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Title: Executive Summary: Cardiovascular Practice Recognition Program

Sponsor: The American College of Cardiology

Partners: Bridges to Excellence

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AMERICAN COLLEGE OF CARDIOLOGY CARDIOVASCULAR PRACTICE RECOGNITION PROGRAM

The American College of Cardiology's (ACC) Cardiovascular Practice Recognition Program (CVRP) is a practice-level recognition program designed specifically to identify quality in cardiovascular practice. As our healthcare system evolves from one based on volume to one based on value, practices will need a mechanism to show their commitment to continuous quality improvement and their achievement of quality thresholds.

The ACC offers the CVRP as a tool for cardiovascular practitioners and healthcare purchasers, including consumers, to understand and evaluate quality cardiovascular care. The CVRP is designed to:

- Establish relevant goals and targets for cardiovascular specialists and their practices to achieve;
- Provide a road map to guide performance improvement and practice transformation strategies;
- Bring consistency to market by standardizing the methodology for how cardiovascular practices are assessed and recognized.

Background

The current practice environment is changing rapidly for ACC members. Health plans are motivated to develop health insurance products in response to pressure from employers and purchasers to improve quality and moderate costs. To this end, many payers are developing mechanisms to identify quality physicians through specialty designation programs or tiered networks. Often, the criteria for assessing physicians are "proxies" for quality due to the use of administrative claims data and the absence of other meaningful metrics. Such approaches threaten the viability of private and hospital-based practices unless they have the information and tools required to demonstrate that they practice in a patient-centered, quality-driven, cost-efficient manner. To allow the profession rather than external forces to influence this process of performance assessment, the ACC was compelled to develop a cardiovascular practice recognition program.

The ACC has a strong history of advocating for quality and is recognized as a leader in the development of clinical guidelines, appropriate use criteria, and performance measures. The ACC is committed to the development of policies and programs that support and enhance professionalism while implementing strategies that promote and foster practice innovation.

Over the years, the College has been actively engaged in the pay-for-performance arena. This experience has provided the ACC with the ability to identify indicators and criteria for a performance assessment and recognition program that can provide a foundation for continuous quality improvement while retaining the flexibility to change over time as new data, methodologies, and technology become available. This program is important because it demonstrates the ACC's commitment to quality as it aims to raise performance for all members, and assists them in the achievement of quality in cardiovascular practice.

Guiding Principles

The CVRP is consistent with our *2006 Principles to Guide Physician Pay-for-Performance Programs* and our *2008 Health Policy Statement on Principles for Public Reporting of Physician Performance Data*:

Promote quality improvement: A well-designed public reporting program should be aimed at raising the performance of all providers and thereby increasing access to high-quality cardiovascular care for everyone.

Use performance measures with scientific validity: Clinical performance measures must have gone through a recognized development and endorsement process and have been approved for use in the CVRP by the ACC Clinical Quality Committee to ensure that they are clinically relevant. For example, all clinical process measures included in CVRP v1.0 are used as developed and specified by the ACC and the American Heart Association (AHA) in collaboration with the American Medical Association's Physician Consortium for Performance Improvement (PCPI).

Reporting occurs at the appropriate level of accountability: CVRP assessment, recognition, and reporting will occur at the practice level; all individual physicians within the practice are included in the practice assessment.

In addition,

- ACC resources will be leveraged in CVRP implementation, including but not limited to the IC³ (Improving Continuous Cardiac Care) Program, the National Cardiovascular Data Registry (NCDR), the Learning Management System, CardioSource, etc.
- Performance assessment and audit are performed by an objective, third-party performance assessor
- Achievement of recognition status is publicly reported
- Criteria and scoring methodology associated with levels of recognition are transparent
- Individual practice data will be supplied back to practices in a timely manner to encourage performance improvement.

Assumptions

The CVRP is intended as an evolving program that will change over time to encourage innovation, stimulate improvement, and raise the bar for quality cardiovascular care. The first version of the program is designed to set a baseline and gain acceptance from practitioners and purchasers in year one. Subsequent versions will include additional metrics as they become available. A systematic review of the program will occur at least annually.

The College understands the associated risks inherent this endeavor. First, potential alienation and disillusionment of certain segments of the membership is possible. We firmly believe that it is the role of the College to define quality cardiovascular care. We have a responsibility to our members and to the public to characterize quality cardiovascular care and to determine acceptable levels of performance.

