

AMERICAN COLLEGE OF CARDIOLOGY CARDIOVASCULAR PRACTICE RECOGNITION PROGRAM (CVRP)

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 the value-based approach to health care delivery continues to evolve, it is important to identify cardiovascular practices that demonstrate a commitment to the delivery of quality care while providing clear direction about opportunities for improvement for practices that may not.

The ACC offers the CVRP as a tool for cardiovascular practitioners and healthcare purchasers to understand and evaluate quality cardiovascular care. First and foremost, the CVRP provides legitimate criteria for cardiovascular specialists and their practices to achieve in their professional development, clinical processes and operational infrastructure. Next, the CVRP provides a road map to guide performance improvement and practice transformation strategies. Last, the CVRP brings consistency to market by standardizing the methodology for how cardiovascular practices are assessed and recognized.

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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 recognition 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 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 is 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, appropriateness criteria, and performance measures. The ACC is committed to the development of policies 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 criterion 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 data, methodologies, and technology become available. It is important to do this so that

the ACC demonstrates a commitment to quality, to raising the bar for all members, and assisting them in the achievement of quality in practice.

The guiding principles and key characteristics of a CVRP are consistent with ACC health policy statements on pay for performance and public reporting:

Quality Improvement

- The driving force behind physician performance measurement and reporting systems should be to promote quality improvement.
- Set targets for performance through national consensus process.

Sustainable Business Case

- Create business case for investing in structure, best practice, and tools that can lead to improvements in the quality of care.
- Avoid the creation of perverse incentives.

Transparency

- Establish transparent provider rating methods.
- Assign attribution of credit for performance to physician in ways that are credible and encourage collaboration.
- Reward process improvement and sustained high performance.

Best Practice Models

- Utilize evidence-based tools that deliver results.
- Adopt new technologies that aid in process improvements.
- Implement care management process for patients with chronic illness.
- Establish and maintain effective communications and collaborative behaviors and methods within and across care teams and care settings.

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 or more specific elements. 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 likely. 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 in consideration of physicians practicing in a wide array of settings. 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, inconsistent across regions and the country, and do not build trust and collaboration. The administrative burden on a practice to meet multiple demands from multiple payers and refute inaccurate “physician report cards” diminishes 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. True partnerships for system transformation may 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.

The Development Process

The ACC is collaborating with cardiology subspecialty societies to develop the framework of the CVRP. The intent is to provide a menu of quality indicators that can be tailored to a variety of cardiovascular practice settings. We have identified four domains of quality practice and provided indicators and criterion within each domain from which practices can choose to achieve recognition. Practices are not expected to meet every indicator.

The ACC will seek feedback from its members-at-large to ensure transparency and gain acceptance among the membership. In addition, payers, purchasers and others are being brought into the process to ensure broad perspectives and programmatic integrity.

First, four domains were identified within which to organize the criteria for practice recognition. The domains for the first version of the CVRP for implementation in 2009 are:

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

Possible domains to be included in future versions of the CVRP could be related to efficiency, outcomes, and achievement of benchmarked performance thresholds.

Second, within each domain, we identified and vetted indicators of quality to further organize the criteria for practice recognition. These are listed below; brief descriptions of some of the programs included in the CVRP are provided in Appendix A. In addition, hyperlinks to relevant websites are included in the CVRP table on pages 5 and 6 of this document.

Commitment to Quality

1. IAC or ACR Diagnostic Imaging Laboratory Accreditation
2. NCQA Physician Practice Connections Recognition
3. CMS Physician Quality Reporting Initiative (PQRI)
4. Participation in ABIM or ABP Maintenance of Board Certification
5. PCPI/ACC/AHA Performance Measure Implementation
6. Active Participation in a Recognized PCI Data Registry
7. Active Participation in a Recognized ICD Data Registry

Commitment to Professionalism

1. Current ABIM Cardiovascular Disease Board certification or Current ABP Pediatric Cardiology Board Certification
2. Cardiovascular Subspecialty Board Certification (ABIM): Clinical Cardiac Electrophysiology
3. Cardiovascular Subspecialty Board Certification (ABIM): Interventional Cardiology
4. F.A.C.C. or F.A.H.A. Designation
5. Fellowship in Cardiovascular Subspecialty Designation
6. Cardiovascular Subspecialty Certification:
 - Diplomate of the Certification Board of Nuclear Cardiology
 - Certified Cardiac Rhythm Device Specialist
 - Diplomate of the Certification Board of Cardiovascular Computed Tomography
 - NB.....Information regarding the National Board of Echocardiography is pending

Commitment to Lifelong Learning

1. Documentation of Continuing Medical Education
2. Participation in Interactive Educational Activities

Commitment to Patient-Centered Care

1. HIT: Use of CCHIT approved EMR
2. Patient Safety: E-Prescribing
3. Team-Based Care: Heart Failure Management Program
4. Team-Based Care: Anticoagulation Management Program
5. Team-Based Care: Device Management Program
6. Survey of Patient Experience

Third, criterion 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 criterion are expected

to stretch and challenge with each update as data, methodologies, and technology become available.

