The Importance of Specialist Engagement in Accountable Care Organizations

Running title: Joynt; Specialists and ACOs

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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 bonified health outcome, expensive imaging and procedures face increasing scrutiny. Responsible for over $300 billion in medical spending in 2010,\(^1\) 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 towards ACOs, or Accountable Care Organizations. 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 – and if they do so, are eligible to share in the savings. Currently, there are 368 Medicare ACOs up and running, and 154 more in the private sector.\(^2\)

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 non-discretionary, high-value care. In this issue of Circulation, Goodney 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.\(^3\)

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.\(^3\)

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 didn’t this set of incentives and requirements 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 manuscript. 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 most frequently proposed manner of engaging specialists seems to be to avoid them. There is a great deal of pressure on primary care physicians to limit referrals to specialists (the “gatekeeper” role), with the idea that once a patient makes it to a specialist, that clinician will run roughshod over any spending limits – and that much of the care that specialists provide constitutes overuse. Further, there seems to be support for the idea that if we strengthen primary care there will be much less of a need for specialists. Though critical to support primary care,
focusing solely on primary care oversimplifies the issue.

So how can we, as a cardiovascular community, conceptualize our role in ACOs and other delivery system reform efforts, keeping the study by Goodney 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 would suggest that this may not be the best choice for patients or for value. True, specialists tend to order more tests and procedures than primary care physicians, and consequently tend to provide more expensive care. However, there is a growing body of evidence to suggest that this may, in many cases, 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 30-60% higher in the inpatient setting to achieve these outcomes. 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 achieve better outcomes. 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. Now, to be sure, the question is not whether we need to reign in overuse; the question is whether we as a cardiovascular community want to do it ourselves, or if we want it to be done to us. Being part of the conversation is important to avoid the kind of indiscriminate cost-cutting that could be detrimental to patients. To this end, there have been
major movements within the community to create and disseminate appropriate use criteria – for
PCI and imaging studies, for example. Further, through the Choosing Wisely campaign, a
number of cardiovascular groups have signed on to make recommendations about low-value care
that should be avoided, including the American College of Cardiology, the American Society of
Nuclear Cardiology, the Heart Rhythm Society, the Society for Cardiovascular Angiography and
Interventions, the Society of Cardiovascular Computed Tomography, the Society for
Cardiovascular Magnetic Resonance, and the Society for Vascular Medicine. However, this
approach has limitations as well – innovations here are iterative rather than transformative.

Option three is to try to become the leading edge of the solution. We have the collective
experience and ability to help fundamentally transform health care delivery, particularly for our
complex patients. We can, and should, be leading the way in thinking of new and truly
innovative ways 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 primary care physician has 229 other physicians working in 117 other
practices with whom care must be coordinated, a deeply daunting task. Perhaps in part due to
this complexity, the relationship between primary care physicians and specialists is often
fragmented – 68% of specialists report receiving no information from the primary care physician
prior to referral visits, and 25% of primary care providers report receiving no information from
specialists within a month after referral visits. Clearly, if we want to transform care, we have
to 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\textsuperscript{13} has the potential to vastly improve care for our complex patients, but has been under-studied and under-embraced by specialty communities as yet. As primary care physicians under ACOs attempt to cut costs without inappropriately cutting high-value services, input from specialists is essential – for example, 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 with both patients and primary care physicians must be built before they can be utilized. Finally, the availability of new payments for care coordination from Medicare\textsuperscript{14} though in most cases most appropriate for primary care, may be billable by specialists in cases in which the specialist is the hub of a complex patient’s coordination. Patients with heart failure, transplant, 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 health care delivered in this country. With such a large proportion of health care spending coming from cardiovascular care, ACOs are unlikely to move the needle, particularly in a safe and efficient way, without meaningfully engaging these clinicians. The study by Goodney 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 need to be at the ACO table.

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