Navigating the New Health Care Horizon: What It Will Take to Be Successful in Cardiovascular Medicine Moving Forward

Ohio ACC Chapter

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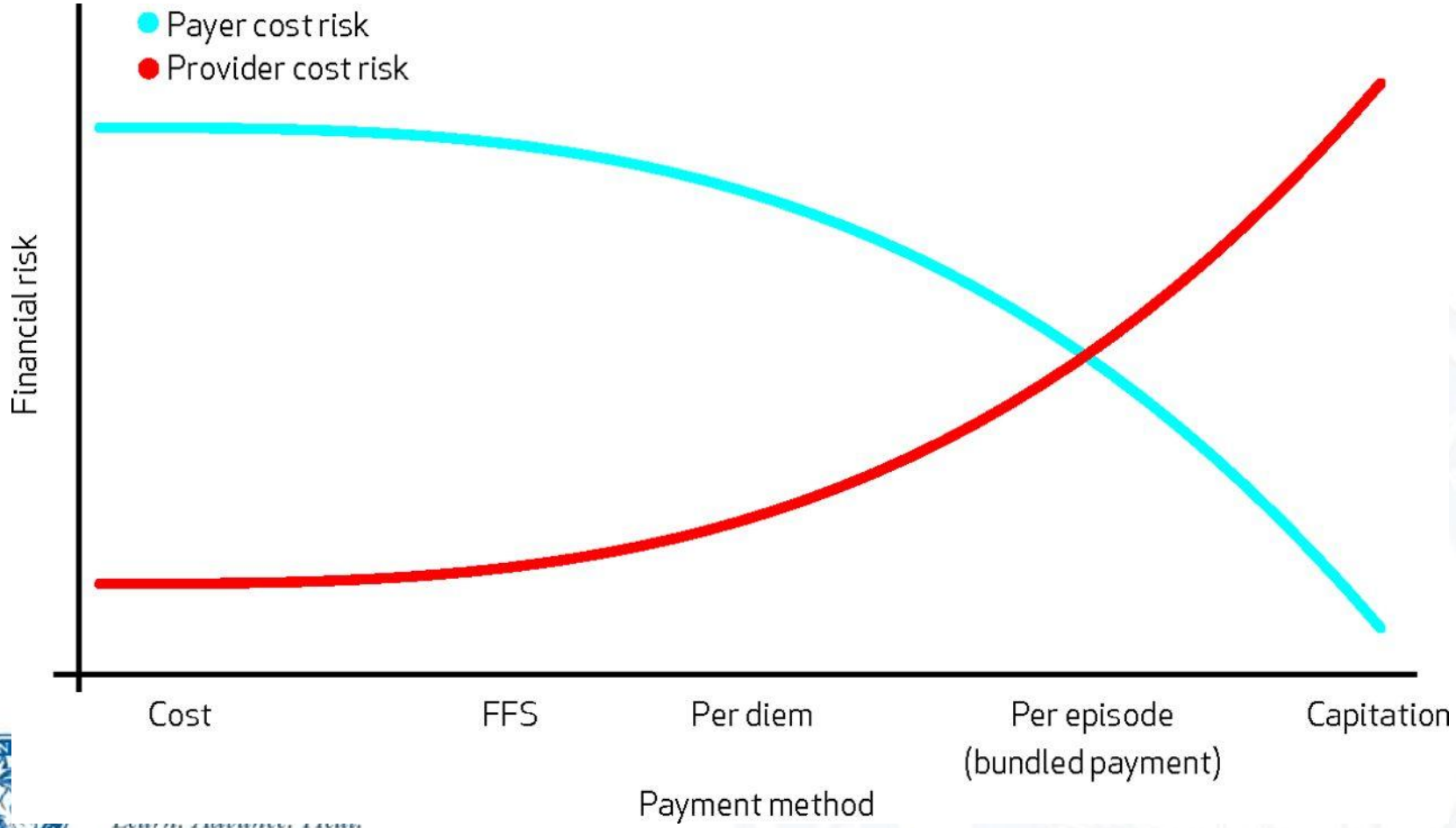
Navigating the New Health Care Horizon: What It Will Take to Be Successful in Cardiovascular Medicine Moving Forward

- Volume to value
- Team-based care
- Shared-decision making
- Population health management

Financial risk is shifting from payors to providers

Financial Risk Of Care For Provider And Payer, By Payment Method.



Austin B. Frakt, and Rick Mayes Health Aff 2012;31:1951-1958

What's Happening Now: *Shifts in Healthcare*

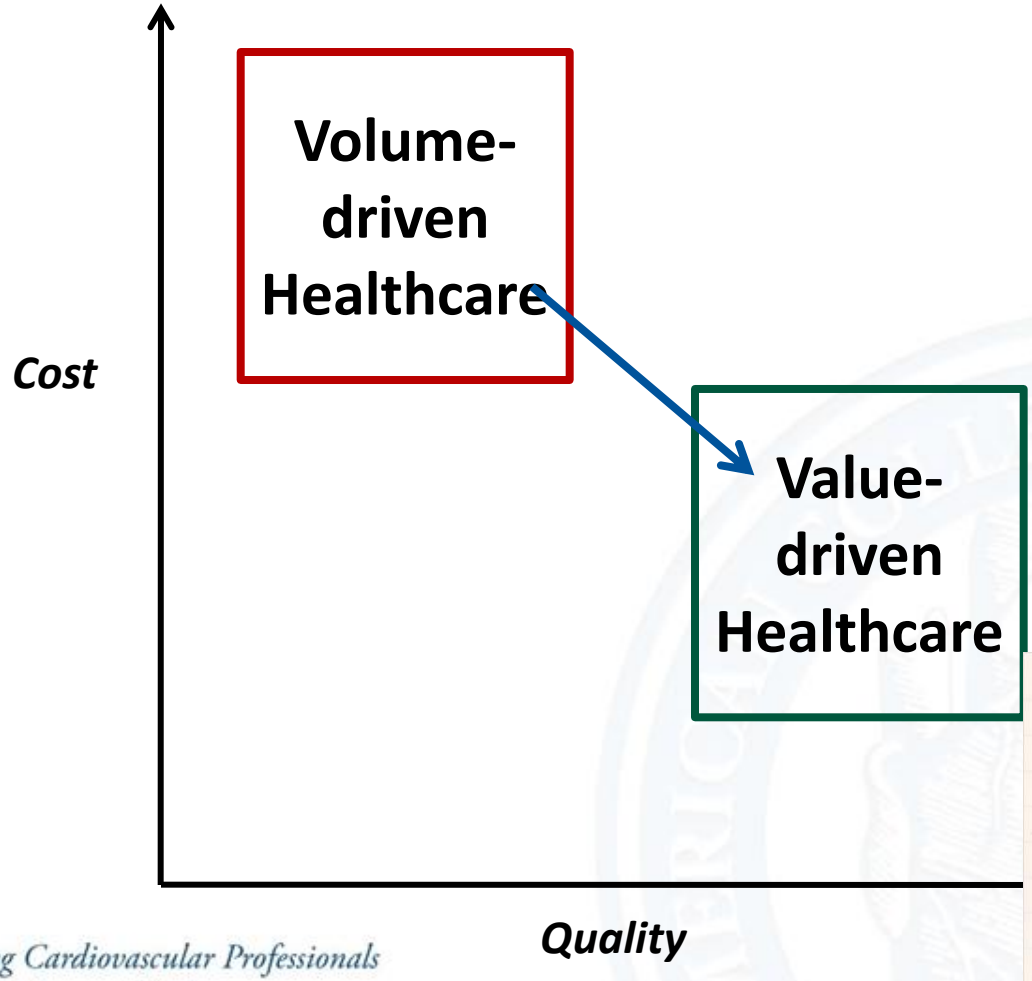
- Increased use of non-doctor's office or hospital settings (pharmacies, local health clinics) to get care

