The Quadruple Aim: How the ACC Can Improve the Lives of Its Members

Mike Valentine, MD, FACC
ACC Vice President
Centra Medical Group
Stroobants Cardiovascular Center
Lynchburg, VA
ACC Update: Member Value
(What have you done for me lately??)

Mike Valentine, MD, FACC
ACC Vice President
Stroobants Cardiovascular Center
Centra Health
Lynchburg, VA
Disclosures

• None
Objectives for Today

1. Brief ACC Update
2. Describe current CV practice environment
3. Discuss ACC focus on “Quadruple Aim”
4. Review current and future plans for Member Value/Well-Being
5. ACC position on Health Care Reform
6. Plea for Help!!
Our Mission
To Transform Cardiovascular Care
&
Improve Heart Health
More than 85 percent of U.S. cardiologists are ACC members

52,000+ members across the entire cardiovascular care team

48 Domestic Chapters

38 International Chapters

10 NCDR Registries
ACC in **2000** (26,000 Members)

- Associate Fellow
- FIT
- FACC/MACC

ACC in **2017** (52,000+ Members)

- FACC/MACC
- CV Team/AACC
- CV Admin
- Resident/CVT Student
- FIT
- Int'l Associate
- Associate Fellow

Source (Right): Data compiled from 2015 Year End Official Member Count
Other Membership Category Growth Since 2000

- Assoc Fellow
- Int'l Assoc
- CV Team
- FIT/Resident/CVT
- Student
Old Cardiologists; Really old General Cardiologists!

<table>
<thead>
<tr>
<th>CARDIOLOGY AGE QUARTILES</th>
<th>OVERALL</th>
<th>2013 BY SUBSPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 46 and below</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>Age 47 - 58</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>Age 59 - 70</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Age 71 and over</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: 2014 MedAxiom Annual Survey
ACC Focus 2016-17

1. MACRA, MACRA, MACRA
2. MOC (The “War” with ABIM)
3. Member Value
4. Governance Changes
5. Education/Guidelines
6. Health Systems/Accreditation
The Strategic Plan positions the College and its members for success in meeting the **Triple Aim** of improving cardiovascular health through **lower costs, better health and better outcomes**

**Align with the TRIPLE AIM to Improve Cardiovascular Health**

- Population Health
- Purposeful Education
- Member Value and Engagement
- Transformation of Care

**The ACC is the PROFESSIONAL HOME for the cardiovascular team**

**DATA, INFORMATION & KNOWLEDGE AND ADVOCACY ARE KEY ENABLERS OF THE COLLEGE’S MISSION.**
The Healthcare Environment

- MACRA: MIPS + Alternative Payment Models
- Value based purchasing
- Accountable Care Organizations
- Physician Quality Reporting System (PQRS)
- Preauthorization
- Bundled payments (capitation)
- Claims data profiling
- Utilization review
- Appropriate use auditing
- EHRs; meaningful use
- Public Reporting
- Payment cuts
- CMS audits
- Payer Programs
- Hospital employment
- Coverage determinations
- MOC / MOL requirements
- Certification exams

Less research funding
What’s Missing From the Triple Aim of Health Care?

It’s time to prioritize worker satisfaction, along with the aims of patient experience, population health, and cost reduction.

BY LARRY SOBAL, MBA, MHA, CMPE, AND SUZETTE JASKIE
From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD1 and Christine Sinsky, MD2,3

Author Affiliations

CORRESPONDING AUTHOR: Thomas Bodenheimer, MD, Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California at San Francisco, Bldg 80-83, SF General Hospital, 995 Potrero Ave. San Francisco, CA 94110, TBodenheimer@fcm.ucsf.edu or tbodie@earthlink.net

Abstract

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

© 2014 Annals of Family Medicine, Inc.

REFERENCES

Figure 2. The Fourth (missing) Aim is improved clinician experience.
What Percentage of Physicians Are “Burned Out?”

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>53%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>52%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>50%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>50%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>50%</td>
</tr>
<tr>
<td>HIV/Infectious Diseases</td>
<td>50%</td>
</tr>
<tr>
<td>Radiology</td>
<td>49%</td>
</tr>
<tr>
<td>Obstetrics &amp; Women's Health</td>
<td>49%</td>
</tr>
<tr>
<td>Neurology</td>
<td>49%</td>
</tr>
<tr>
<td>Urology</td>
<td>48%</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>47%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>46%</td>
</tr>
<tr>
<td>Diabetes &amp; Endocrinology</td>
<td>45%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>45%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>45%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>45%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>44%</td>
</tr>
<tr>
<td>Oncology</td>
<td>44%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>44%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>43%</td>
</tr>
<tr>
<td>Allergy &amp; Clinical Immunology</td>
<td>43%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>41%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>41%</td>
</tr>
<tr>
<td>Pathology</td>
<td>39%</td>
</tr>
<tr>
<td>Psychiatry &amp; Mental Health</td>
<td>38%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>37%</td>
</tr>
</tbody>
</table>

Figure 3. Recent data from Medscape show that burnout is not limited to a certain physician type.
Figure 4. Cardiologists rank number 2 in terms of severity of physician burnout, according to Medscape data.
What Are the Causes of Burnout?

