

# Cardiovascular Perspectives

## Dueling Registries?

### An Alternative Perspective and the Case for Competitive Collaboration

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In his commentary, "Duelin' Registries," published in this issue of *Circulation: Cardiovascular Quality and Outcomes*, Oetgen<sup>1</sup> argues that the country would benefit if the American College of Cardiology (ACC) and the American Heart Association (AHA) were to combine efforts and resources to collaborate on a single ambulatory (outpatient) cardiovascular registry rather than to continue independent efforts to build their own. His metaphor of the dueling banjos is quite clever, creating a strong visual and aural backdrop for his arguments.

In general, the notion of collaboration between organizations is a valuable one (think clinical practice guidelines as an example). Oetgen's arguments are thoughtful and born out of substantial experience with this work; moreover, the notion of shared resources makes sense at a time of constrained resources and limited spending on health care. However, his essay leaves out an alternative strategy for the ambulatory registries to develop more rapidly and completely through a stage of competitive collaboration before eventually arriving at a common shared format.<sup>2</sup> His main point seems to be that this is pretty hard work, that there are many societal and cultural obstacles, and that an ambulatory registry differs considerably from such predominantly inpatient registries as the National Cardiovascular Data Registry (cardiac catheterization and percutaneous coronary intervention) and the ACTION (acute coronary syndromes) registry.<sup>3,4</sup>

Oetgen specifically notes 3 barriers to the start-up success of each registry: lack of provider interest, technical challenges associated with extracting data from electronic health records (EHRs), and little incentive for EHR vendors to collaborate or cooperate with registries. Although we would agree that these are challenges, are they also reasons enough for the 2 organizations to combine their efforts? Are there not equally relevant reasons to encourage the 2 groups to continue to aggressively and creatively pursue their separate initiatives while at the same time advocate sharing of knowledge and know-how when appropriate and remaining open to a combined approach at some point?

Perhaps first it is reasonable to consider some of the commonalities as well as some of the differences between the organizations to better understand what perspectives each might bring to the creation of a truly national ambulatory registry. As the largest and most inclusive professional society for cardiovascular medicine, the ACC is the organi-

zational home of the cardiovascular practitioner, with a mission that speaks to advocacy, science, quality, and education across the many spheres of cardiovascular medicine and care.<sup>5</sup> Its 39 000 members include cardiologists, nurses, midlevel practitioners, pharmacists, and practice administrators. Its budget is ≈\$90 million per year, with the bulk of it allocated for member support (including advocacy), education, science, clinical policy documents, and the building and maintenance of clinical practice registries.<sup>6</sup> The focus of the ACC is clearly centered on the provider-patient interface.

The AHA is a different organization. With its foundation as a public health organization, the mission of the AHA is to build "healthier lives, free of cardiovascular disease and stroke." It measures its success by its impact goal for 2020: To improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.<sup>7</sup> It does this, in part, by supporting research and education about cardiovascular disease and stroke. The AHA has a broader public health mandate than the ACC, and its membership of 27 000 includes professional representation from across the spectrum of cardiovascular science (basic through population) and multiple disciplines of medicine (and nursing), including cardiology, neurology, nephrology, general internal medicine, and radiology (among others). As a major philanthropic organization, it encourages membership among the lay public. Fund-raising from the public constitutes a major effort of the AHA, with most of its annual revenue generated through philanthropy. The AHA has a budget of >\$600 million, with most (>70%) of it devoted to public health education and original cardiovascular research across all domains (basic to translational to clinical to population<sup>8</sup>). A sizable portion is used to support professional education and training.

The organizations already collaborate on the ACTION Registry-GWTG (Get With the Guidelines), as pointed out by Oetgen; however, ambulatory care is far different from registries involving predominantly inpatient care and procedures. Most health care is delivered in the outpatient arena, which is a busy setting where professional data collectors (eg, those used in the hospital quality improvement setting) are likely not possible, relying instead on the challenges associated with establishing relationships and collaborations with EHR vendors. Patient care is less focused in the ambulatory setting, and the goal becomes collecting data not just on a single

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*Circ Cardiovasc Qual Outcomes* is available at <http://circoutcomes.ahajournals.org>

DOI: 10.1161/CIRCOUTCOMES.111.961250

syndrome (eg, acute coronary syndromes or heart failure), but instead on a range that stretches from established disease states like cerebrovascular disease, chronic heart failure, and atrial fibrillation to no overt cardiac disease but having risk factors (hypertension, diabetes, hyperlipidemia, etc) for it. In the ambulatory care setting, providers also must contend with providing quality care and prevention services for multiple diseases beyond patients' cardiovascular conditions, which partly explains why the AHA is partnering with cancer and diabetes organizations and provides a good example of the benefits of the AHA's broad view of population health.

