to individual hospitals and providers via its NCDR (National Cardiovascular Data Registry); create national quality initiatives aimed at closing specific gaps in evidence-based care; and develop appropriate use criteria that would help define "what to do," "when to do," and "how often to do" in the context of local care environments combined with patient and family preferences and values.

"It is the role of our profession to self-monitor, critically review, and advance our concept of quality," wrote Michael J. Wolk, MD, MACC, and colleagues in an August 2004 *JACC* President's Page at the time. "We must be good stewards of the gifts—and responsibilities—that have been entrusted to us" (3).

Over time, the term "pay-for-performance" transitioned to paying for quality. In 2006, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Quality Reporting Initiative—a voluntary quality reporting program that offered incentives for providers who submitted quality data to CMS. As expected, this initiative evolved into a mandatory program called the Physician Quality Reporting System. Between 2010 and 2014, the program offered both incentives and penalties, with 2014 being the last calendar year for a Physician Quality Reporting System incentive.

The ACC further stepped up its quality reporting efforts to help its members successfully benefit from the incentives and avoid penalties. The College worked closely with the American Heart Association, National Quality Forum, and others to develop and map performance measures. These measures, as well as appropriate use criteria and clinical guideline recommendations, were incorporated into the ACC's clinical data registries. The College also launched its first outpatient registry, now known as the PINNACLE Registry. The PINNACLE Registry was officially recognized by CMS as an eligible reporting mechanism, allowing the College to report Physician Quality Reporting System data to CMS on behalf of providers and practices choosing to do so.

"When we went into medicine we took the Hippocratic Oath, which states, 'If I keep the oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot,'"

ISSN 0735-1097/$36.00
https://doi.org/10.1016/j.jacc.2018.04.005

JACC VOL. 71, NO. 20, 2018
MAY 22, 2018:2373–5

wrote Ralph Brindis, MD, MPH, MACC, and colleagues in a January 2011 *JACC* President's Page. "We have the opportunity over the next several years to make an impact by producing outcomes-based quality assurance programs based on appropriate metrics and benchmarking, thus assuring compliance with this oath" (4).

In the last 5 years, the College has been focused on taking its quality improvement efforts even further. We have moved beyond developing measures and clinical documents to focusing on development of resources. Registry data have proven to be useful beyond just identifying trends and gaps in care. Data are increasingly used for research, performance improvement, and lifelong learning activities. Physician-level dashboards, like those associated with the CathPCI Registry, support quality improvement, volume tracking, and maintenance of certification activities, as well as overall outcomes reports that have evolved over time to incorporate appropriate use criteria-based metrics.

National quality campaigns and initiatives have also been taking advantage of NCDR data. The ACC's Anticoagulation Initiative was developed in response to the gaps in anticoagulation care identified by the PINNACLE Registry, whereas the Surviving MI Initiative leveraged the broad registry community to improve survival after myocardial infarction. Hospitals and health systems can also showcase their commitment to quality improvement by participating in the ACC's Find Your Heart a Home, a voluntary public reporting initiative. The Find Your Heart a Home website lets patients and/or their family and caregivers search, compare, and select the best hospital for their needs based on their participation in NCDR and public reporting.

"Over the last several years, the subject of how best to measure outcomes, improve care, and lower health care costs has engendered much debate and discussion in the health care community as well as among consumers, industry, and state and local lawmakers," wrote Patrick T. O'Gara, MD, MACC, John S. Rumsfeld, MD, FACC, and Frederick A. Masoudi, MD, FACC, in a June 2014 *JACC* President's Page. "An overarching strategic goal of the ACC is to be the preeminent source of cardiovascular clinical data that can help physicians and hospitals deliver high-quality and affordable patient care. The challenge lies in continuing to engage physicians, nurses, administrators, hospitals, and other stakeholders in the registry programs in a manner that ensures the highest level of data quality, broader use and interpretation of data reports, and ongoing commitments to improving the delivery of care" (5).