- Tele-medicine gaining traction for patient follow-up and hospital admissions

What's Happening Now: *Shifts in Healthcare*

- Broader use of Electronic records; physicians in instant contact with patients
- Greater access to prevention information and treatment options than ever before
- Changes in delivery systems: Passage of MACRA in the U.S.

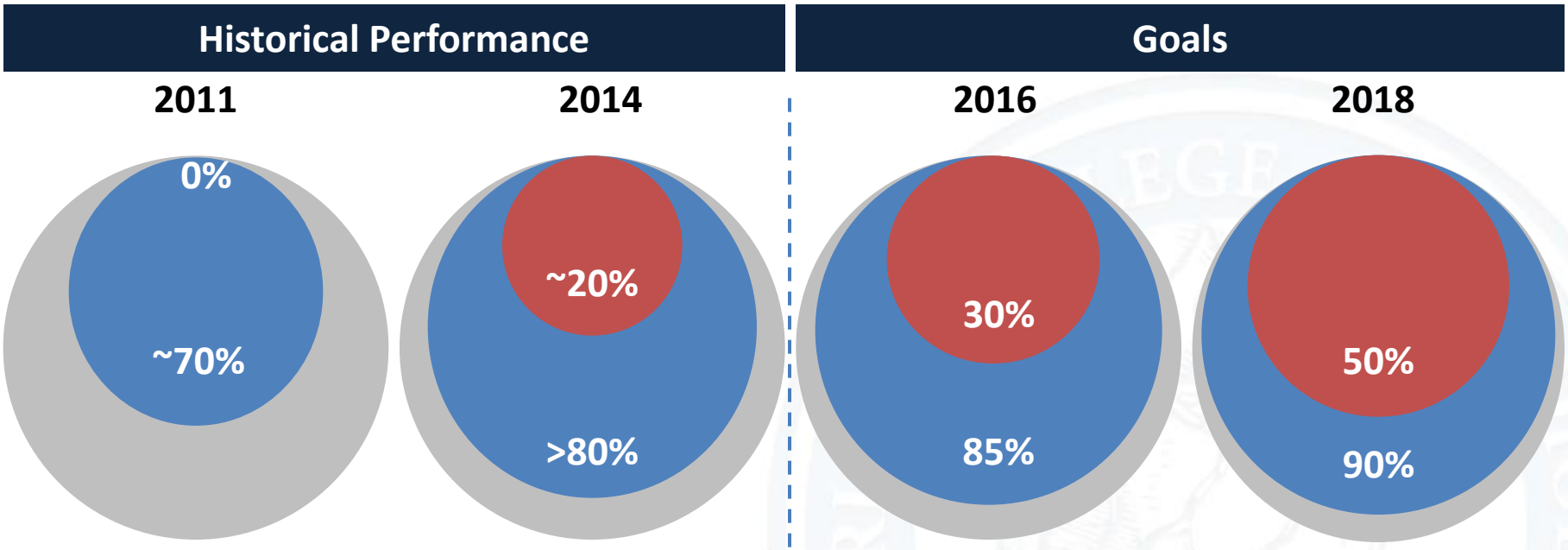
Payment is Transitioning From Volume-Driven to Value-Driven



A National Transition to Value-Based Reimbursement

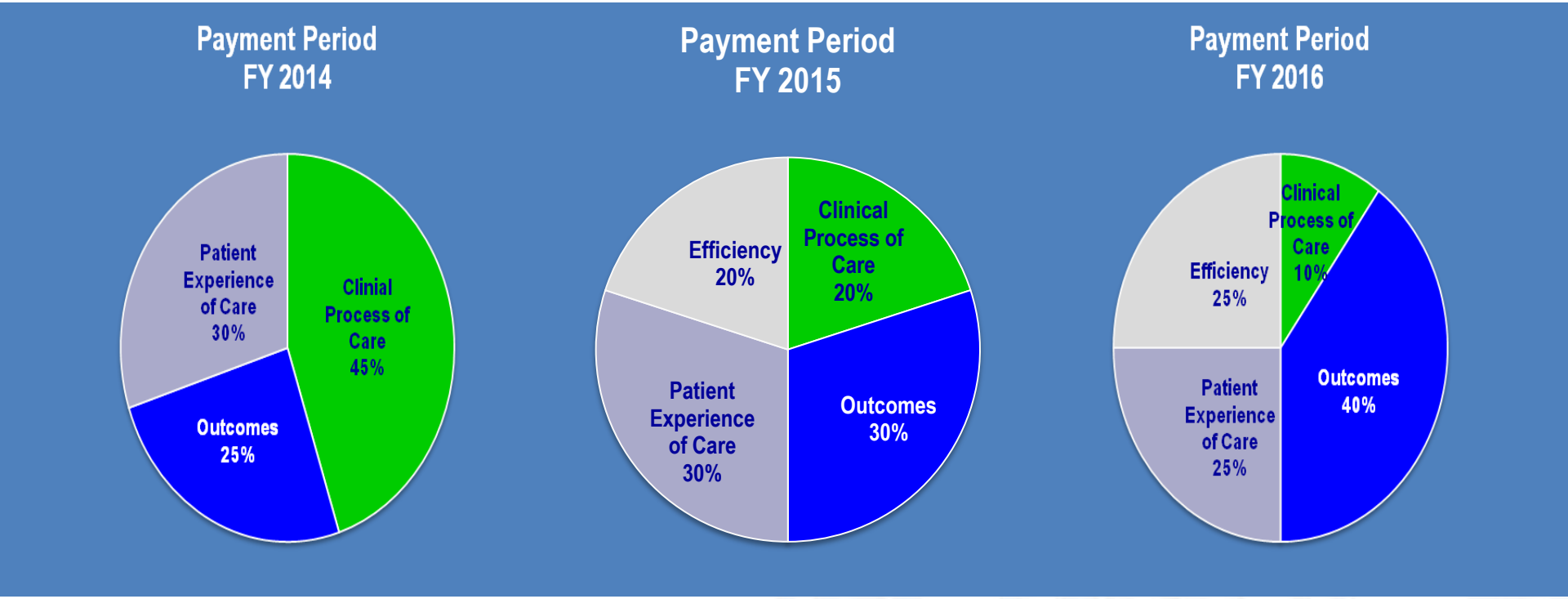
CMS Timeline Expects By 2018, 50% of Payments in Alternative Payment Models

