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THE PRESENT AND FUTURE

ACC ADVISORY

The National Cardiovascular Data Registry Voluntary Public Reporting Program

An Interim Report From the NCDR Public Reporting Advisory Group

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ABSTRACT

Public reporting of health care data continues to proliferate as consumers and other stakeholders seek information on the quality and outcomes of care. Medicare's Hospital Compare website, the *U.S. News & World Report* hospital rankings, and several state-level programs are well known. Many rely heavily on administrative data as a surrogate to reflect clinical reality. Clinical data are traditionally more difficult and costly to collect, but more accurately reflect patients' clinical status, thus enhancing the validity of quality metrics. We describe the public reporting effort being launched by the American College of Cardiology and partnering professional organizations using clinical data from the National Cardiovascular Data Registry (NCDR) programs. This hospital-level voluntary effort will initially report process of care measures from the percutaneous coronary intervention (CathPCI) and implantable cardioverter-defibrillator (ICD) registries of the NCDR. Over time, additional process, outcomes, and composite performance metrics will be reported. (J Am Coll Cardiol 2016;67:205–15) © 2016 by the American College of Cardiology Foundation.

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ABBREVIATIONS AND ACRONYMS

ACC = American College of Cardiology

CABG = coronary artery bypass graft

ICD = implantable cardioverter-defibrillator

NCDR = National Cardiovascular Data Registry

PCI = percutaneous coronary intervention

STS = Society of Thoracic Surgeons

Public reports of health care data, quality metrics, and outcomes have been available for over a decade (1). The Federal government, some state departments of health, and numerous private organizations regularly report measures of health care-related quality including outcomes using publicly available financial, administrative, and descriptive data, and often apply proprietary methods. Administrative data are readily available to payers and thus are attractive sources of information. Unfortunately, many studies have shown that administrative data are payer and market specific, use old and sometimes nonactionable data, and may poorly reflect acute severity of illness, correct diagnosis, and clinical outcomes (2–5). Although considerable financial resources are spent on such reports, it is not clear how and to what extent individual consumers use this information (6).

Professional organizations including the American Medical Association, the Society of Thoracic Surgeons (STS), the American Heart Association, and the American College of Cardiology (ACC) have articulated key principles to guide public reporting initiatives, as have several public and private initiatives (7–9). Fundamental to these principles is the use of clinical data whenever possible and returning timely, benchmarked reports to participating institutions to support their quality improvement programs. Since 1997, the ACC has developed a suite of registries within the National Cardiovascular Data Registry (NCDR) program that collect, audit, benchmark, and report clinical data and outcomes on specific cardiovascular procedures and diagnoses to participating institutions (10). This has occurred in partnership with the Society for Cardiovascular Angiography and Interventions for the CathPCI Registry, focused on percutaneous coronary interventional (PCI) patient care, and the Heart Rhythm Society for the ICD Registry, focused on implantable cardioverter-defibrillator (ICD) patient care. The timeliness and clinical detail of these data and reports are superior to administrative data. Facilities submit clinical data to the NCDR and receive quarterly reports of their own data compared with aggregated national data for quality benchmarking. Traditionally, NCDR data have only been available directly to participant facilities, consortia, or health plans. Several scientific publications from the NCDR have reported aggregate data to identify quality gaps at the national level to stimulate efforts to improve care (11). Now, the ACC, in partnership with Society for Cardiovascular Angiography and Interventions and Heart Rhythm Society, has developed a pathway for participant institutions to voluntarily publicly report their NCDR hospital-level data (1,12).

RATIONALE FOR PUBLIC REPORTING

The most compelling justification for public reporting is the right of an individual to know about the care that he or she is likely to receive. With the current national emphasis on the quality, accountability, and cost-effectiveness of health care, the various stakeholders and consumers of health care are eager to obtain information about health care facilities and providers. This has created a “market” for public reporting that, at present, is not well coordinated as different stakeholders have somewhat divergent goals and varying confidence in the utility of nonclinical data sources (**Figure 1**). Many public reports use data that are several years old, were not designed for clinical performance reporting, or are constructed using proprietary analytic methods that are difficult to reproduce or verify. This diverse reporting environment can confuse patients and purchasers, has the potential to misdirect our focus away from the rights of the individual patient, and has led to divergent public rankings of the same facility in different reporting systems (13).

Hospital-level public reporting, in its various formats, is now familiar to most clinicians. Public reporting of individual provider data is becoming more prevalent (14). However, physician-level reporting has additional challenges, such as attributing process and outcome of care metrics to specific providers and addressing variability in individual metrics in smaller practice groups or for individuals.

Public reporting is primarily based upon the belief that accessible, transparent high-quality information will affect decisions and behaviors of the various stakeholders, ultimately resulting in an improvement in health care delivery and outcomes. However, use of this information by various segments of the population is variable, and the effect of this information on patients’ decision-making is uncertain (15,16). Reporting efforts to define the “best of the best” can motivate an unnecessary performance-reporting race and may not provide the information most patients are seeking. Patients’ quality concerns seem more focused on access to empathetic, interactive providers and the availability of local common services that meet an acceptable standard of care (17–20). As public reporting efforts continue to grow, the ACC and its partnering organizations are committed to a leadership role in quality of care