So, where are we today? Although we have made great strides in developing tools and resources to address quality improvement over the years, we are also at a place where increasing regulatory requirements and technological advances are placing significant administrative burdens on health care professionals, cardiology included. The Quality Payment Program, created under the Medicare Access and CHIP Reauthorization Act of 2015 is posing challenges as physicians, administrators, and others get up to speed on new and changing requirements. While electronic health records have become the norm, interoperability is still more of a concept than a reality. Prior authorization required by payers for some drugs and procedures is also proving overly onerous for health care professionals. These elements, coupled with the fact that we have more information than we know what to do with, are keeping cardiovascular professionals awake at night and leading to burnout.

"It's no wonder that we're burning out," Brush said during his James T. Dove Keynote at ACC's recent Annual Scientific Session in Orlando, where he questioned whether the thinking cardiologist is dead. "Even the quality movement has been distorted and has turned us into automatons, procedures have turned us into proceduralists, payers have turned us into commodities. The push for productivity values speed over quality, leaving little room for reflection and study" (6).

The College is committed to helping members make wise decisions and better choices that ultimately drive high-quality care, while being mindful of health care costs. We continue to find new, streamlined, and innovative ways to help move forward. Mobile applications like the Guidelines Clinical App, NCDR Clinical Quality Coach App, and the ASCVD Risk Estimator have been nationally recognized to help cardiovascular professionals easily apply guideline recommendations at the point of care. Shared decision-making tools also aim to help cardiovascular professionals and patients make informed decisions about their care and treatment options. A new national quality campaign to help hospitals reduce bleeding risk is launching this year.

But we have so much more planned! As we work to finalize the next Strategic Plan that will guide the College from 2019 to 2023, further defining a health care strategy will be a key component. Key to this will be creating solutions to help clinicians, hospitals, health systems, and institutions improve quality. Are there ways to leverage individual and institutional electronic health record and NCDR data to "personalize" approaches to quality improvement? How do

we make quality a more personal *and* institutional directive?

Two Board of Trustees task forces are hard at work looking at ways to answer these questions. The goal: to identify tools that will help members address administrative burdens and improve individual and system quality. Ultimately, we hope to create a suite of options that will engage both administrative leaders and clinical leaders in driving quality improvement within their respective practices, hospitals, and health systems.

The ACC's new vision calls for the creation of a world where innovation and knowledge optimize cardiovascular care and outcomes. Our core values, in part, call for us to hold ourselves and our profession to the highest standards of evidence and knowledge; constructively challenge the status quo through innovation; and promote a culture of continuous improvement and lifelong learning. We are no longer just a knowledge organization, but a place where individual and institutional members can find the resources and tools to drive higher quality. We are a knowledge and service organization, with the ultimate goal of providing the highest member value possible.

ADDRESS FOR CORRESPONDENCE: Dr. C. Michael Valentine, American College of Cardiology, 2400 N Street NW, Washington, DC 20037. E-mail: president@acc.org.

REFERENCES

1. Congress hears testimony on pay for performance. Cardiology Today. September 2006. Available at: https://www.healio.com/cardiology/news/print/cardiology-today/%7B90a43aec-9d85-4f94-a8f9-cf8c2c8c566d%7D/congress-hears-testimony-on-pay-for-performance. Accessed April 7, 2018.

2. Brush J, Krumholz H, Wright J, et al. American College of Cardiology 2006 principles to guide physician pay-for-performance programs. J Am Coll Cardiol 2006;48:2603–9.

3. Wolk M, Peterson E, Brindis R, Eagle K. President's page: the appropriate cardiologist: Responsible stewardship in a golden era of cardiology. J Am Coll Cardiol 2004;44:933–5.

4. Brindis R, Goldberg SD, Turco MA, Dean LS. President's page: quality and appropriateness of care: the response to allegations and actions needed by the cardiovascular professional. J Am Coll Cardiol 2011;57:111–3.

5. O'Gara P, Rumsfeld J, Masoudi F. President's page: letting data do the talking. J Am Coll Cardiol 2014;63:2429–31.

6. American College of Cardiology. Dove lecture examines how better reasoning can lead to higher quality. ACC Scientific Session Newspaper. March 11, 2018. Available at: http://www.acc.org/latest-in-cardiology/articles/2018/03/10/14/42/dove-lecture-examines-how-better-reasoning-can-lead-to-higher-quality-acc-2018. Accessed April 7, 2018.