- Payments linked to alternative payment models
- Fee-for-Service ("FFS") linked to quality
- All Medicare FFS



Source: Centers for Medicare and Medicaid Innovation ("CMMI") Center, Bundled Payment Summit, June 2015

CMS Value Based Purchasing



CMS is rapidly changing the weighting of each Value Based Purchasing Domain as well as the content within each domain making systematic and proactive performance improvement more difficult.

Bundled Payments

- In July, CMS released a proposal for a new mandatory bundled payment model for CABG and AMI.
- The proposed rule contains three new significant policies:
  - A mandatory episode payment model (EPM) for CABG and AMI (note they are also extending the existing bundled payment model for hip replacements to other hip surgeries)
  - A new payment model for cardiac rehab meant to increase utilization
  - A track that would enable physicians with significant participation in bundled payment models to qualify for the Advanced Alternative Payment model track in MACRA

Bundled Payments

- MI
  - 30-day, all-cause, risk-standardized mortality post-AMI
  - Excess days in acute care after AMI
  - HCAHPS
  - Voluntary hybrid 30-day, all-cause, risk-standardized mortality eMeasure data submission
- CABG
  - 30-day, all-cause, risk-standardized mortality post-CABG
  - HCAHPS
- Cardiac rehab
  - increased hospital payment for greater utilization of cardiac rehab services following hospitalization for a MI or CABG

The CMS Comprehensive Care Model and Racial Disparity in Joint Replacement

- In April 2016, CMS implemented the Comprehensive Care for Joint Replacement (CJR) model, an alternative payment model (APM) involving knee and hip replacement
- The CJR encourages hospitals to work closely with physicians and post–acute care clinicians and facilities to reduce fragmentation of care, improve quality of care, and reduce costs.
- In 2015, the number of total knee replacements performed in the United States exceeded 1 million, representing a 2-fold increase in total knee replacement operations over the past decade and making Medicare the single largest payer for these procedures.

JAMA. 2016;316(12):1258-1259

Potential for Unintended Consequences

- Evidence suggests that hospitals select patients to treat based on a patient's baseline risk of poor outcomes and potential profitability
- Although arthritis-related activity, work limitations, and severe pain disproportionately affect African American patients compared with white patients, AA patients received fewer joint replacements
- Minority patients are also more likely to receive joint replacement at low-volume or low-quality hospitals compared with nonminority patients and may have poorer surgical outcomes including higher rates of hospital readmission

JAMA. 2016;316(12):1258-1259

Need for Team-Based Care

Table 6. Average U.S. Staffing by Practice Size: Role Composition

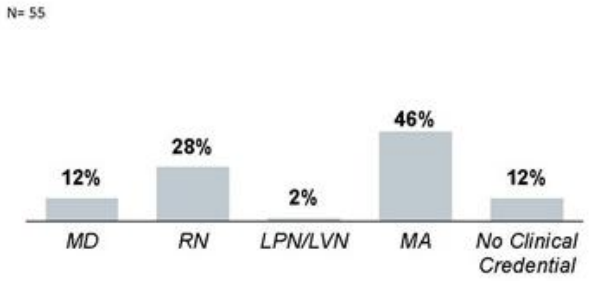
	Total (%)	Small Program (<4 staff) n=107 (%)	Small-Medium Program (4–10 staff) n=86 (%)	Medium Program (11–20 staff) n=45 (%)	Large Program (>20 staff) n=14 (%)
MD/DO FTEs	28.0	29.6	25.5	29.4	28.4
NP/PA FTEs	23.3	29.2	23.6	20.6	24.0
RN coordinator FTEs	27.6	21.4	24.4	29.3	33.0
Financial consultant	3.1	0.2	3.6	3.9	2.7
Social worker	5.2	2.8	6.1	5.4	5.1
Exercise physiologist	2.2	3.2	2.9	1.8	1.3
Nutritionist	3.8	5.1	4.9	3.3	2.1
Psychologist	2.7	2.8	3.2	3.0	1.5
Pharmacologist	4.1	5.6	5.8	3.3	1.8
Total no. of staff	2,386	298	762	826	500

DO indicates doctor of osteopathy; FTE, full-time equivalent; MD, medical doctor; NP, nurse practitioner; PA, physician assistant; and RN, registered nurse.

