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SCAI President's Page

Quality and Appropriateness of Care: The Response to Allegations and Actions Needed By the Cardiovascular Professional

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Maryland state agencies and the U.S. Attorney's Office for Medicare Fraud have launched a full-fledged investigation of alleged inappropriate use of percutaneous coronary intervention (PCI) by a small number of operators and allegations of substantial overutilization of stents at several Maryland hospitals [1]. In addition, an ongoing investigation under the auspices of the Maryland Department of Health and Mental Hygiene and other regulatory agencies is in full operation. A final report is due before the Maryland state legislature reconvenes in January.

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In an effort to pro-actively respond to these allegations, the Maryland Chapter of the American College of Cardiology (ACC), in close partnership with the national ACC and The Society for Cardiovascular Angiography and Interventions (SCAI), developed a taskforce charged with restoring patient confidence and assuring Maryland lawmakers that processes can be put in place at hospitals to closely monitor cardiac catheterization (cath) labs and prevent similar allegations going forward.

To date, the taskforce has met with all levels of state government, including the Maryland governor's office, and has drafted innovative legislation regarding the oversight required to ensure delivery of optimal high quality cardiovascular care in the state. The proposed legislation entitled "The Maryland Cardiovascular Patient Safety Act 2011," has several prominent supporters in both the Maryland House and Senate and provides an opportunity consistent with the goal of patient-centered, quality care. More importantly, it will provide assurance to a wary public through independent cath lab accreditation.

The issues facing Maryland hospitals and cardiovascular professionals present an opportunity to illustrate how professional societies can take a leadership role in ensuring quality care in the areas of peer review, accreditation, and data management. The issue of quality and appropriateness of cardiovascular care has not been confined to the state of Maryland or to the field of interventional medicine. We have seen other high profile allegations of overutilization and questions of appropriateness across the country in reference to other areas of cardiovascular care (and, indeed, in numerous other areas of medical care). It is time for our profession to step forward locally, regionally and nationally to take the leadership position in this vital area of patient care. This is a natural progression, since for many years, cardiovascular professional societies—and the field of cardiology in general—have been well ahead of other specialties in producing data from clinical registries and in developing quality and appropriateness guidelines [2].

Internal peer review is the crux of a successful cardiovascular program, regardless if it is related to invasive or non-invasive disciplines. It is critical that peer review be performed in a standardized, impartial and effective manner. Present processes for internal peer review in some hospitals are inadequate if not faulty. Internal processes must be clear, rigorous and objective, selecting random cases and guarding against physicians reviewing their own cases. Cases need to be reviewed not only in terms of outcome measures but also on the basis of appropriateness. A standardized internal process must be followed by independent external oversight performed by an external physician body.

To that end, ACC and SCAI leaders have been meeting with Maryland policymakers in an ongoing, candid, and productive dialogue. These leaders have presented a program in partnership with state officials and other stakeholders to allow for accountability, transparency and accurate data collection. During this process we found that the state agency charged with data collection and investigation regarding institutional and operator overuse, the Health Service Cost Review Commission (HSCRC), was wedded to using claims-based administrative data (billing data) to assess appropriateness and evaluate quality of care. This approach raises major concerns, given that administrative data have proven in many analyses to be frequently unreliable, incomplete, and inaccurate. Further, administrative data does not allow for benchmarking of outcomes, assessment of the appropriateness of PCI, or importantly risk stratification or risk-adjustment [3].

ACC and SCAI's proposal to Maryland legislators is a comprehensive initiative providing a mandatory accrediting process applied to all Maryland hospitals performing PCIs. This process includes oversight of hospital peer review through the Accreditation for Cardiovascular Excellence (ACE) program—an independent, external non-profit accreditation organization. It should be stressed that ACE, in which ACC and SCAI are partners, pre-dates issues in Maryland and was established to fulfill a need identified by the organizations as a service to the cardiovascular community and hospitals.

The ACE program has an independent governing board allowing for removal of any perceived or real conflicts of interest in oversight of hospital and physician quality performance. The program calls for strict adherence to use of National Cardiovascular Data Registry (NCDR®) registries and appropriate use criteria—both of which are already widely accepted and respected by professional and regulatory communities nationwide. The NCDR registries have an auditing strategy that offers confidence for clinicians, hospitals, payers, and state and national governmental bodies that the data are of high quality—certainly superior to the administrative claims data presently being promoted by some, including several Maryland regulators.

By performing hospital site visits to validate the data and eliminating the biases of self-reporting, the ACE program further strengthens this validity. Gross differences between physicians and hospitals will be identified through active surveillance and use of outcomes—not claims—data, a crucial distinction. Outliers would be provided with quality improvement programs to improve their processes and outcomes or risk loss of accreditation.

As efforts expand across the U.S. towards cost containment, pay-for-performance, public reporting of mortality and other outcomes and performance tracking, our field is under great scrutiny. We have the opportunity to lead and step up to educate the legislative bodies and inform the public about how proper assessment of our patient care should be performed. Both cardiologists and hospitals must recognize their responsibilities to their patients and provide a clear policy of independent external review of cardiovascular procedures. External independent reviews offer the opportunity for the true transparency desired that protects the interests of all stakeholders—government, payers, hospitals, physicians, and most importantly our patients

When we went into medicine we took the Hippocratic Oath stating "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" [4]. 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.

ACC initiatives like "FOCUS," which aims to ensure appropriate use of imaging in our practices, coupled with tools like the PINNACLE Registry™ that can measure long-term outcomes, will help measure the appropriateness and effectiveness of cardiovascular care. Standards can be established for peer-review and hospitals and physician outliers can be identified in a proactive manner. This clinical benchmarked data allows our hospitals and cardiovascular professionals the ability to improve the quality and appropriateness of their local care environment.

In addition, quality tools produced by both the ACC and SCAI allow states, payers and purchasers of care to have on hand the critical, transparent metrics with which to evaluate the quality of care as we shift from a fee-for-service reimbursement model to one more focused on outcomes-based care and commensurate reimbursement. Reliance on claims and billing data is misplaced and the use of NCDR and other similar data sets will assist federal and state agencies in determining appropriate care and reimbursement models.

The ACC, SCAI, and all of the state ACC Chapters have the knowledge base and expertise as cardiovascular leaders to advise and implement such programs. The ACC, SCAI, and the ACC Maryland Chapter believe that—once tested and adopted—the proposed innovative legislation for the state of Maryland will have far-reaching implications allowing the greater field of cardiology to remain ahead of the curve. This will ensure high quality and effective cardiovascular care delivery to our patients, driven by physician oversight and leadership.

We have the tools and are ready to meet that challenge if given the opportunity by the government, payers, and other policy makers.

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