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ACC Cardiovascular Practice Recognition Program version 1.0: 2009

Commitment to Quality	2009 Criteria	Points
Q1. Non-Invasive Diagnostic Imaging Lab Accreditation http://www.intersocietal.org/intersocietal.htm http://www.acr.org/accreditation.aspx	All individuals in practice perform tests and procedures in labs accredited or pending accreditation by IAC or ACR (hospital-based labs excluded) All individuals in practice perform tests and procedures in hospital-based labs accredited or pending accreditation by IAC or ACR	Bonus in version 1.0
Q2. NCQA Physician Practice Connections PPC (2006) http://www.ncqa.org/tabid/141/Default.aspx	Active Recognition	
Q3. CMS Physician Quality Reporting Initiative (PQRI) www.cms.hhs.gov/PQRI	Any individuals in practice participate in PQRI between July 2007 and December 2008	
Q4. 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.	
Q5. PCPI/ACC/AHA Measure Implementation http://www.improvingcardiacare.org/Pages/default.aspx www.cms.hhs.gov/PQRI	Participation NCDR IC ³ and engagement in <i>data quality review (DQR)</i> for quality improvement (QI) Practice submits Cat II codes to health plans per PQRI technical specifications and reporting thresholds for 2008 Measures 5, 6, 7, 8, and 118: <ul style="list-style-type: none"> • HF with LVSD on ACE / ARB therapy • CAD on antiplatelet therapy • CAD post MI on Beta Blocker therapy • HF with LVSD on Beta Blocker therapy • CAD with LVSD and/or diabetes on ACE/ ARB therapy 	
Q6. 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.	
Q7. 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.	

Commitment to Professionalism	2009 Criteria	
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 who have completed necessary training and experience and have applied for Board Certification.	
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.	
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.	
P4. FACC or FAHA Designation	At least 80% of cardiologists in practice hold FACC or FAHA designation	Bonus
P5. Cardiovascular Subspecialty Designation	Up to 50% of sub-specialists in practice hold fellowship designation in up to two cardiovascular subspecialty organizations.	Bonus
P6. Cardiovascular Subspecialty Certification:		
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.cbct.org/index.cfm	At least 50% of cardiologists performing CCT in practice are Diplomates of the Certification Board of Cardiovascular Computed Tomography	
Commitment to Lifelong Learning	2009 Criteria	
L1. 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	
L2. 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	
Commitment to Patient-Centered Care	2009 Criteria	
PC1. HIT: Use of CCHIT-approved EMR www.chhit.org	Practice documents use of CCHIT-approved EMR	
PC2. Patient Safety: E-Prescribing http://www.cms.hhs.gov/EPrescribing/ http://www.acc.org/practicemgt/HealthCareTechnology/e_prescribing.htm	Practice documents implementation of Medicare Part D E-prescribing standards released by CMS in April 2008.	
PC3. Team-Based Care: Heart Failure Management Program	Practice provides a multidisciplinary care process that aims to manage activities across sources and sites of care to ensure that the physician-guided, patient-centered treatment plan is occurring as agreed and adapted as needed. Practice measures and reports Program effectiveness at least annually. NB....We will identify at least three metrics per program for final version.	
PC4. Team-Based Care: Anticoagulation Management Program		
PC5. Team-Based Care: Device Management Program		
PC6. Survey of Patient Experience	Practice documents the use of a standardized method for collecting, reviewing, and using patient experience data.	