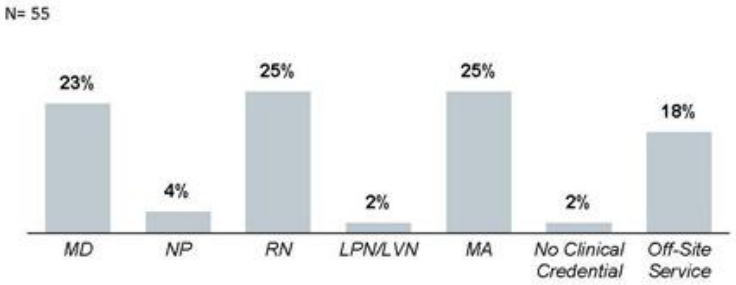
J Am Coll Cardiol 2011;57:2115–24

Working to the top of your license

Pre-visit chart review



Patient self-management support



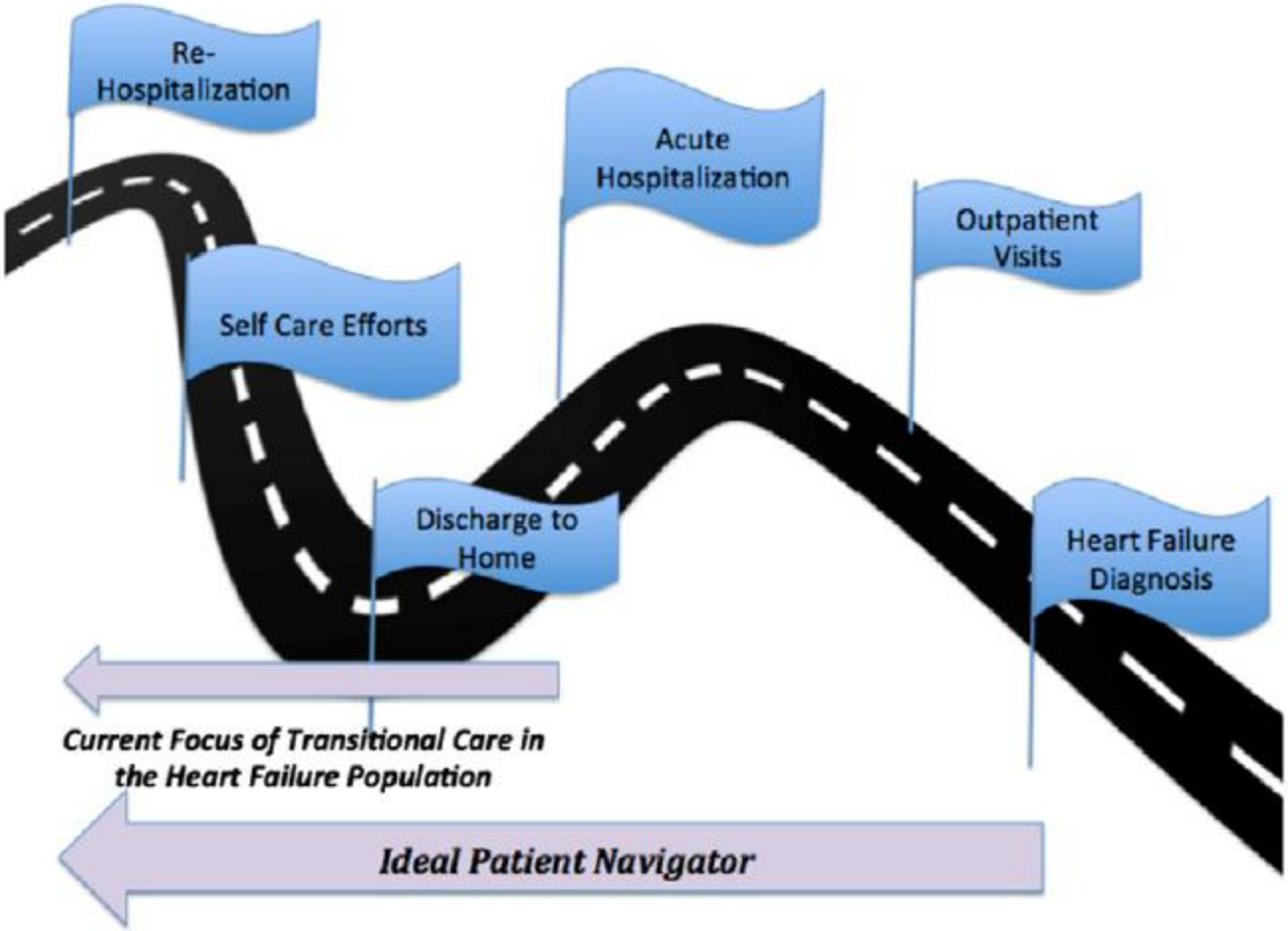
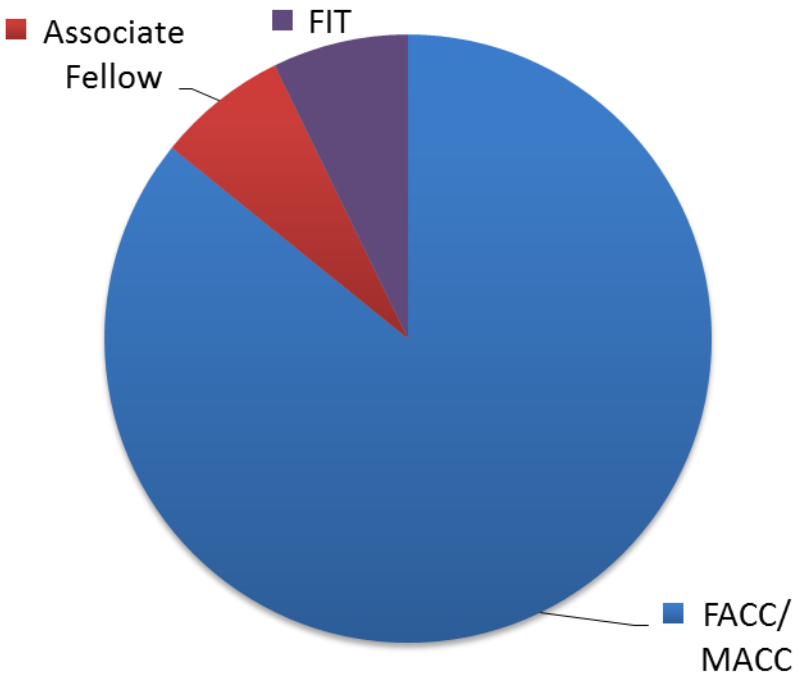


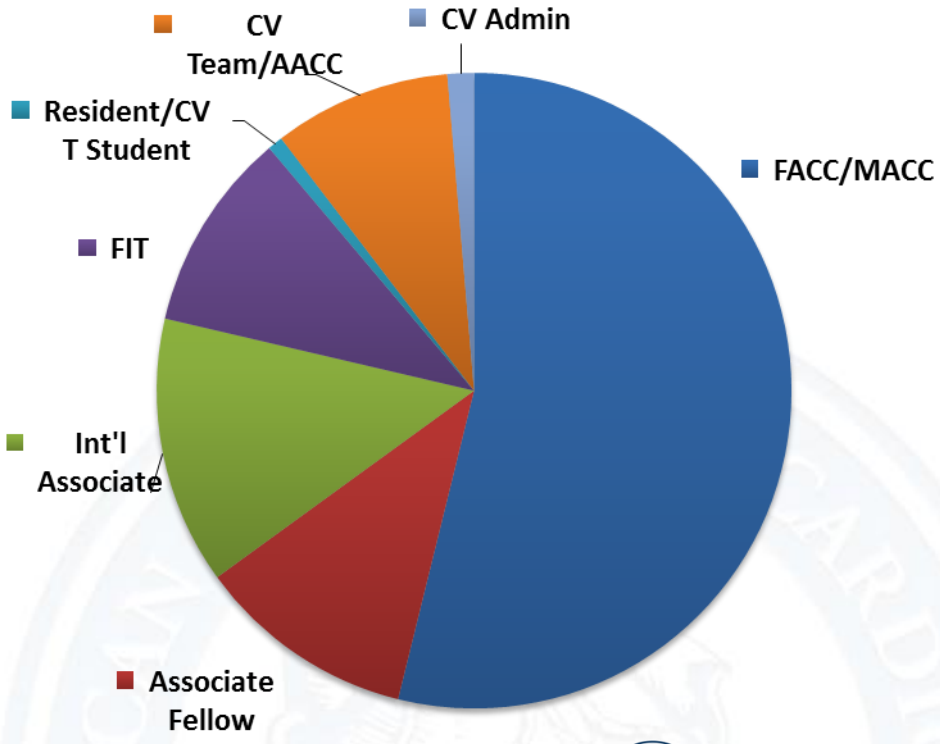
Fig. 2. Patient navigator.