- Too many bureaucratic tasks: 4.74
- Spending too many hours at work: 3.99
- Income not high enough: 3.71
- Increasing computerization of practice: 3.48
- Impact of the Affordable Care Act: 3.45
- Feeling like just a cog in a wheel: 3.54
- Too many difficult patients: 3.37
- Too many patient appointments in a day: 3.34
- Inability to provide patients with the quality care that they need: 3.22
- Lack of professional fulfillment: 3.05
- Difficult colleagues or staff: 2.9
- Inability to keep up with the current research and recommendations: 2.66
- Compassion fatigue (overexposure to death, violence, and/or other loss in patients): 2.6
- Difficult employer: 2.6

Figure 5. The issues that cause burnout in health care professionals, according to a recent Medscape report.
“The joy of practicing medicine is gone.”

“I hate being a doctor...I can’t wait to get out.”

“I can’t tell you how defeated I feel...The feeling of being punished for delivering good care is nerve-racking.”

“I am no longer a physician but the data manager, data entry clerk and steno girl... I became a doctor to take care of patients. I have become the typist.”
So What Did We Find Out from Our Members?
Biggest Challenges in CV Medicine

- Payment issues/new models continues to be a challenge in CV medicine. Two fifths (39%) of members identify new payment models/MACRA/ACOs as the biggest issue facing CV medicine. Work-life balance (28%), certification/MOC (21%), and extensive work load/work hours (20%) are also challenges.

Q: What are the three biggest issues you will face in cardiovascular medicine over the next three years?

* New category added in 2016
So, What did the ACC do in response?
MACRA (QPP) 2016-17

• Task Force
• >30 Chapter Presentations
• Leg Conference(3)
• Website- ACC.Org
• Webinars(Multiple)
• CV Summit
  – 50 Plenaries/Breakouts
  – Over 800 Attendees
ACC MACRA Task Force

• 16 Member MACRA Task Force appointed. Will be chaired by Dr. Paul Casale (BOT member)

• Develop strategic plan for ACC’s role in the MACRA environment
  – Advocacy
  – Education
  – Defining Quality CV Care
  – Resource Innovation

• Coordinate activity across College to ensure initiatives are aligned
HHS Advisory Committee on MACRA Physician Payment Models

- Jeffrey Bailet, MD
- Robert Berenson, MD
- Paul Casale, MD (ACC Nominee)
- Tim Ferris, MD
- Rhonda M. Medows, MD
- Harold D. Miller
- Elizabeth Mitchell
- Len Nichols, PhD
- Kavita Patel, MD
- Bruce Steinwald, MBA
- Grace Terrell, MD

Technical Advisory Committee for Assessing Physician Focused Payment Model (PFPM)
## MACRA Payment Adjustments

### Low Performance
- **Negative Adjustment**
  - 2015: ~+ 5%<br>  - 2016: TBD <br>  - 2017: TBD <br>  - 2018: TBD <br>  - 2019: TBD <br>  - 2020: TBD <br>  - 2021: +6%<br>  - 2022+: +10% or more

### Benchmark
- **Neutral Adjustment**

### High Performance
- **Positive Adjustment**

### PQRS+Value Modifier+Meaningful Use
- **PQRS+VM+MU Adjustments (combined)**

### MIPS Bonus/Penalty (max)
- **PQRS+Value Modifier+Meaningful Use**

### APM Bonus^<br>  - 2015: TBD <br>  - 2016: TBD <br>  - 2017: TBD <br>  - 2018: TBD <br>  - 2019: +5%<br>  - 2020: +5%<br>  - 2021: +5%<br>  - 2022+: +5%

* May be increased by up to 3 times to incentivize performance
$500 million funding for bonuses allocated through 2024
^ Alternative Payment Model APM +5% bonus funded through 2024
Pick Your Pace in 2017

Test the Quality Payment Program
- Report a minimum amount of data in at least one of the categories (for example, one quality measure, one CPIA, or all five required ACI measures)
- Avoid a negative payment adjustment in 2019

Participate for part of the calendar year
- Submit MIPS data across all categories for at least 90 days, which could begin anytime between Jan 1, and Oct 2, 2017
- Potential for a small positive payment adjustment in 2019

Participate for the full calendar year
- Submit data across all MIPS categories covering the full year reporting period, starting Jan 1, 2017
- Potential for a modest positive payment adjustment in 2019

Participate in an Advanced Alternative Payment Model
- Participate in an recognized Advanced APM and meet the patient or payment threshold in 2017
- 5 percent incentive payment on Medicare Part B payments in 2019
MOC-Progress with ABIM?

