

ACC NEWS

President's Page: Reframing Debate in Patient Care Image

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If you think the current crisis in cardiac imaging does not apply to you, read on. Imaging concerns impact all of us, regardless of our clinical subspecialty. Whether you directly provide imaging services to your patients or not, this contentious issue reflects the larger dilemma of introducing new technology into clinical care plans. With legislators, regulators, payers, and media scrutinizing our medical decisions, it feels as if the once hallowed patient-physician relationship is quickly eroding into a free-for-all medical melee, where decisions about patient care are made by those least qualified to make them.

Concerns about imaging volumes are valid. The absolute number of diagnostic scans is rising and, consequently, so is the associated cost. The shift of imaging out of the hospital and into the physician's office means that technical revenue is more likely to be realized by cardiovascular providers than ever before. Although potentially inappropriate financial gain is made possible by this shift, it must be—and will be—sternly guarded against (1).

At the same time, new technologies, such as computed tomography (CT), magnetic resonance (MR), positron emission tomography, and combined modalities, are quickly pushing the envelope beyond the scope of our clinical guidelines. Early adopters of imaging technology are left to justify their utilization decisions in an environment devoid of credible data defining what constitutes quality imaging. Once again, cardiovascular specialists are pioneers and are unfairly becoming the target of misguided accusations.

Specialists are faced with a challenging conundrum: imaging tests are becoming ubiquitous tools for everyday patient care, yet physicians continue to battle cost-conscious restrictions on using imaging for their patients. Cardiovascular specialists with years of imaging experience face being told they are “unqualified” to perform imaging services by private health plans (2) or by the federal government through its advisory arm, MedPAC, and its funding agent, the Centers for Medicare & Medicaid Services (3).

What is missing is the evolution in cardiovascular care that properly imbeds imaging into a patient's care plan. This tectonic plate shift from imaging as an external diagnosis confirmation to an internal care tool continues to be missed in the discussion. Imaging is now considered fundamental to daily treatment by many cardiovascular specialists, on par

with blood pressure cuffs and stethoscopes, albeit much higher tech.

Unfortunately, radiology leadership has taken the lead in shaping the debate, framing the issue in terms of specialty rather than application. Using terms like “non-radiologist,” the American College of Radiology (ACR) is polarizing the House of Medicine and pushing an agenda that promotes its proprietary, specialty-centric guidelines, appropriateness criteria, and accreditation programs as the foundation for imaging reimbursement policies (4).

The ACR's self-serving turf battle is a disservice to the medical profession and, most importantly, to our patients. Collaboration, not exclusion, is the key to appropriately addressing imaging application to daily patient care. Working with our chapters, cardiovascular organizations and other specialty groups, the American College of Cardiology (ACC) is reaching out to Congress, state legislatures, federal agencies, and private health plans to ensure that imaging policies reflect a system that encourages appropriate imaging given by qualified providers to produce the best patient outcomes.

The Cardiovascular Imaging Collaborative, comprising nine colleague associations, has developed a position paper on specialist-delivered imaging that will soon be presented to each group's leadership for adoption. The ACC also has led the formation of the Coalition for Patient-Centered Imaging (CPCI), which counts more than 20 medical specialties as members. Kim Williams, MD, FACC, successfully testified on the CPCI's behalf before the House Ways and Means Subcommittee on Health in March about this issue.

Recognizing that we need clinical guidance in this emerging field, the ACC is developing patient-based decision-making tools. An American College of Cardiology Foundation/American Heart Association clinical competence statement on computed tomography and magnetic resonance imaging outlines the essential cognitive and technical skills necessary to adequately perform cardiac CT and MR scans. This statement was developed in concert with the American Society of Echocardiography, American Society of Nuclear Cardiology, Society of Atherosclerosis Imaging, Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance.

This summer, the ACC will release appropriateness criteria that will focus on nuclear imaging. Resulting from another cooperative effort among relevant medical societies and other stakeholders, these first-ever criteria will build upon our guidelines and evaluate the appropriateness of ordering and performing nuclear imaging tests for indications specific to cardiovascular patients. This methodology will serve as our model for future policies on CT and MR services and, eventually, will be employed in the determination of imaging efficiency across all modalities.

As cardiovascular specialists incorporate imaging into ongoing patient care regimens, interest in continuing education has skyrocketed. The ACC's programs related to imaging are consistently full, and the inaugural Integrated Cardiovascular Imaging Conference directed by James D. Thomas, MD, FACC, has sparked unprecedented interest. This August, a program in San Francisco will examine four modalities over a three-day period, bringing together more than 30 nationally recognized faculty. Participants will receive, for the first time, companion copies of CMRSAP and EchoSAP to enable continued learning at home following the conference.

In fact, all of the ACC's self-assessment products with imaging-related content, including CMRSAP, EchoSAP, and ACCSAP 6, are selling briskly. These signs point to the fact that we are just cresting the first wave of interest in cardiovascular imaging modalities. This is not a fad or a phase; this is a new era of cardiovascular medicine, and ACC members must lead the way or be led by others.

With imaging guidelines and research sometimes lagging behind the revolution of judicious application of cardiovascular imaging, physician experience is critical in keeping

decision-makers informed about practice realities. Legislators, regulators, and payers need to learn more about the importance of imaging to your practice and to your patients. If you are currently using diagnostic imaging technology in your practice, please get involved with the ACC's imaging activities. We cannot afford to assume that imaging restrictions will not happen. Join the brand-new grassroots Cardio Advocacy Network (CAN) (5), donate to the ACC Political Action Committee (PAC) (6), attend the ACC Legislative Conference (September 18 to 20 in Washington, DC), or invite a legislator or health plan officer to visit your practice for a day. The crisis is real, and it affects us all.

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