Tingley J, Dolansky MA, Walsh MN. Heart Failure Clin 11 (2015) 371–378

ACC in 2000 (26,000 Members)



ACC in 2016 (52,000+ Members)



Source (Right): Data compiled from 2015 Year End Official Member Count

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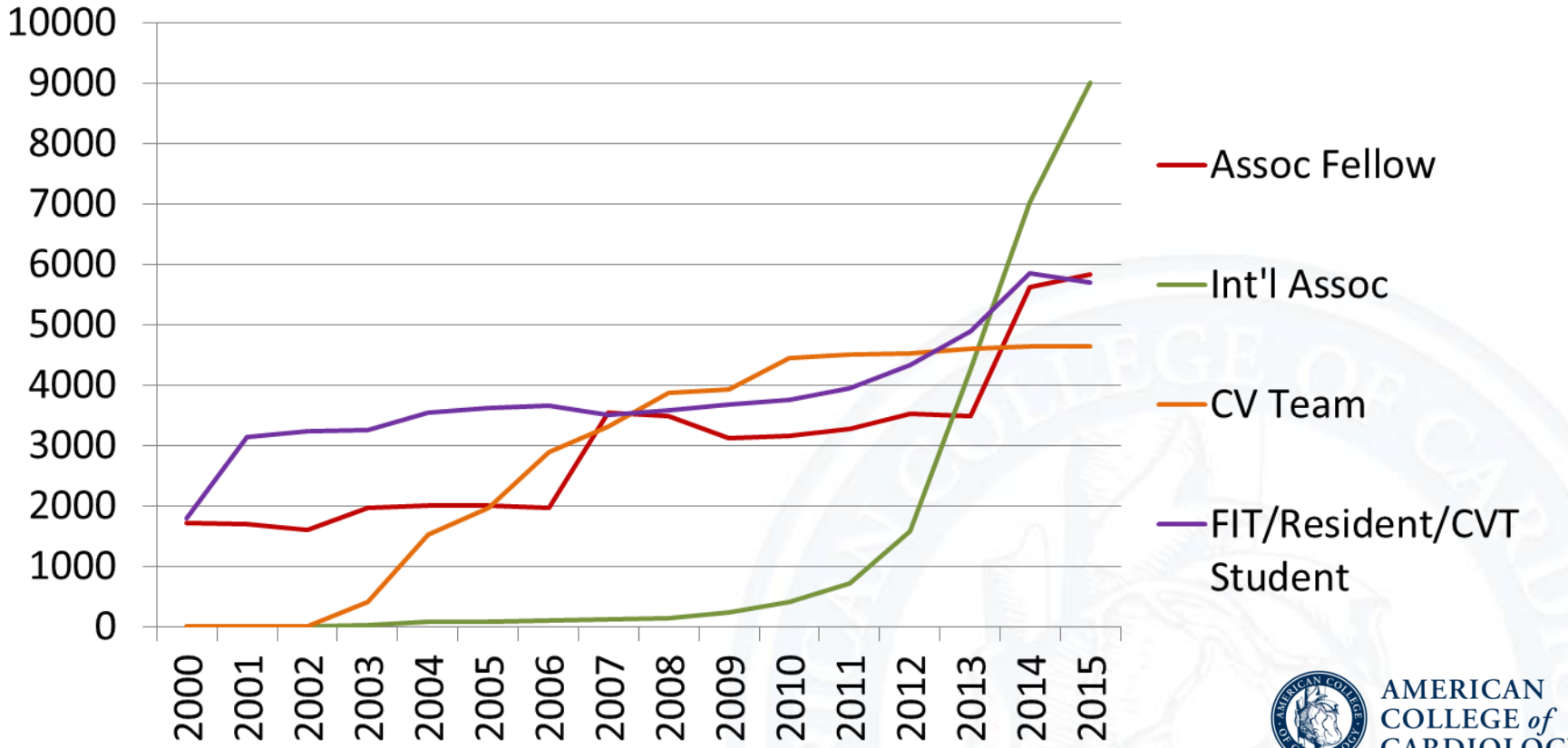
Other Membership Category Growth Since 2000



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2007

- CCA membership **extended to Clinical CV Pharmacists.**
- First **CCA-specific educational track** held during ACC.07.
- The **CCA State Liaison Work Group** becomes an official work group of the ACC.

2008

- Cardiac Care Team Committee becomes the **Cardiovascular Team** (CVT) Council – to act as an advisory group to the BOT.
- CCA members become eligible to **vote in ACC Chapter Elections**.
- The **Cardiovascular Nursing: Scope and Standards of Practice** was published.

2009

- The **Associate of the American College of Cardiology (AACC) designation** is approved by the BOT to recognize advanced professional achievement by CCA members.
- Eileen M. Handberg, ARNP, PhD, becomes the **first CCA to advance to Fellow of the American College of Cardiology (FACC)**.

2010

- The **Cardiovascular Team Section** launches – providing CCAs with an organized forum and focused community within the College.
- Formation of **Cardiovascular Team Section Working Groups** to provide team members with additional volunteer opportunities.
- Launch of the **Cardiovascular Team Section monthly eNewsletter.**
- Additional position on the **Board of Trustees** (31st seat) opened to a non-physician member. Handberg is the first nurse appointed to the BOT.

