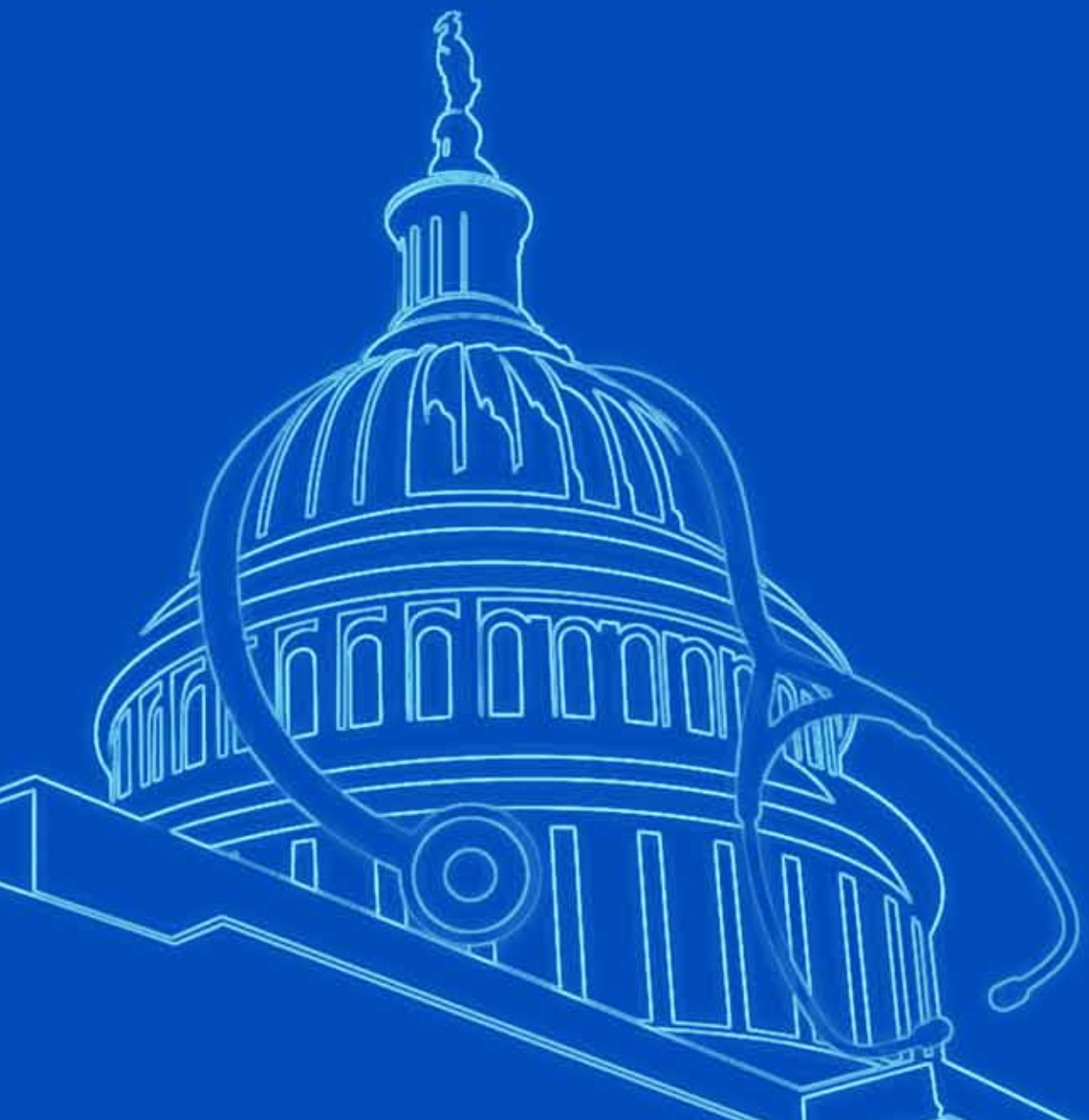
Quality First

Transforming Health Care from the Inside Out

The American College of Cardiology's Blueprint for Reform



Quality First:
The American College of Cardiology's Blueprint for Reform

Executive Summary

At its finest, U.S. health care is the best in the world, with tremendous advances made over the last several decades in the treatment and diagnosis of cancer, cardiovascular disease, stroke and other life-threatening diseases. However, all too often misalignments within the current health care system get in the way of high quality, cost-effective and continuous care. To this end, the American College of Cardiology (ACC) is taking a leading role in health care reform efforts by engaging patients, lawmakers, payers and others in the medical community around a new standard of health care delivery centered on increasing the quality of care and ensuring greater patient value.