In a similar way, the ACC's interest in the patient-provider interface has led it to creatively consider how to integrate participation in registries with providers' educational needs.<sup>9</sup> This novel approach to continuing medical education and continuous quality improvement allows for individualized education based on actual registry-measured performance gaps. Not only does this member-focused activity provide education for providers that fulfills some of the requirements for board recertification, but also the measurement ability of the registry offers the potential for improving patient care and outcomes. Thus, during this early stage of an ambulatory registry development, differing visions of the problem may yield different ideas about design, participation incentives, and implementation strategies. The result should be a net positive outcome for the highest quality ambulatory registry.

There are certainly specific grounds for collaboration now that would benefit all ambulatory cardiovascular registries, including working together at the national and international level to standardize the data elements that define common cardiovascular syndromes and procedures.<sup>10</sup> In fact, the ACC and AHA have collaborated on these efforts through data standards working groups. Such efforts would facilitate the work of many groups that are trying to understand how to extract data from EHRs and aggregate them into larger, integrated data sets that, in addition to research purposes, could inform clinical practice and improve quality of care. This issue is largely a technical one, revolving around the use of informatics and information technology.

The more daunting issue of how best to integrate a cardiovascular registry into the work flow of busy outpatient practices requires creative thinking and likely some innovative pilot programs searching for best practices. Likewise, understanding how a cardiovascular registry might best dovetail with registries addressing other medical problems and procedures also requires some creativity and trial and error. As such, having both the ACC and the AHA supporting innovative programs might well lead to some best practices that will benefit the entire field. In this area, the AHA's broader mandate to involve other professional entities in its registry efforts might prove advantageous. It may well be that 1 approach will emerge as the preferred one, or as the 2 approaches reach a greater level of maturity, a merger might become the optimal strategy. The 2 groups represent very different constituencies and, as organizations, have different missions. From these differences might emerge different responses to the challenges that favor 1 approach over the other; this is one of the best aspects of competition in the scientific arena.

Recently, the ACC President Ralph Brindis and AHA President Clyde Yancy wrote eloquently about the synergies between the 2 organizations.<sup>11</sup> For most cardiovascular practitioners, both organizations offer value in different, but frequently overlapping ways, and certainly, in these times of intense economic constraints in medicine, wasting resources is both inappropriate and frustrating. But at this early stage of the 2 registry projects, when both are just starting to gain traction and modest momentum, competitive collaboration seems consistent with the notion of having the best ideas rise to the top. The ACC is the primary professional home of the nation's practicing cardiologists and, as such, should have the best insight into the practical aspects of the delivery and the business of cardiovascular care. The AHA's public health and education mandate offers a different perspective on moving ambulatory information into a registry environment. The time might eventually come for a combined effort, but not yet. For now, let us encourage healthy, but not wasteful competition in the spirit of coming up with the best national plan for the aggregation, and ultimately the usage, of ambulatory cardiovascular data.

### Acknowledgments

I thank Ms Penny Hodgson for her expert editorial advice and counsel.

### Disclosures

Dr Harrington is a member of the ACC Board of Trustees and serves as the Vice Chair for the AHA's 2011 Scientific Sessions. The Duke Clinical Research Institute, which he serves as the director, has research contracts with both organizations.

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KEY WORD: registries ■ health policy ■ outcomes research

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*Circ Cardiovasc Qual Outcomes.* 2011;4:486-487

doi: 10.1161/CIRCOUTCOMES.111.961250

*Circulation: Cardiovascular Quality and Outcomes* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

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Print ISSN: 1941-7705. Online ISSN: 1941-7713

The online version of this article, along with updated information and services, is located on the World Wide Web at:

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