2011

- AACC participate along with FACCs in the **annual Convocation ceremony** at ACC.11.
- The ACC is recognized as the **2011 ANCC Accreditation Premier Provider of the Year** for exemplifying excellence in the field of continuing nursing education.
- Membership category for **CCA International** (CCA-I).
- Launch of the **Partner in Care** membership category for CV Technologists credentialed by Cardiovascular Credentialing International (CCI) and the American Registry for Diagnostic Medical Sonography (ARDMS).

2012

- CV Nurse, Physician Assistant and Clinical Pharmacist researchers are invited to participate in **Young Investigators Awards Program.**
- **CCA CardioSmart Advisory Board** formed.

2013

- Nurse Education Committee becomes the **Team-Based Education Workgroup**.
- The first **Distinguished Associate Award** recipient to be recognized during the annual Convocation ceremony at ACC.13.
- CCA membership **includes over 4,000 cardiovascular health care professionals** – making the ACC one of the most professionally diverse cardiovascular organizations.

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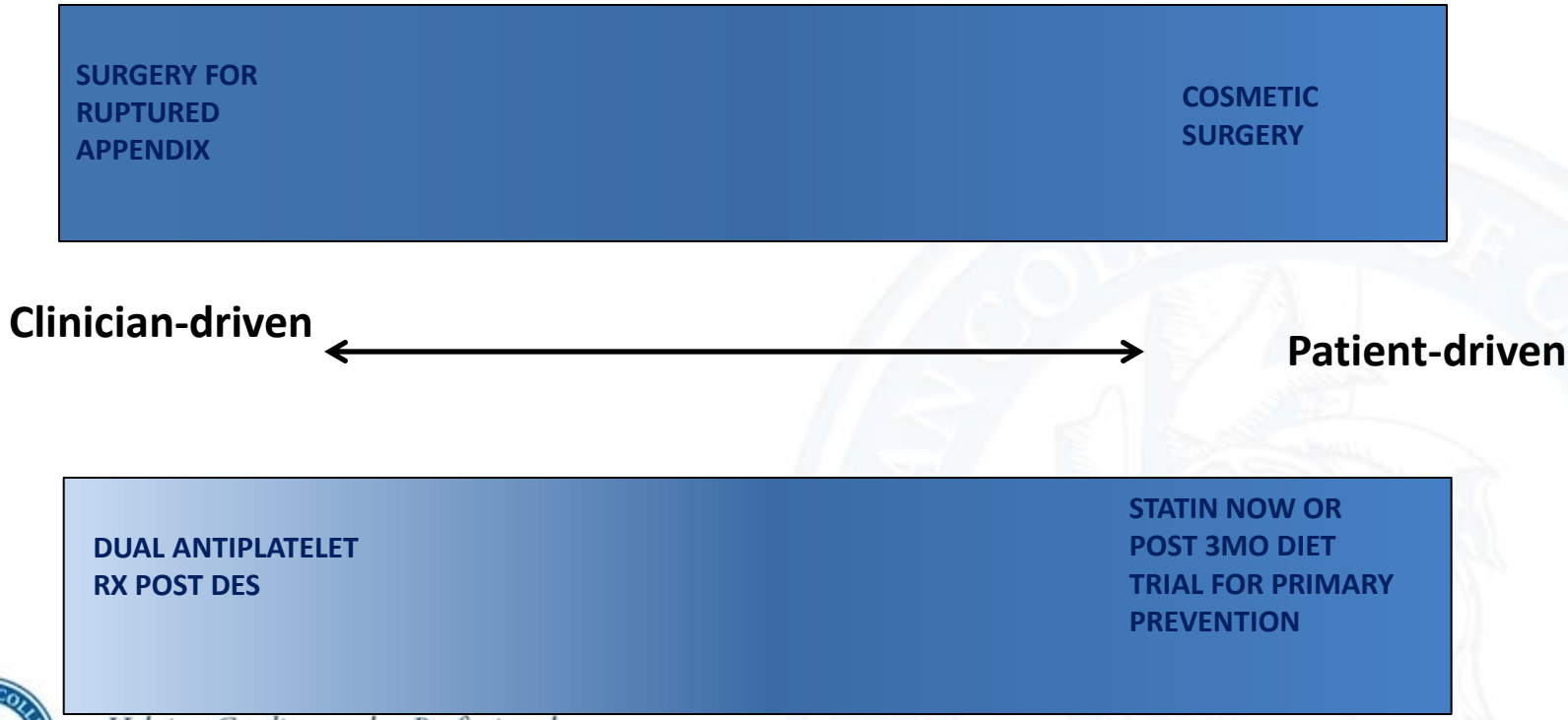
Shared Decision-Making (SDM)

- One of the most important attributes of patient-centered care is the active engagement of patients when health care decisions must be made
- These decisions are often made when the diverging paths have different and important consequences with lasting implications.
- Examples include decisions about major surgery, medications that must be taken for the rest of one's life, and screening and diagnostic tests that can trigger cascades of serious and stressful interventions.

Barry MJ, Edgman-Levitan, S.N Engl J Med2012;366:780781March 1, 2012

The respective roles that clinician and patient play in negotiating a decision vary with the clinical situation and the treatment options



HEALTH

Thinking About Pregnancy Like an Economist

How it became clear that I needed to sort through the valuable, and useless, information — on alcohol, prenatal testing, deli meats — for myself.

3.5k 219

EMILY OSTER | AUG 21, 2013

Torsten Mangner/flickr

Thinking about Pregnancy Like an Economist

- Ultimately, microeconomics is the science of making decisions--a way to structure your thinking so you make good choices.
- Making good decisions--in business, and in life--requires two things: the right data, and the right way to weigh the pluses and minuses of a decision personally.
- The key is that even with the same data, this second part--this weighing of the pluses and minuses--may result in different decisions for different people. Individuals may value the same thing differently.
- Making this decision correctly requires thinking hard about the alternative, and that's not going to be the same for everyone.

Thinking about Pregnancy Like an Economist

- Pregnancy medical care seemed to be one long list of rules:
- **“You can have only two cups of coffee a day.“**
- **"The guidelines say you should have an amniocentesis only if you are over thirty-five.“**
- **One or two drinks a week was "probably fine.“**

The recognition that patient preferences might differ, which might play an important role in deciding on treatment, is at least sometimes ignored.

Example of a Decision Aid

Decision Point

You may want to have a say in this decision, or you may simply want to follow your doctor's recommendation. Either way, this information will help you understand what your choices are so that you can talk to your doctor about them.

Turn on Accessibility Mode

Herniated Disc: Should I Have Surgery?