Under the organizing principle of "Quality First," the ACC is encouraging health care providers to act on their professional responsibility to transform health care from the inside out. Physicians, nurses, and other health care professionals are on the front lines of care delivery and are ideally positioned to ferret out waste and unnecessary or inappropriate care to focus instead on improving quality of care and empowering patients.

With the health of patients and the future of medicine at stake, the ACC seeks through the following six principles to reform the current system into one that:

1. **Provides universal coverage;**
2. **Provides coverage through an expansion of public and private (pluralistic) programs;**
3. **Focuses on patient value — transparent, high quality, cost-effective, continuous care;**
4. **Emphasizes professionalism, the foundation of an effective partnership with empowered patients;**
5. **Ensures coordination across sources and sites of care; and**
6. **Includes payment reforms that reward quality and ensure value.**

While coverage and financing are extremely important, cardiovascular professionals can have the most impact on the last four principles, which focus on reforming delivery and payment systems to improve quality of care, reduce disparities and empower patients. In addition to the fundamental principles outlined above, a renewed focus on measurable health outcomes; reduction in legal and defensive medicine costs; promotion of basic and clinical research and clinical comparative effectiveness; and a focus on projected workforce needs must be part of any overall reform. The implementation and use of health information technology (IT) is also critical and should be embedded in the systematic practice of quality.

In striving to fulfill its mission of helping cardiovascular professionals provide high quality care, the ACC already addresses many of these issues. The ACC is a leader in creating clinical practice guidelines and criteria for the appropriate use of medical technology that are grounded in data collection and professional consensus. The ACC has invested millions in its quality infrastructure, including the nation's largest national cardiovascular data registry, which is operational in most of America's hospitals. From this work, it is clear the ACC can contribute much to the health care reform discussion. The College offers proven strategies and tools to reduce unnecessary spending and unjustified variations in care and promote systematic quality improvement.

Health care reform must be about the quality of care delivered — not the volume of care provided. As a profession, the medical community has a responsibility to provide care that is patient-centered, evidence-based and cost-effective. While it is not an easy task, it is one that is necessary for the future of health care in America. The ACC believes that carefully crafted partnerships between patients, the Centers for Medicare and Medicaid Services (CMS), Congress, the Obama administration and willing professional societies will achieve these results and expedite the progress needed.

Patient Value — Transparent, High Quality, Cost-effective, Continuous Care

In 1910, William Mayo, founder of the Mayo Clinic, said, "The best interest of the patient is the only interest to be considered." Nearly 100 years later, these words still ring true. One of the most important ways the physician community can influence change in the health care system is by partnering with patients to improve access, reduce disparities and ensure high quality, cost-effective care. This focus can and should be supported through the consistent use of evidence-based tools that deliver results, as well as the routine practice of robust data collection. Data collection should focus on key performance metrics applied to health care delivery surrounding not only patient outcomes but also structural and procedural measures of care and measures of the patient experience.

The ACC leads in the creation of patient value using an end-to-end systems approach to continuous quality improvement. This approach starts with the creation of evidence-based clinical treatment standards and criteria for the appropriate use of new technology. As early as the 1980s, the ACC partnered with the American Heart Association (AHA) to develop the first clinical practice guidelines that translate the best science into everyday practice. Today, the ACC continues its work with other specialty medicine societies and national organizations like the National Heart, Lung and Blood Institute (NHLBI) to develop and update more than 2,800 recommendations contained in 18 published guidelines. Funding for more research will enable even more progress here.