Next Steps

1. Assign points to each of the criterion within each domain using a Delphi process. Each domain will be worth a certain number of points to comprise a total score. Practices will then be designated as “recognized” or “not recognized” based on achieving an established threshold. PAR⁴ will determine appropriate subject matter experts to guide the Delphi process.
2. Payers are clearly interested in an ACC “branded” CV Practice Recognition Program. PAR⁴ will recommend options for partnering with a “recognition agent”, such as NCQA.
3. Implement Member Communication Plan:
 - May 14: Webinar for members
 - May 15- June 15, 2008: 30-day member comment period; mechanism TBD
 - June 15- July 15, 2008: PAR⁴ incorporates feedback from members and produces final current draft for key committee approval and subsequent BOT approval during August meeting.
4. Implement Health Plan and other Stakeholder Communication Plan
 - June 17: Present to AHIP Leadership
 - June 24: MDI Strategy Roundtable
5. Determine most rational approach to implementation. Need to move cautiously to avoid launching before its time.
6. Work with practice administrator groups and others to ensure that tools and resources are available to facilitate successful practice participation.

Your Feedback is Greatly Appreciated. To Provide Comments on the CVRP, go to:

<http://www.surveys.acc.org/se.ashx?s=0B87B74403CF1D84>

Appendix A: Program Descriptions of Interest

The **Intersocietal Accreditation Commission (IAC)** is a national, nonprofit organization in operation to evaluate and accredit diagnostic imaging facilities, thus improving the quality of patient care provided in private offices, clinics and hospitals where such medical tests are provided. There are five divisions within the IAC:

The Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

The Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL)

The Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL)

The Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories (ICAMRL)

The Intersocietal Commission for the Accreditation of Computed Tomography Laboratories (ICACTL)

Using common goals and methods, each member organization is structured to provide accreditation within its specific diagnostic medical specialty.

Designed to help laboratories attain the highest possible imaging quality to improve patient care, each of the accreditation programs is composed of two critical steps. The first is an **internal self-assessment** by laboratory staff. During the accreditation process, applicant laboratories must submit documentation on every aspect of their daily operations, including sample case studies along with their corresponding final reports. While completing the application, laboratories are required to identify and correct potential problems, revising protocols and validating quality assurance programs. The second step in the process is a **confidential peer review** by members of the medical community. Accreditation is granted only to those facilities that are found to be providing quality patient care, in compliance with the published Standards. Participation in the accreditation process demonstrates the diagnostic imaging facility's clear commitment to the provision of quality care. Laboratories are encouraged to use accreditation as the foundation to create and achieve realistic patient care goals. Because accreditation is renewed every three years, a long term commitment to quality care and self-assessment is developed and maintained.

NCQA Physician Practice Connection (2006): Physician Practice Connections[®] (PPC) recognizes practices that use systematic processes and information technology to enhance the quality of patient care. Meeting PPC standards shows practices have established connections to information, patients and other providers that allow them to:

- Know and use patient histories
- Follow up with patients and other providers
- Manage patient populations and use evidence –based care
- Employ electronic tools to prevent medical errors.

There are nine PPC standards and three levels of recognition. Practices seeking PPC Recognition will complete a web-based data collection tool and provide documentation that validates responses.

The Certification Commission for Healthcare Information Technology (CCHIT):

The Certification Commission is a recognized certification body for electronic health records and their networks, and a private, nonprofit initiative. Their mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program.

Certification is an important part of HHS Secretary Michael Leavitt's vision for transforming the health care system, in part through the widespread adoption of interoperable HIT - allowing EHRs to be linked through a system that protects privacy while ensuring care providers have the data they need to deliver care of the highest quality with safety, cost-efficiency, and convenience. Certification will help increase the transparency of the EHR marketplace and reduce risk for physicians and hospitals that purchase and implement HIT.

The Certification Commission for Healthcare Information Technology (CCHITSM) was formed in July 2004 by three leading industry associations in healthcare information management and technology - American Health Information Management Association (AHIMA), Healthcare Information and Management Systems Society (HIMSS), and The National Alliance for Health Information Technology (Alliance). These associations provided initial funding and staff. In 2005 additional funding was supplied by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the California HealthCare Foundation (CHCF), Hospital Corporation of America, McKesson, Sutter Health, United Health Foundation, and WellPoint, Inc. The ACC supports and participates in CCHIT activities.

The ACCF Learning Portfolio System:

The ACCF learning portfolio system will be a competency-based personalized web-enabled system for ACC members that will support the learner in meeting training, certification, re-certification, licensing, and payer requirements. The portfolio will:

- Facilitate assessment of individual learning needs
- Be organized by the six mandated competencies set forth by ACGME and ABIM, expanded by the learning competencies specific to cardiology content domains
- Link competency-based learning activities to the needs of the individual learner
- Document learner improvement in knowledge, outcomes, performance, and patient care
- Enable life-long learning and self-assessment.