1 Get the facts	2 Compare Options	3 Your Feelings	4 Your Decision	5 Quiz Yourself	6 Your Summary

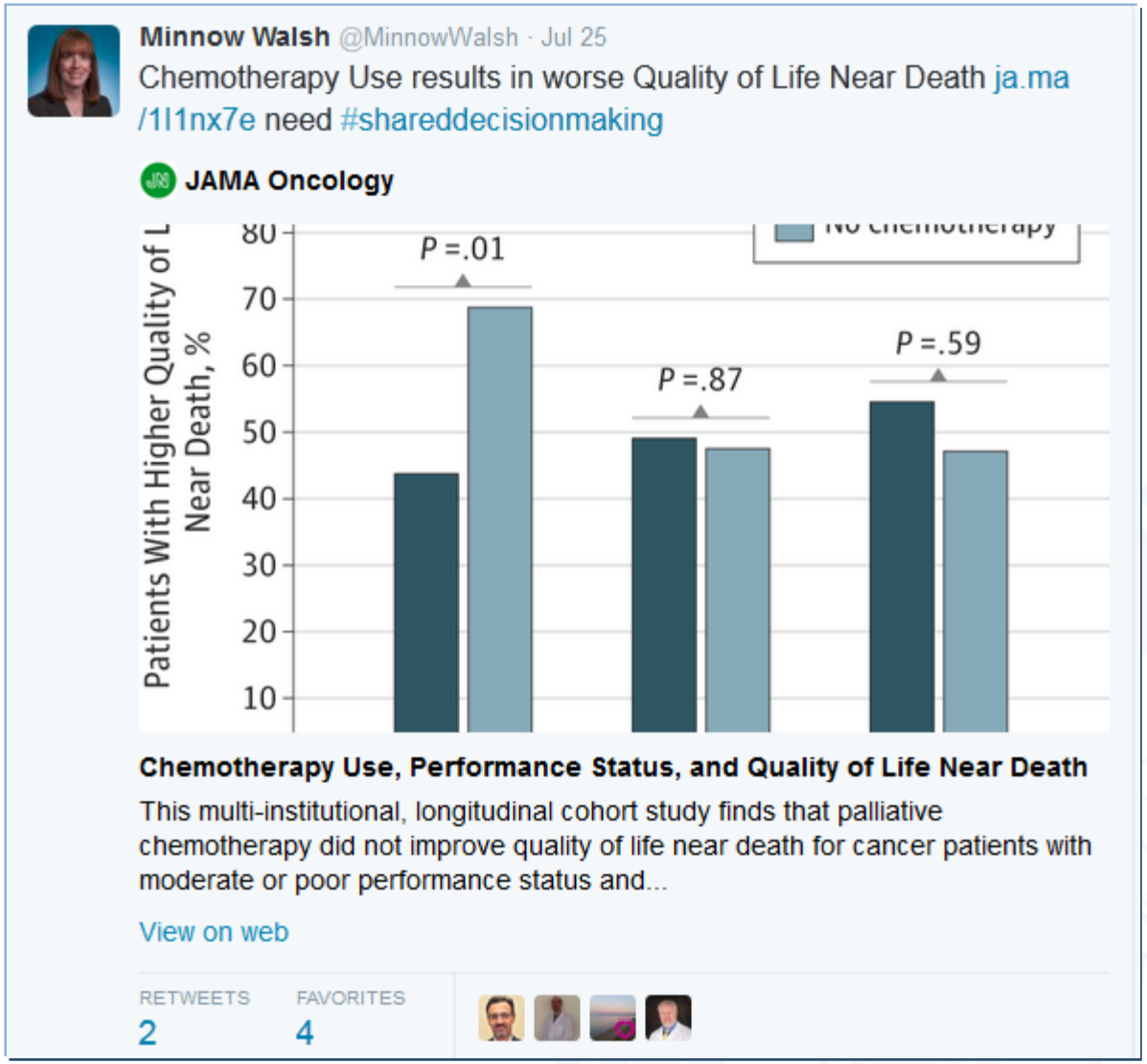
Get the facts

Your options

- Have surgery for your herniated disc.
- Don't have surgery.

This decision guide is for you if your herniated disc is in your low back. It does **not** cover information about herniated discs in the neck area of the spine (cervical disc herniation).

Palliative Chemotherapy Does Not Improve Quality of Life



Shared Decision Making: Impact on Care and Cost

- As many as 20% of patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids.

- In 2008, the Lewin Group estimated that implementing shared decision making for just 11 procedures would yield more than $9 billion in savings nationally over 10 years

- A 2012 study by Group Health in Washington State showed that providing decision aids to patients eligible for hip and knee replacements substantially reduced both surgery rates and costs — with up to 38% fewer surgeries and savings of 12 to 21% over 6 months.

Stacey D, Bennett CL, Barry MJ, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev 2011;10:CD001431-CD001431

Arterburn D, Wellman R, Westbrook E, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. Health Aff (Millwood) 2012;31:2094-2104

Shared Decision Making to Improve Care and Reduce Costs

- "Section 3506 of the ACA aims to facilitate shared decision making by encouraging greater use of shared decision making in health care.
- However, more than 2 years after enactment of the ACA, little has been done to promote shared decision making.
- We believe that the Centers for Medicare and Medicaid Services (CMS) should begin certifying and implementing patient decision aids, aiming to achieve three important goals:

  -promote an ideal approach to clinician–patient decision making

  -improve the quality of medical decisions

  -reduce costs
- In our view, it seems most critical to begin with the 20 most frequently performed procedures and to require the use of decision aids in those cases."

Emily Oshima Lee, M.A., and Ezekiel J. Emanuel, M.D., Ph.D. New Eng J Med Jan 3, 2013

Decision Summary

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit under the Medicare program only if all of the following criteria are met:

Beneficiary eligibility criteria:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for LDCT lung cancer screening that meets the following criteria:
    - *For the initial LDCT lung cancer screening service:* a beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Social Security Act). A lung cancer screening counseling and shared decision making visit includes the following elements (and is appropriately documented in the beneficiary's medical records):
        - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
        - Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
        - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
        - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and
        - If appropriate, the furnishing of a written order for lung cancer screening with LDCT.
    - *For subsequent LDCT lung cancer screenings:* the beneficiary must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Social Security Act). If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria described above for a counseling and shared decision making visit.
    - Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information, which must also be appropriately documented in the beneficiary's medical records:
        - Beneficiary date of birth;
        - Actual pack - year smoking history (number);
        - Current smoking status, and for former smokers, the number of years since quitting smoking;
        - Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and
        - National Provider Identifier (NPI) of the ordering practitioner.