The ACC recognizes that quality is not only about under-use of guideline-recommended therapy but also involves over-use of services in patients who may not see a sufficient corresponding benefit to justify their use. Over the last few years, the ACC has added appropriate use criteria (AUC) to its toolbox to enable physicians to educate each other, outside stakeholders and patients on when and how often to perform diagnostic imaging exams and therapeutic procedures. To date, the College has published criteria for Single-Photon

Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI), Cardiac Computed Tomography (CCT) and Cardiac Magnetic Resonance (CMR) Imaging, Resting Transthoracic and Transesophageal Echocardiography (TTE/TEE), Stress Echocardiography and Coronary Revascularization.

The ACC's guidelines and AUC are critical resources that used more broadly could save millions of lives and billions of dollars. The ACC is working with lawmakers and payers on pilot programs to test the use of these decision-support tools at the point of care to facilitate appropriate tests and procedures, and to address unwarranted regional variations in care and resource utilization. The ACC's collaboration with United Healthcare to test implementation of Appropriate Use Criteria for SPECT MPI is an example of the types of efforts already underway.

Moving forward, the ACC would like to see these tools disseminated to practices and adopted by other medical specialties and primary care providers as a means of reducing disparities in care. To this end, the ACC is leading the Coalition to Reduce Racial & Ethnic Disparities in Outcomes (CREDO) in an effort to measurably reduce disparities in the management of cardiovascular disease. CREDO targets health care professionals responsible for cardiovascular care with education tailored to their needs. It also aims to integrate quality improvement measures like guidelines and AUC with educational efforts in order to close persisting performance gaps.

Applying care standards to increase patient value also requires data collection, reporting and evaluation. The ACC's National Cardiovascular Data Registry (NCDR®) is the nation's premiere recognized source for measuring and quantifying outcomes and identifying gaps in the delivery of quality care. The NCDR allows facilities to see how they stack up against their peers and gauge where there may be room for quality improvement. Participation in NCDR registries is also recognized by numerous states, private payers, CMS and quality groups for demonstrating quality for both reporting and pay-for-performance (P4P) purposes.

The ACC has developed five different registries since 1997 and is actively working with lawmakers, payers and other stakeholders to identify opportunities to take these registries to the next level and use them to facilitate participation in quality

ACC's Commitment to Patient Value

- Work in partnership with lawmakers and payers on pilot programs to test the use of decision support tools at the point of care
- Use practice-based registries to collect data, evaluate and report
- Identify opportunities to expand registries to
  - facilitate participation in quality-reporting initiatives
  - facilitate compliance with guidelines and appropriate use criteria
  - provide feedback on quality of care to physicians and practices
  - develop longitudinal registries that link process measures back to clinical outcomes
  - promote the use of a unique patient identifier in order to accomplish longitudinal registries and coordinate care
- Support the integration of health care technology, including a unique patient identifier that will allow complete interoperability among the various information systems currently in use
- Educate members on the importance of adopting an integrated electronic health record

reporting initiatives, ensure compliance with guidelines and AUC, and provide much-needed feedback on quality of care to physicians and practices. In addition, these are extremely valuable in advancing comparative effectiveness research and related data. Partnership with CMS on early efforts to expand the registries to the outpatient environment could accelerate achievement of the quality goals espoused by leading Congressional committees and members, as well as by the Obama administration. Such a partnership would facilitate payment reform and reduce unnecessary spending.

In addition, the ACC is educating its members on the importance of adopting and integrating health care technology in all aspects of patient care. The College also continues to develop decision support tools and other resources that support national and international interoperability efforts. The adoption of interoperable electronic health records (EHRs), electronic patient privacy policy, and immediate access to patient care information are critical to measuring quality, improving performance and increasing efficiency.

Professionalism, the Foundation of an Effective Partnership With Empowered Patients

The pathway to quality health care is through a revitalized patient-physician relationship. The patient plays the central role in a care team. Strategies and tools must be developed to empower patients and involve them in their care decisions and outcomes to the extent that they are able and choose to do so. Transparency and accountability – on the parts of both clinicians and patients – will provide the trust and active participation so necessary to effective health care.