Next, we risk being perceived by government and commercial payers as developing a self-serving program. The ACC strongly believes that a critical element of the health system transformation process is an increased level of physician professionalism and stewardship. This program is intended to foster these characteristics in ways that are meaningful and actionable to all cardiovascular practices. Therefore, the CVRP must be developed with consideration of physicians practicing in a variety of settings and practice sizes. All practices should have the reasonable ability to participate in year one. As the program evolves, practices will be expected to set new goals and achieve improved levels of performance on a continuous basis.

Rationale

The ACC recognizes a significant opportunity to lead the performance assessment process by collaborating with payers to implement valid and meaningful practice recognition programs. Through the CVRP, the College can influence the assessment activities that impact our members.

Health plan acceptance and implementation of this program will enhance collaboration among physicians and health plans. Currently, the programs being utilized by health plans are not actively supported by physicians, are flawed methodologically, and are inconsistent across regions and across the country. The administrative burden on a practice to meet multiple demands from multiple payers and reconcile inaccurate “physician report cards” interferes with a practice’s ability to provide efficient and effective care. Implementation of the CVRP may help practices and plans allocate resources appropriately to the delivery of accessible and affordable health care. We anticipate that true partnerships for system transformation will begin to occur.

The CVRP is intended to support the four cornerstones of Value-Driven Health Care established by the Department of Health and Human Services by promoting the adoption of health information technology, measuring and sharing quality information, improving efficiency, and promoting the use of incentives to support ongoing quality improvements.

Environmental Scan

The American College of Physicians, with the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association have developed a recognition program with the National Committee for Quality Assurance (NCQA) for the purpose of designating and reimbursing practices that achieve established thresholds for the patient-centered medical home (PCMH). Public and private payers are considering payment models that provide additional payments per visit or per patient per month for recognized practices. <http://www.ncqa.org/tabid/631/Default.aspx>

The Society for Thoracic Surgeons is working to combine multiple NQF-endorsed measures into an overall Coronary Artery Bypass Graft (CABG) composite quality score and using those scores to rate providers.¹

The Centers for Medicare and Medicaid Services has implemented a physician quality reporting system with payment incentives for voluntary participation. The Physician Quality Reporting Initiative (PQRI) provides a bonus payment of 2% of total allowed charges for covered services

¹ O'Brien et al Quality Measurement In Adult Cardiac Surgery Statistics In Measure Scoring/Provider Rating Annals of Thoracic Surgery. 2007;83:S13–26.

payable under the Medicare Physician Fee Schedule. To be eligible for the incentive payment, an eligible professional must report on at least three quality measures. For each of the three measures, reporting must occur on at least 80 percent of the cases for which that measure is reportable.

Most health plan pay-for-performance programs are targeted to primary care providers. Specialists are typically rewarded with designation in a tiered network or with one or two stars indicating high levels of quality and efficiency, respectively.

Oversight

Work on the CVRP began in June 2007 under the direction of the Performance Assessment, Recognition, Reward, and Reporting Task Force. The task force and the CVRP work group were formed to ensure collaboration with cardiology subspecialty societies in the development and implementation of value-based purchasing initiatives and products within the College. In 2009, the Partners in Quality and Quality Projects and Programs Subcommittees of the Clinical Quality Committee provide oversight and direction for the CVRP work group.

Development Process:

Phase 1: July 2007-June 2008

- ***Develop framework***

Four domains were identified within which to organize the criteria for practice recognition:

1. Commitment to Quality
2. Commitment to Professionalism
3. Commitment to Lifelong Learning
4. Commitment to Patient-Centered Care

- ***Draft content***

Within each domain, we identified and vetted indicators of quality to further organize the elements for practice recognition. Criteria for ascertaining that a practice successfully achieves a particular quality indicator were developed and vetted. Some criteria have thresholds to ensure that the bar is high enough to be meaningful. Thresholds and targets for each indicator are expected to stretch and challenge with each update as data, methodologies, and technology become available.

- ***Identify and implement processes and opportunities to seek stakeholder input***

At key points in the drafting process, feedback from stakeholder committees and boards within the College was sought and incorporated. In addition, payers, purchasers and others were brought into the process to ensure broad perspectives and programmatic integrity. In an effort to ensure transparency and gain acceptance among the membership, ACC presented the CVRP via an interactive webinar on May 14, 2008 for members and held a 30-day public comment period.

