We are in the midst of a tumultuous time in health policy. As new payment models gradually replace fee-for-service systems, new quality metrics proliferate, and costs of care become a bona fide health outcome, expensive imaging and procedures face increasing scrutiny. Responsible for >$300 billion in medical spending in 2010, more than any other diagnostic group, cardiovascular disease is understandably at the forefront of many new efforts to improve quality and reduce costs of care.

One of the most visible such efforts is the movement toward accountable care organizations (ACOs). As designed within the Medicare program, ACOs are groups of physicians and other providers who agree, as a unit, to provide high-quality care at costs that are lower than projected; if they do so, they are eligible to share in the savings. Currently, there are 368 Medicare ACOs up and running and 154 more in the private sector.

The hope, of course, is that providers participating in ACOs cut costs by cutting back on discretionary care where safe and appropriate while maintaining current levels of provision of nondiscretionary, high-value care. In this issue of Circulation, Colla et al use evidence from the pre-ACO demonstration project on which much of the ACO program is modeled, the Physician Group Practice Demonstration (PGPD), to determine whether this in fact took place.

Interestingly, the authors find that, despite the investment of millions of dollars into infrastructure, there was no difference in trends in utilization of either discretionary or nondiscretionary cardiovascular imaging or procedures between the PGPD groups and local controls. In fact, the groups were remarkably similar in both the pre-PGPD period and the post-PGPD period on all metrics of utilization that the authors examined.

Of course, every story has both good news and bad news. First, the good news: There was no drop in the use of nondiscretionary cardiovascular imaging or procedures over the study period for PGPD providers relative to controls. This can be interpreted as a safety signal or, in this case, a lack thereof. The authors found no evidence that care was inappropriately withheld from patients who needed it simply because it was expensive. This is highly reassuring, particularly given concerns that have been raised about whether the ACO model and spending targets will lead to rationing or withholding of high-value, potentially lifesaving care.

Now, the bad news: There was also no reduction in the use of discretionary cardiovascular imaging or procedures, which is where proponents of the ACO model had likely hoped that savings might accrue. Why did this set of incentives and requirements not lead to reductions in what seems like “low-hanging fruit” for clinical leaders hoping to cut costs? The authors offer a number of suggestions regarding why this may have been the case, including heterogeneity within systems, a focus on primary care, a lack of incentives at the locus of control over these tests, and an imbalance between the financial incentives on the side of savings versus the side of revenue.

The importance of the financial incentives cannot be overstated, as clearly outlined in the article. However, the systems problem runs deeper than that. One major issue is that to date, there has been little formal involvement of specialists in general, and cardiovascular clinicians in particular, as a focus of many ACO programs. In much of health delivery system reform, the first manner of engaging specialists may be to avoid them. There is a great deal of pressure on primary care providers (PCPs) to limit referrals to specialists (the “gatekeeper” role), with the rationale that much of the care that specialists provide constitutes costly overuse. Furthermore, many believe that if we strengthen primary care, there will be much less of a need for specialists.

In that context, how should we, as a cardiovascular community, conceptualize our role in ACOs and other delivery system reform efforts, keeping the study by Colla et al in mind?

One option would be to just step away (or stay away) from the table and leave the hard work of figuring this out to the primary care world. However, evidence suggests that this may not be the best choice for patients or for value. It is true that specialists tend to order more tests and procedures than primary care physicians and consequently tend to provide more expensive care. However, a growing body of evidence suggests that, in many cases, this may be high-value care despite its expense. For example, prior studies have shown that cardiologists have higher use of evidence-based therapies and lower mortality rates for heart failure, acute myocardial infarction, and stroke, despite a higher
burden of disease in specialist-managed patients. On the other hand, costs are 30% to 60% higher in the inpatient setting to achieve these outcomes.6,7 There is less evidence in the outpatient setting, but prior work generally suggests that specialists provide care that is more often in keeping with guidelines and quality metrics, and they achieve better outcomes.8 Further research is needed to understand the value of specialist care for these conditions, but certainly having cardiovascular specialists step away from the management of complex cardiovascular disease is a waste of considerable knowledge and training.

The second option is to focus on improving the efficiency of cardiovascular care through societies and guidelines. Decision making about which tests and procedures can be safely forgone, and which are high-value and should be obtained, despite their expense, is often complex and should involve input from clinicians most experienced with the test and procedures in question. To this end, there have been efforts within the community to create and disseminate appropriate use criteria (eg, for percutaneous coronary imaging and imaging studies).9 Furthermore, through the Choosing Wisely campaign, a number of cardiovascular groups have agreed to make recommendations about low-value care that should be avoided, including the American College of Cardiology, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, and Society for Vascular Medicine.10,11 However, this approach has limitations as well; innovations here are iterative rather than transformative.

Option 3 is to try to become the leading edge of the solution. We have the collective experience and ability to help to fundamentally transform healthcare delivery, particularly for our complex patients. We can and should be leading the way in thinking of truly innovative ways to work with PCPs to care for patients with cardiovascular disease. Of course, one foundational innovation that is necessary is in the area of coordination and communication. Prior studies have found that the typical PCP has 229 other physicians working in 117 other practices with whom care must be coordinated, which is a deeply daunting task.12 Perhaps in part because of this complexity, the relationship between PCPs and specialists is often fragmented: 68% of specialists report receiving no information from the PCP before referral visits, and 25% of PCPs report receiving no information from specialists within a month after referral visits.13 Clearly, if we want to transform care, we must address our interactions with the primary care community.

Providing innovative, preference-sensitive, patient-centered care that also is high in value will require thinking about new organizational structures as well. For example, the recognition of the concept of a “medical neighborhood,” in which primary care and specialty care are linked together to provide patient-centered care in a seamless fashion,13 has the potential to improve care for our complex patients, but this has been understood and underembraced by specialty communities at this point. As PCPs under ACOs attempt to cut costs without inappropriately cutting high-value services, input from specialists is essential (eg, helping to decide which patients need stress testing with imaging or which patients should be referred for coronary angiography), but the relationships that allow for collaborative decision making must be built before they can be utilized. Finally, new payments for care coordination from Medicare,14 although in most cases most appropriate for primary care, may be billable by specialists in cases in which the specialist is at the hub of a complex patient’s coordination of care. Patients with heart failure, transplantation, ventricular assist devices, or congenital heart disease, for example, may ultimately need to center their care with their specialist rather than with their primary care physician.

Cardiovascular clinicians must be involved and engaged if we are to meaningfully increase the value of healthcare delivered in this country. With such a large proportion of healthcare spending coming from cardiovascular care, ACOs are unlikely to make a significant difference in regard to this problem, particularly in a safe and efficient way, without meaningfully engaging these clinicians. The study by Colla et al should be a wake-up call to those ACOs who have not yet developed a strategy for doing so, and a reminder to those who have, that specialists can contribute at the ACO table.

Disclosures
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References


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