In particular, cardiovascular professionals need to play a crucial role in improving the patient-physician relationship because of their wide-sweeping reach and high level of trust. Nearly three-fourths of Americans know someone affected by heart disease, and cardiologists are among the most trusted specialists, according to an independent survey conducted for the ACC in September 2008 by Luntz, Maslansky Strategic Research. For these reasons, the ACC has dubbed 2009 as the "Year of the Patient," during which the College is focused on better understanding the needs of patients, and reconfiguring the College's work towards a more patient-centered perspective in the future.

The patient theme will resonate throughout national and state activities not only in 2009, but as a long-term theme for the College. Educational programming is being developed to strengthen the patient-physician relationship. For example, the ACC's new competency-based, Web-enabled Learning Portfolio System, is designed to support members in meeting training, certification, re-certification, licensing and payer requirements. The portfolio links education and quality by documenting member improvements in knowledge, outcomes, performance, quality and patient care. By enabling life-long learning and self-assessment, the value of such a personalized system will become ever more apparent as regulatory agencies and payers call for documentation of physician competence and measurement of physician performance.

In addition to educating providers on ways to best involve patients, the ACC provides educational resources to help patients understand relevant disease processes, including the impact of lifestyle and behavior choices on disease progression. CardioSmart is a key

component of the ACC's patient education toolbox in that it provides information about cardiovascular diseases and new research and clinical documents in a way that is accessible to patients. Patients and physicians should have shared accountability for treatment plan implementation and outcomes based on mutual goals and expectations.

ACC's Commitment to Professionalism and Patient Empowerment

- Develop educational programming to strengthen the patient-physician relationship, including strengthening the Learning Portfolio
- Provide educational resources and referrals to assist patient understanding of disease processes and progression; address lifestyle and behavioral choices that affect disease state
- Expand CardioSmart to provide new patient empowerment tools, research and clinical content so that patients can better understand and manage their cardiovascular disease

Coordination Across Sources and Sites of Care

Effective communication and collaboration within and across care teams and care settings is an essential component of system transformation. Effective collaboration ensures that relevant clinical information is available at the point of care while duplicative tests and procedures are avoided.

The ACC believes that care management activities should exist on a continuum from patient self-management to specialty care management. The continuum moves through:

- Self Care: Patient is able to maintain an optimal level of health and well-being within natural boundaries and capabilities;
- Primary Care: Patient requires diagnostic and intervention services that promote health;
- Episodic Care: Patient requires health restorative services, which could be delivered in a myriad of care settings ranging from home to outpatient to inpatient levels of care;
- Specialty Care: Patient requires specialized diagnostic and intervention services that are temporarily beyond the capabilities of the patient and his/her primary care team.

Care management resources should be directed toward managing activities across sources and sites of care to ensure that the physician-guided, patient-centered treatment

ACC's Commitment to Coordination of Care

- Develop pilot programs to test implementation of care management processes for
  - chronic illness
  - reducing hospital readmissions in heart failure patients
  - acute myocardial infraction
- Promote the development of chronic disease models that facilitate coordination of patient-centered care by all members of the care team
- Promote the use of a unique patient identifier with proper privacy protection as an essential care-coordination tool
- Develop prevention pilot programs that can be used at the community level or by primary or specialty care physicians to prevent and/or facilitate early detection of disease

plan is occurring as agreed and adapted as needed. Care management resources should also handle the referral process, including appropriate use decisions and evaluation of outcomes. Care management roles and responsibilities should be clearly identified and delineated across multidisciplinary teams; full-time equivalents could be shared among practices. Care management for a given patient may very well be managed best by the physician providing the majority of the care.

The ACC is developing pilot programs designed to test implementation of care management processes. One such program, currently under development, would work with hospitals and practices on the transition of patients from the hospital to "home" with the goal of reducing unwarranted readmissions for heart failure patients. This new initiative will address the complex challenge of creating a coordinated health care team across the settings of care in order to provide reliable, safe and health-enhancing transitions for patients. Studies have shown substantial opportunities to improve early rehospitalization rates, particularly for patients hospitalized with cardiovascular conditions, such as heart failure and acute myocardial infarction.