- ***Revise content to incorporate feedback from members and stakeholders***

- **Obtain support for CVRP from members and stakeholders**
Members agreed to support the CVRP if practices are able to demonstrate quality through a single program and if incentives to participate are meaningful and include reduced administrative burdens such as waiver of pre-authorization.

Health plans agreed they could adopt the CVRP if the program is transparent, reportable, and auditable and if there is a clear timeline for raising the bar and including robust performance, outcomes, and efficiency measures over the next 2-3 years.

Employers expressed enthusiasm for a standardized methodology to identify quality because of the conflicting messages to employers and consumers when a physician/practice meets the quality standards for one payer and not another.

Phase 2: July 2008-June 2009

- **Identify partner to serve as third-party administrator**
 Bridges to Excellence enthusiastically agreed to collaborate with the ACC. Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and are committed to the delivery of safe, timely, effective, efficient, equitable and patient-centered care.
- **Determine roadmap for including robust performance, outcomes, and efficiency measures**
 Given that the science of quality measurement is still in its early stages, assessing physician performance is particularly challenging. Our policy is to use measures that have been through a recognized development and endorsement process. Clinical process measures for Coronary Artery Disease, Heart Failure, and Hypertension are available; however the PCPI is currently revising these measures with the expectation that intermediate patient outcomes and functional status measures will be incorporated. Efficiency measures are also under development by other organizations. Therefore, the timeline for including measures of interest to stakeholders is:

2009	CVRP v1.0	Process measures
2010	CVRP v2.0	Intermediate patient outcome measures Functional status measures
2011	CVRP v3.0	Efficiency measures

- **Refine, weigh, and score program elements**
 With Bridges to Excellence, we refined the program by sorting the indicators within the four domains into three categories: structural elements, professional elements, and clinical process measures. Candidate indicators were graded on their relative impact across the Institute of Medicine’s six national quality aims: safety, timeliness, effectiveness, efficiency, equity, and patient-centered (STEEEP). Weights were assigned to each indicator using the Delphi process.

For pilot testing, the indicators were scored using a 100-point scale with clinical measures worth 50 points, structural elements worth 30 points, and professional elements worth 20 points.

Scoring calculation strategies include:

- **Dichotomous:** Measure score is determined by the ability to meet or exceed the measure criteria; “All or none” point distribution; no partial credit. Recognizes achievement to goal only.
- **Continuous:** Measure score is a function of the applicant’s performance on individual measures; incremental point distribution; partial credit allowed. Recognizes actual achievement.
- **Graded:** Measure score is determined by ability to meet different measure criteria levels; graded points distribution; partial credit allowed. Recognizes different grades of achievement.

Scoring calculation strategies, measure thresholds, and levels of recognition will be determined during the analysis phase of the pilot. Data may be analyzed using more than one method, with the final method to be determined upon pilot completion.

- **Produce CVRP version 1 for pilot-ready implementation in 3/4Q 09**
A table describing the elements and measures included in the CVRP is provided in Appendix A. Hyperlinks to relevant websites are included in that table as well.
- **Identify elements for inclusion in CVRP v2.0**
For version 2, the clinical measures will have increased weight while the structural and professional elements will have reduced weights as more meaningful clinical process and intermediate outcome measures become available. Additional measures planned for inclusion are listed in the table below.

Structural Elements	Active Participation in the NCDR IC ³ Registry
Professional Elements	Cardiovascular Subspecialty Certification: Heart Failure Certification Completion of Echo Appropriate Use Performance Improvement Module (PIM) Completion of SPECT-MPI Appropriate Use PIM
Clinical Measures	Hypertension: Blood Pressure Control CAD: Blood Pressure Control CAD: LDL Control CAD: Functional Status HF: Functional Status

Phase 3: July 2009-June 2010

- ***Create user interface for data collection and submission***

CECity.com is creating the CVRP tool that users will access via the ACC Lifetime Portal. Methods for data submission of those CVRP measures captured in the IC³ Registry are being explored to ensure alignment with the IC³ Program and avoid redundancy of data submission for practices already participating in the IC³ Program.

- ***Conduct and complete pilot***

ACC members will be notified about the pilot through a variety of College communication vehicles. Interested practices will be asked to complete and submit a practice profile. Practices will be selected to participate in the pilot with the goal of ensuring that the pilot sample is representative of a variety of cardiology practices today: small, medium, large, urban, rural, academic, hospital-based, private, with and without electronic medical records, etc. The target number of practices in the pilot is twenty, with the expectation that approximately 250 cardiologists will be represented in those 20 practices.