• 6 Leadership Meetings
• Progress on Many fronts
• Reasonable solutions are very close
ACC Input to ABIM Has Created Change:

- Reversal of the double jeopardy provision
- Decoupling of the initial board exam from MOC participation
- Streamlining the ability for practitioners to get both CME and MOC Part II credit
- Suspending MOC Part IV requirement
- Developing alternatives to ten year exam
The ACC is seeking the following from ABIM:

- Use the ACC SAP models as a potential replacement for the 10 Year recertification exam.
- Successful completion over 5 Years; eliminates need for exam.
- Join Sub-specialty societies for those exams as well.
The ACC is seeking the following from ABIM:

– An open-book format for those members choosing to take the 10-year exam. Allow access to all resources during exam (i.e., not limited to Up-to-Date)
The ACC is seeking the following from ABIM:

– Enable diplomates to seamlessly receive credit for activities in which they lead and participate in on behalf of hospitals, health care systems, payers and state medical boards.
MOC offered with Journal-Based CME

- As of September 1, 2016
- Read journal article
- Answer post-test questions
- Correctly answer 70% or better
- Self reflect in evaluation
- Claim CME and MOC
Future Plans

• “All CME is MOC eligible”
  – Virtually all of ACC.17 gained MOC credit
  – All live courses
  – All digital products
• Automated EBAC credit for European learners
• MOC eligibility for ABP and other boards
MOC offered with self-paced digital learning

- In depth core cardiology knowledge covering all topics in the ABIM topic blueprint
- Learning from text, audio, video
- Practice knowledge comprehension with hundreds of rigorous case-based questions with rationale and references
- Simulated Board exam sessions to identify areas of needed study
- Offers up to 155 MOC points
So What Comes Next?

2018 and Beyond..........
How the Proposed Priorities Were Developed

The proposed set of **2018 Strategic Priorities** was developed based on top-down input from the BOT and bottom-up input from committees and staff.
The following guidance on priorities was provided at the May BOT Meeting:

- “We need to take care of members, and help them take care of themselves”
- “Focus on younger members”
- “Consider practice management”
- “Develop the next Strategic Plan”
- “Advance current and future value to members”
- “Quadruple aim – wellbeing”

The following committees provided input:

- Accreditation Management Board
- Health Affairs Committee
- Lifelong Learning Oversight Committee
- Membership Committee (includes input from the Task Force on Diversity)
- NCDR Management Board
- Publications & Editorial Coordination Committee
- Science & Quality Committee
<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Strategies to <strong>Maintain Professional Competency</strong></td>
<td><strong>Reduce Members' Administrative and Professional Burdens</strong></td>
<td>Expansion from competency focus to encompass other burdens</td>
</tr>
<tr>
<td>Ensure <strong>Future Relevance of ACC Membership</strong> to CV Specialists</td>
<td><strong>Enhance Access to Education and Knowledge</strong></td>
<td>New priority</td>
</tr>
<tr>
<td>Further <strong>Develop and Grow Health Systems Strategy</strong></td>
<td><strong>Ensure Future Relevance of ACC Membership</strong> to CV Specialists</td>
<td>Continuation from 2017</td>
</tr>
<tr>
<td>Implement Programs and Initiatives that Support <strong>Population Health Management</strong></td>
<td><strong>Implement the Health Systems Strategy</strong></td>
<td>Continuation from 2017</td>
</tr>
<tr>
<td>N / A</td>
<td><strong>Enable Population Health Management</strong></td>
<td>Continuation from 2017</td>
</tr>
<tr>
<td>Implement the <strong>Governance Transformation Plan</strong></td>
<td><strong>Prepare for the Next Strategic Plan</strong></td>
<td>New priority</td>
</tr>
<tr>
<td>N / A</td>
<td>N / A</td>
<td>Superseded given this is largely complete</td>
</tr>
</tbody>
</table>
**Reduce Members' Administrative & Professional Burdens**

**Description:** Increasing administrative and professional burdens are taking caregivers away from what they do best – providing care. These pressures are leading to clinician burnout, increasing overhead costs, and impacting the appeal of cardiology as a career field. The initiatives related to this priority aim to address particular challenges with regulations, EHR usability and interoperability, quality reporting, payment transformation, MOC, and data collection.