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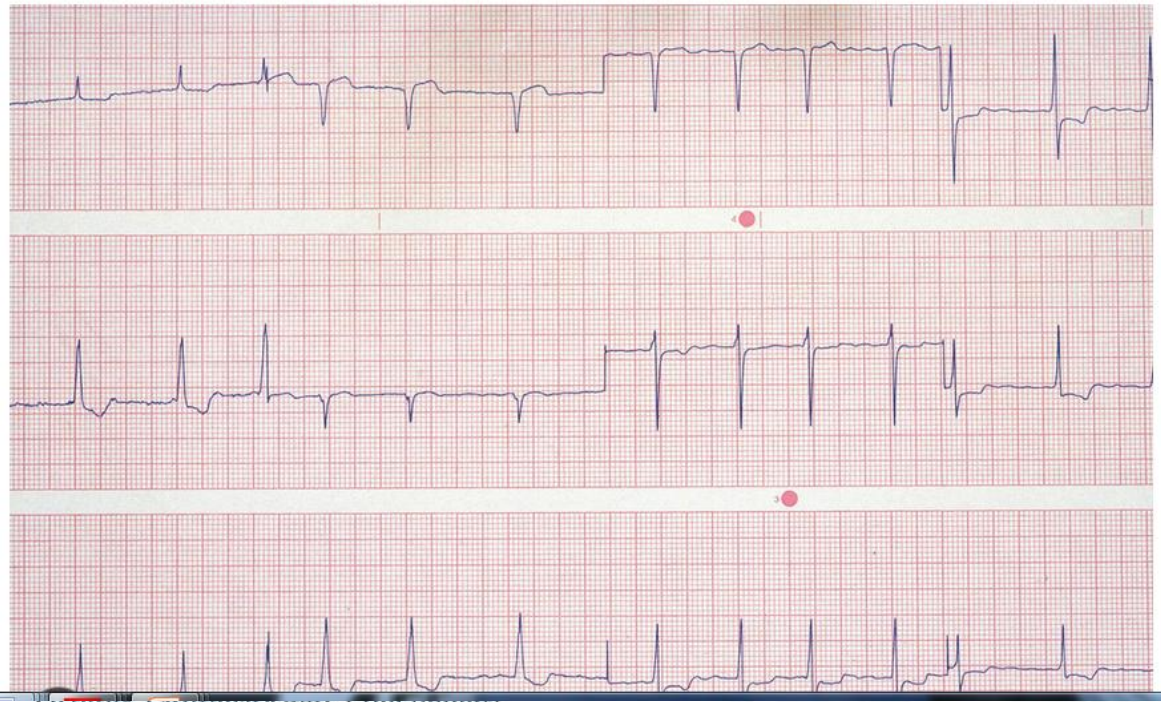
Medicare Requires Some Heart Patients to See a Second Doctor

Impartial medical counseling before surgery helps patients make decisions about their own care, leading to more satisfaction



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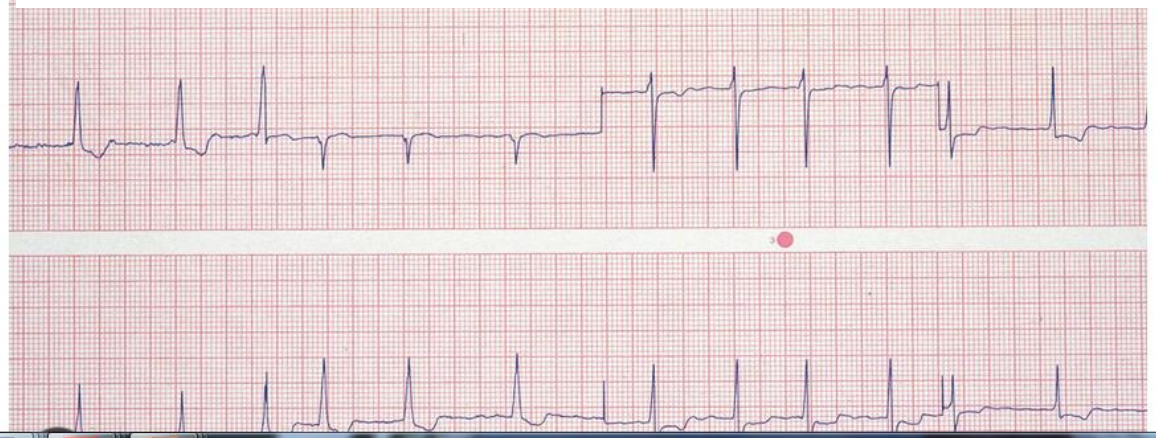
Medicare Requires Some Heart Patients to See a Second Doctor

Impartial medical counseling before surgery helps patients make decisions about their own care, leading to more

Medicare's new rule isn't about a second opinion, but rather about ensuring that patients' own opinions and values are taken fully into account when weighing risks and benefits to reach a treatment decision. Before Medicare will pay for Watchman, a doctor who doesn't implant the device must have a conversation with a prospective patient using so-called shared-decision making aids designed to elicit the patient's preferences.



Bringing the "Medicine of the Future" into Current Practice: *Opportunities*

- Team based care
- Remote telemetry
- Population management
- Selective genetic testing

Bringing the "Medicine of the Future" into Current Practice: *Examples*

- Team-Based Care
- Remote Telemetry
  - Home weights
  - Implantable monitors (rhythm, PA pressure)
  - Phone apps for BP and rhythm
- Population Management
- Selective Genetic Testing

Bringing the "Medicine of the Future" into Current Practice: *Examples*

- Team-Based Care
- Remote Telemetry
- Population Management
  - Risk pools
- Selective Genetic Testing

Bringing the "Medicine of the Future" into Current Practice: *Examples*

- Team-Based Care
- Remote Telemetry
- Population Management
- Selective Genetic Testing
  - Cardiomyopathy
  - Sudden death/long QT
  - Familial hypercholesterolemia

The Future of Cardiology in the Immediate Future: In and Out of the Hospital

IN HOSPITAL

1. Increased case complexity
2. Shift toward less invasive evaluations
3. Outcome metrics
4. Increased scrutiny for appropriateness, cost (*value*)
5. Emphasis on team care

OUT OF HOSPITAL

1. Increased case complexity
2. Remote monitoring ("there's an app for that")
3. Telemedicine
4. Increased use of TVU's
5. Increased supervisory role
6. Emphasis on shared decision making

“Imagination is rapid, but progress is often both uncertain and slow because of the many constraints of cost, regulation, and time needed to test and evaluate new developments. Yet we can now foresee a future in which medical science might actually defeat cardiovascular disease the way it has defeated polio, smallpox, and other serious scourges of the past.”

- Drs. Flower, Weintraub, Bove and Dreifus