Practices will enter data required to satisfy assessment requirements. Practice results will be analyzed to apply scoring strategies, determine thresholds, and assign levels of recognition. Program revisions will be made as needed. All program revisions and processes (scoring, thresholds, levels of recognition, and audit methodologies) will be vetted among ACC leaders and members and payer and purchaser stakeholders.

- ***Establish incentives for practices to participate in the CVRP***

The CVRP is designed so that the individuals within the participating practices will be eligible for CME and receive credit toward Part IV, Maintenance of Certification requirements.

A strategy document, including value proposition and business case, will be developed and discussed with payers and purchasers in order to clearly identify incentives for participation in the CVRP. Payer rewards for CVRP achievement could include:

- Compensation incentives based on fee schedule differentials or per practice per month payments
- Other alternative financial incentives
- Waiver of prior-authorization requirements
- Other alternative reductions in administrative burden

- ***Draft operations manual***

Bridges to Excellence and ACC staff are collaborating to draft a CVRP Policies and Procedures Manual to document the structure, process, and outcomes of the program.

- ***Confirm value proposition and Launch***

Appendix A

ACC Cardiovascular Practice Recognition Program version 1.0: 2009

Structural Elements	2009 Criteria	Points
S1. Non-Invasive Diagnostic Imaging Lab Accreditation http://www.intersocietal.org/intersocietal.htm http://www.acr.org/accreditation.aspx	All individuals in practice perform nuclear and echocardiographic procedures in labs accredited or in process for accreditation by IAC or ACR (hospital-based labs excluded). For those labs in process of accreditation by IAC, accreditation must be achieved within 18 months of application.	5
S2. CMS Physician Quality Reporting Initiative (PQRI) www.cms.hhs.gov/PQRI	Any individuals in practice successfully participate in PQRI between July 2007 and December 2008.	3
S3. Active Participation in PCI Registry https://www.accncdr.com/webncdr/DefaultCathPCI.aspx	At least 50% of the PCI cases performed by each individual operator within the practice are reported to a recognized PCI data registry, such as the NCDR, for the purpose of benchmarking outcomes against current national norms. The data registry should track clinical and procedural information and patient outcomes for individual operators and the institution. Individual operators within the practice demonstrate active engagement in data quality review for quality improvement purposes at least annually.	4
S4. Active Participation in ICD Registry https://www.accncdr.com/webncdr/ICD/Default.aspx	At least 50% of the ICD cases performed by each individual operator within the practice are reported to a recognized ICD data registry, such as the NCDR, for the purpose of benchmarking outcomes against current national norms. The data registry should track clinical and procedural information and patient outcomes for individual operators and the institution. Individual operators within the practice demonstrate active engagement in data quality review for quality improvement purposes at least annually.	4
S5. HIT: Use of CCHIT-approved EMR www.chhit.org	Practice documents use of CCHIT-approved EMR	4
S6. Patient Safety: E-Prescribing http://www.cms.hhs.gov/EPrescribing/	Practice documents implementation of Medicare Part D E-prescribing standards released by CMS in April 2008.	5
S7. Patient Satisfaction: Survey of Patient Experience	Practice documents the use of a standardized method for collecting, reviewing, and using patient experience data.	5
Total Structural Points Available		30