<table>
<thead>
<tr>
<th>2018 Initiatives Category</th>
<th>Proposed Strategic Initiatives / Projects Submitted by Committees and Staff To be tracked on the Enterprise Strategic Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Wellbeing</td>
<td>1 Advocate for reduced administrative burdens, including prior authorization, electronic health record usability and interoperability, and improved consistency/validity of quality measures and reporting</td>
</tr>
<tr>
<td></td>
<td>1 Advocate for and educate members on changes in payment, including MACRA/QPP and alternative payment models</td>
</tr>
<tr>
<td></td>
<td>Launch working group to determine path forward on non-clinical best practices, CV team management, and clinician well-being</td>
</tr>
<tr>
<td>Maintenance of Certification</td>
<td>2 Support maintenance of CV certification for physician members</td>
</tr>
<tr>
<td></td>
<td>3 Further expansion of CME/MOC offerings on JACC.org</td>
</tr>
<tr>
<td></td>
<td>Continue negotiations with ABIM on Society Maintenance Pathway</td>
</tr>
<tr>
<td>Reduce Data Burden</td>
<td>4 Continue efforts to reduce participant data collection burden by enhancing NCDR’s integration with EHRs and other electronic data sources</td>
</tr>
</tbody>
</table>
The BOT engaged in a review and approval of the proposed Strategic Priorities that will serve as critical input into the 2018 budget process:

- Form a work group for Health Systems Strategy
- Form a work group for CV Team Management and Well-Being
- Imperative for an All Member Data Base
NOW THAT YOU HAVE SCARED ME TO DEATH, WHAT SHOULD I DO?

- Yell, “I’m mad as hell, and I'm not going to take it anymore!” Joel Landzberg
- Find Rick Chazal, as he will drink with me at any time
- Find Pam Douglas, as her cellar is better than Rick’s
- Realize that I am 63, and quit while I can!(Norm Lepor)
- Write down everything from the next slide, so that I will be prepared for all of the changes
PREPARATION FOR MACRA(QPP), A CHECKLIST FOR ROOKIES

• Meet with my practice manager on Monday and find out how much they understand
• Ensure that we have a CHAMPION physician in our group to work with administration
• Take today’s PowerPoint and review it with administration
• Develop the timeline checklist for our practice and hospital
• Meet with our EHR vendor to ensure we have the templates set to reach our MIPS goals
• Contact the ACC and join the PINNACLE Registry if we have not done so
• Go to ACC.ORG and get further information to help us get ready
And Finally….

The #1 reason to LOVE your ACC for the next several years?
The Best Chapters & Governors of Any Medical Organization in the World!
The ACC Vision

A world where innovation and knowledge optimize cardiovascular care and outcomes.
Congress, the Trump Administration, and ACA

- Current outlook: uncertainty
- Congress and new administration clearly committed to some manner of repeal/replacement of Affordable Care Act
- Congress has voted to trigger budget reconciliation, which will allow for repeal of some provisions
- Timing and manner of repeal and/or replacement unclear
- Trump executive orders further muddy waters
- Legislative and administrative changes must follow process
Health Affairs Committee Approach

• ACC and its leaders must:
  – Be engaged and informed
  – Maintain ACC’s reputation for rational non-partisan approach
  – Focus our engagement on desired outcome, not process or design

• HAC has developed ACC Principles for Health Reform to meet these aims
ACC Principles for Health Reform

- Principles provide ACC a rubric to evaluate new legislation and arm leaders and staff with focused, effective talking points.

- Principles follow three essential themes:
  - Maintain or improve patient access to quality, affordable insurance
  - Strengthen health system to foster innovation and quality
  - Improve patient and clinician satisfaction
Any new legislation to reform the health care system must:

• Expand access to and prevent loss of health care coverage through public and private programs

• Guarantee access to affordable coverage options for patients with cardiovascular disease or other pre-existing medical conditions

• Improve access to and coverage of preventive care and expand the nation’s investment in research, prevention, public health, and disease surveillance

• Continue and build upon policies to promote usability and interoperability of health information technology to improve patient care and outcomes

• Maintain commitment to patient-centered, evidence-based care and reverse the trends toward decreased personal contact between the patient and the physician/care team

• Emphasize professionalism, transparency, and the clinician-patient relationship to improve quality and promote better outcomes