Payment Reforms That Reward Quality and Ensure Value

Current public and private payment systems do little to reward or facilitate quality or coordination of care. In fact, the incentives are often perverse. The current Sustainable Growth Rate (SGR) formula used to determine annual updates to Medicare physician payment devalues the patient-physician relationship because it is driven by volume and episodic care without regard to improved quality, better patient outcomes or patient satisfaction. This misalignment of incentives stifles innovation, limits communication and creates hurdles to the practice of quality care.

Provider payment systems must be redesigned with the patient's interests in mind. They must reward patient value — high quality, cost-effective care. The ACC supports payment reforms for improved coordination of care, team-based care delivery, and the appropriate use of tests and procedures. There should be disincentives for care providers — and patients themselves — who over- or under-use tests and technologies. It should also provide rewards and incentives for care providers who achieve high levels of quality and improvement outcomes.

Over the long term, compensation models should enable the transition to new models of care delivery — for example: the patient-centered medical home. In accomplishing these transitions, physicians will incur costs for their investments in health IT, hiring and training support personnel for outreach activities, establishing multidisciplinary teams and implementing other practice design changes. A reformed system should support or provide incentives (a "business case") for such infrastructure costs. In addition, a significant portion of savings achieved through gains in efficiency and reductions in inappropriate care should be reinvested in system improvements.

In general, the ACC supports the establishment of a public-private body for making coverage and payment decisions (i.e., resource allocation) on the basis of clinical outcomes data, medical literature and possibly comparative effectiveness research. This body should be independent from special interests and political pressure and from the entities directing and performing the comparative effectiveness research itself. In addition, methodologies for determining payments should be straightforward and transparent, and physicians should have a key role in designing and maintaining those methodologies.

The ACC believes that physicians who use validated clinical decision support tools at the point of care, adhere to clinical guidelines, report valid performance data on clinical processes and outcomes, and receive timely feedback on their performance will achieve meaningful quality improvement and cost reductions. However, a business case is needed to support the costly and difficult investments and changes in practice workflow that such goals will require. The College is eager to work collaboratively with all willing stakeholders — Medicare, private payers, Congress, patients and others — to demonstrate the value of this model and to test different payment methodologies, including bundling, capitation and enhanced incentives, that could encourage adoption of an improved system.

Various pilots at the state and national level over the next one to two years could contribute significantly toward a better understanding of what types of incentives are needed for improved care coordination, as well as what various-sized practices might need in terms of health IT and workflow redesign to ensure all patients are receiving the quality of care they deserve. The ACC has drafted legislation that would provide practices with a financial incentive for participation in Medicare's Physician Quality Reporting Initiative (PQRI) and a certified patient registry, as well as using health IT and adhering to clinical guidelines.

The ACC's Blueprint for Reform is a continuous work in progress in such a dynamic environment. It is fair to say, however, that the principles described here are all essential to developing a reformed system that can solve the access, quality and cost dilemmas we face today.

As health care reform proceeds—hopefully more successfully this time around—the ACC believes medical profession engagement is an essential aspect of actually reforming the delivery and payment system, encouraging meaningful use of health IT and empowering patients. These are all elements necessary for a genuine and coordinated health care system. The ACC stands ready to be accountable and to lead in this process.

ACC's Commitment to Payment Reforms

- Work collaboratively with willing stakeholders — Medicare, private payers, Congress, patients, etc. — to test and demonstrate the value of various payment reform models such as:
  - bundling
  - capitation
  - enhanced incentives
  - modified fee-for-service
- Understand various incentives needed to improve care coordination through participation in state and national pilots
- Develop pilot incentive programs aimed at improving quality and reducing costs such as:
  - reducing hospital readmissions in heart failure patients
  - reducing inappropriate use of cardiac imaging services
  - facilitating health IT adoption and e-prescribing
  - facilitate medication reconciliation, as well as adherence and compliance