Professional Elements	2009 Criteria	Points
P1. CV Board (ABIM or ABP) Certification http://www.abim.org/certification/policies/imss/card.aspx https://www.abp.org/ABPWebSite/	At least 90% of cardiologists in practice hold current ABIM Cardiovascular Disease Board Certification or ABP Pediatric Cardiology Board Certification. This includes those within 3 years of fellowship have completed necessary training and experience and have applied for Board Certification.	4
P2. CV Subspecialty Board (ABIM) Certification: EP http://www.abim.org/certification/policies/imss/ccep.aspx	At least 50% of electrophysiologists in practice hold current ABIM Subspecialty Board Certification in Clinical Cardiac Electrophysiology.	3
P3. CV Subspecialty Board (ABIM) Certification: Intervention http://www.abim.org/certification/policies/imss/icard.aspx	At least 50% of interventionalists in practice hold current ABIM Subspecialty Board Certification in Interventional Cardiology.	3
P4. Maintenance of Board Certification http://www.abim.org/moc/policies.aspx https://www.abp.org/ABPWebSite/	All cardiologists in practice holding time-limited certificates from ABIM and ABP are participating in Maintenance of Certification.	3
P5. FACC or FAHA Designation	At least 80% of cardiologists in practice hold FACC or FAHA designation	2
P6. Cardiovascular Subspecialty Designation	Up to 50% of sub-specialists in practice hold fellowship designation in up to two cardiovascular subspecialty organizations.	1
P7. Cardiovascular Subspecialty Certification:		1
Certification Board of Nuclear Cardiology (CBNC) http://www.cbnc.org/	At least 50% of nuclear cardiologists in practice are Diplomates of the Certification Board of Nuclear Cardiology	
International Board of Heart Rhythm Examiners (IBHRE) www.ibhre.org	At least 50% of electrophysiologists in practice who do not hold CV Subspecialty Board Certification in Electrophysiology are Certified Cardiac Rhythm Device Specialist (CCDS)	
Certification Board of Cardiovascular Computed Tomography (CBCCT) http://www.cbccct.org/index.cfm	At least 50% of cardiologists performing CCT in practice are Diplomates of the Certification Board of Cardiovascular Computed Tomography	
National Board of Echocardiography (NBE) http://www.echoboards.org/	At least 50% of cardiologists in practice providing echocardiographic services are certified by the National Board of Echocardiography in all modalities performed by the provider (trans-thoracic, stress, and trans-esophageal).	
P8. Documentation of Continuing Medical Education	At least 80% of cardiologists in practice have documented 100 Category CME hours with at least ½ in CV disease in prior 2 years	3
P9. Participation in Interactive Educational Activities	At least 80% of cardiologists in practice are actively engaged in educational activities that focus on quality improvement, such as the ACCF Learning Portfolio or the HRS e-Learning Platform	0
Total Professional Points		20

Clinical Process Measures <i>(as developed and specified by ACC/AHA/PCPI)</i>	2009 Criteria	Points
HTN1: Blood Pressure Screening	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension with blood pressure measurement recorded.	4
HTN2: Plan of Care	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg, with documented plan of care for hypertension.	1
CAD1: Lipid Profile	Percentage of patients aged 18 years and older with a diagnosis of CAD receiving at least one lipid profile during the measurement period.	5
CAD2: Symptom and Activity Assessment	Percentage of patients aged 18 years and older with a diagnosis of CAD who were evaluated for both level of activity and anginal symptoms during one or more office visits.	0
CAD3: CAD w/DM or LVSD: ACE / ARB Therapy	Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes and/or LVSD who were prescribed ACE inhibitor or ARB therapy.	5
CAD4: Antiplatelet Therapy	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed antiplatelet therapy.	5
CAD5: Drug therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)	5
CAD6: CAD w/ prior MI: Beta Blocker Therapy	Percentage of patients aged 118 years and older with a diagnosis of CAD and with prior MI at any time who were prescribed beta-blocker therapy	5
HF1: Assessment of Activity Level	Percentage of patient visits for patients aged 18 years and older with a diagnosis of HF with assessment of activity level.	0
HF2: Assessment of Clinical Symptoms of Volume Overload	Percentage of patient visits for patients aged 18 years and older with a diagnosis of HF with assessment of clinical symptoms of volume overload (excess).	0
HF3: Left Ventricular Function Assessment	Percentage of patients aged 18 years and older with a diagnosis of HF who have quantitative or qualitative results of left ventricular function (LVF) assessment recorded.	4
HF4: ACE / ARB Therapy	Percentage of patients aged 18 years and older with a diagnosis of HF who also have left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy.	5
HF5: Beta-Blocker Therapy	Percentage of patients aged 18 years and older with a diagnosis of HF who also have LVSD who were prescribed beta-blocker therapy.	5
HF6: Weight Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of HF who had weight measurement recorded.	3
HF7: Patient Education	Percentage of patients aged 18 years and older with a diagnosis of HF who were provided with patient education on disease management and health behavior changes during one or more visits.	3
AF1: Monthly INR Measurement for Patients on Warfarin	Percentage of calendar months during the reporting period during which patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter, receiving warfarin therapy, have at least one INR measurement made.	0
Total Clinical Points		50