• Foster collaborative development, testing, and expansion of models that promote and reward value, team-based care, and shared decision making through the Center for Medicare and Medicaid Innovation (CMMI) and other entities
ACC Principles for Health Reform

“Emphasize professionalism, transparency, and the clinician-patient relationship to improve quality and promote better outcomes”

• Point engendered lively conversation among HAC members
• HAC members expressed desire to advocate for practice stability/viability
• Practice stability is a core advocacy function included in 2017 ACC Advocacy Priorities; inclusion in these principles may be redundant
• Potential added text:
  “Avoid undue barriers to the delivery of efficient, high-quality care by cardiologists and other clinicians in the practice setting of their choice.”
ACC in Action

ACC sent 17 Congressional Letters in 2016

Comment Letters

• Senate Finance Committee - Improving Care for Individuals with Chronic Disease (1/16)
• Senate Finance Committee - Stark Law Principles (1/16)
• Senate HELP Committee - Bipartisan Health IT Discussion Draft (1/16)
• House Energy and Commerce Committee – Site-Neutral Payment Policy Clarification (2/16)

Letters of Support

• H.R. 3355/S. 488 – A bill that would allow PAs, NPs, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs (2/15)
• H.R. 3952/S. 2248 – Congenital Heart Futures Act (11/15)
• H.R. 546/S. 298 – Advancing Care for Exceptional (ACE) Kids Act (1/15)
• S. 2141 – TRUST IT Act of 2015 (1/16)
• H.R. 5001/S.2822 – Flexibility in EHR Reporting Act (4/16)

Letter of Opposition

• H.R. 5088 – Promoting Integrity in Medicare Act – (bill opposing removing the IOASE exception to the Stark law) – (5/16)

Coalition Letters

• Supporting increased funding for the NIH, FDA, and CDC – (3/16)
• Opposing an appropriations measure that would weaken the FDA’s authority over several tobacco products including e-cigarettes and cigars (4/16)
• Supporting level funding for the Agency for Health Research Quality (AHRQ) – (5/16)
• Supporting level funding for the CDC Office of Smoking and Health (OSH) – (7/16)
• Opposing all appropriations policy riders that would weaken FDA’s authority to regulate tobacco products – (9/16)
• American Academy of Pediatrics support letter for the Ensuring Children’s Access to Specialty Care Act, allowing pediatric medical and surgical subspecialists and pediatric mental health specialists to participate in the National Health Service Corps loan repayment program
ACC in Action

ACC sent **31 Regulatory Letters** in 2016

- Letter requesting that CMS implement a shortened reporting period in 2016 for the Meaningful Use EHR program.
- MIPS-APM proposed rule
- Physician Fee Schedule Proposed Rule (AUC, global services data collection, moderate sedation unbundling policy, specific codes, other items)
- Hospital Outpatient Proposed Rule (EHR reporting period, Section 603 site-neutral implementation, imaging APC assignments)
- Hospital Inpatient Proposed Rule (facility performance measures, new technology add-on payments, MS-DRG assignments)
- VA APRN proposed rule
- LAA NCD
- Leadless Pacemaker NCD
- Episode Grouper comments and nominations to clinical workgroup
- Venous Ischemic Limb Disease Medicare Evidence Development & Coverage Advisory Committee Meeting
- Part B Medication Demonstration Project Proposed Rule
- Update to UNOS/OPTN heart transplant criteria
- Medicare provider enrollment
- Ability of ACC to obtain Medicare claims data for research purposes
- Certification of EHRs for electronic measure reporting
- Draft PDUFA goals letter
- First proposed revisions to the Common Rule (the regulations governing research involving human subjects) in more than 20 years
- PDUFA & MDUFA stakeholder meetings as the FDA worked with industry to reach agreement. The results are borne out in the draft PDUFA agreement released last month (which we did comment on) and we think they are represented in the MDUFA agreement from what we know of it at this time (which we will comment on when released).
- Letter to FDA on sodium reduction targets
- Nominated Dr. Sherman to AHRQ National Advisory Council
- Medicare Shared Savings Program Benchmarking Rule Comments
- Comments to the LAN Cardiac Bundle White Paper
- Letter on the episode groups summary, patient encounter codes, supplemental episodes, and the clinical committee sign on
- Comments to the CMS measure development plan under MACRA
- JACC supplement on the population health summit, 2015
- First Lady Message for Opening Ceremony at ACC.16
- Letter to NHBLI on their website content
- Sign on letter to FDA on track and trace system for tobacco
- Sign on letter to FDA on new tobacco products
- Sign on letter to MLB on “knocking tobacco out of the park”
- Statement to USDA on Dietary Guidelines