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ACC NEWS

# President's Page: Cardiovascular Professionals: Are We Knights in Shining Armor or Just Knaves and Pawns?

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*ACC President*

"We are all in the same boat in a stormy sea, and we owe each other a terrible loyalty," wrote English author G. K. Chesterton in the early 1900s (1). While he was not referring to cardiovascular professionals at the time, his quote could not be a more fitting description of the current state of cardiology.

To date, cardiovascular professionals across the U.S. are facing ever-increasing demands for quality reporting, maintenance of certification, and adoption of health information technology. At the same time, reimbursement for services provided continues to decline and administrative burdens on practices related to pre-authorization and coding changes are on the rise. We are now also being faced with accusations of practicing cardiovascular medicine in a manner that promotes a waste of valuable resources and, at times, gross abuse or fraud. This is our storm, and we are most definitely all in the same boat.

How we react to this storm will determine our future. At the American College of Cardiology's (ACC's) Legislative Conference this past September, I presented our alternatives in medieval terms as posed in a recent editorial by Drs. Sachin H. Jain and Christine K. Cassel in *JAMA* (2). Are we going to be knights, knaves, or pawns?

If we react as knights, we can take stewardship for the health care system into our own hands. Society will view us as true professionals who can be trusted to practice appropriate use of resources because we are basing our treatments on the latest and best scientific evidence. As knights, we will put the interests of patients before personal financial gain and we will be rightfully perceived as champions of patients and respected advisors on health care policies that affect public health.

If we react as knaves, we can expect policy, management, and educational efforts will be designed to combat and work against us, rather than with us. Monitoring for abuse, fraud, and waste will be required, because we will be perceived as putting our self-interest before that of our patients. As knaves, we will only learn new techniques and procedures and stay on top of the latest research out of the need for self-glorification and/or the financial rewards tossed our way as our means of motivation.

If we are perceived to be pawns, we can rest assured that policymakers and regulators will develop systems that decide our clinical priorities and guidelines because we will be viewed as unpredictable and lacking the judgment to reliably do what is right. As pawns, we will study because licensing and board exams require we do so, not because we want what is best for our patients. We will perform tests and procedures based on external requirements, not clinical need.

The implications of being pawns or knaves are clear. We will inevitably be viewed as an obstacle, not as leaders in creating a functioning health care system, and our actions will be guided by strict regulations or incentive payments, not by our professional ethics. We can also expect increased scrutiny over quality of care in order to control unwarranted variation in care, waste, and even fraud.

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It is apparent to many of us that government, payers, and others are increasingly regarding the modern U.S. clinician as a knave or a pawn. Very rarely are we viewed as knights. If we are to survive the current stormy sea, I believe the "terrible loyalty" we owe each other is to prove ourselves as knights of the health care system in support of our patients. We must continuously demonstrate professional competence and a commitment to ensuring patient access to high-quality, appropriate care. In addition, we must be honest with patients and maintain trust by effectively managing conflicts of interest, including an increased commitment to transparency. We must also demonstrate our scientific knowledge and have the courage to lead and even take a public stance on issues and policies that will affect our patients.

During my presidency, I have been honored to be at the helm of a professional society like the ACC, which is constantly adapting to best serve as a training ground for knights through our continual development of a broad array of "armament" to best equip us in our noble mission. We have taken a stand on health care reform and have stood by the principles we drafted two years ago, even when others disagreed with us. These principles stated that health reform should:

- Provide universal coverage;
- Provide coverage through an expansion of public and private (pluralistic) programs;
- Focus on patient value—transparent, high-quality, cost-effective, continuous care;
- Emphasize professionalism, the foundation of an effective partnership with empowered patients;
- Ensure coordination across sources and sites of care; and
- Include payment reforms that reward quality and ensure value.

The new health reform law addresses several of these principles, but it does little to address others. As Congress, the Centers for Medicare and Medicaid Services (CMS), and others work to implement the law, we are working hard to change those things we do not like (i.e., the Independent Payment Advisory Board), as well as ensure elements that are not included (i.e., payment and tort reforms) are addressed in a way that ensures patient access to quality cardiovascular care.

We are also tackling issues related to accountable care organizations (ACOs), payment reform, and team-based health care in an increasingly successful effort to prove that we can be trusted with stewardship of our health care resources. Government and payers are now consulting with the ACC, and we are more and more becoming viewed as a sage health care advisor and partner. Most recently, the College submitted comments to CMS Administrator Dr. Donald Berwick on the development of ACOs. ACOs, by definition, are required to adopt a patient-centered approach to providing evidence-based medical care. The comment letter (3) highlights the College's leadership in the realm of data registries and clinical guideline development, as well as its commitment to patient-centered care through initiatives such as a clinician/patient shared decision-making project, which is being designed to support appropriate use of medical therapy, percutaneous coronary intervention (PCI), and coronary bypass graft surgery for stable coronary heart disease patients.

"All of these quality initiatives will be for naught, however, if there are legal impediments to unrelated physicians working together to develop quality improvement strategies and initiatives and to specialty societies employing those strategies in a swath of unrelated institutions and practices across the country," the letter states. "Physicians should be rewarded for the role that they play in reducing the costs of care, whether through reductions in inappropriate testing or increased patient compliance as a result of additional time spent on patient education."

Other areas where we are sharpening our swords: reducing racial disparities through our credo program, empowering patients through the CardioSmart national care initiative, and training the next generation of cardiovascular leaders through the Cardiovascular Leadership Institute. We are also making it easier for cardiovascular professionals to stay abreast of the latest science and use guidelines and appropriate use criteria at the point of care.

Another example of the ACC's knighthood is our active discussions with several health plans regarding adoption of an ACC-sponsored alternative to radiology benefit managers; this alternative is based on the ACC's appropriate use criteria and would be tied to quality improvement and education tools. Discussions also continue with health plans on the use of registries, such as the PINNACLE Registry™, as a means of reporting and measuring quality that does not involve relying solely on claims data. We are also finalizing plans to fully implement our IMPACT congenital heart disease registry. With this latest registry, ACC demonstrates its commitment to life course issues—from children to the elderly—in the use and evaluation of evidence-based practices. Finally, the College's Cardiovascular Practice Improvement Pathway is also nearing completion. The pathway is designed to help practices establish relevant quality goals and targets and to provide a road map to guide performance improvement activities. It is also intended to bring consistency

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to market by standardizing the methodology for how cardiovascular practices are assessed and recognized.

The Hospital to Home (H2H) initiative and the D2B Alliance for Quality are proof positive that we can come together as a profession to address care issues and—more importantly—fix them. Through the D2B Alliance we have seen door-to-balloon times around the globe decrease to meet the guideline recommended time of 90 min or less. The H2H initiative is on its way to doing the same and reducing cardiovascular-related hospital readmissions by 2012.

Our partnership with the Society for Cardiovascular Angiography and Interventions (SCAI) to provide accreditation of hospitals that perform invasive cardiac and endovascular procedures is also an area where we are acting as "knights of cardiology." The Accreditation for Cardiovascular Excellence (ACE) organization will review hospitals and then accredit those that achieve pre-determined benchmarks for quality care that have been shown to improve patient care. Currently, ACE is providing accreditation for hospitals that do carotid artery stenting, but plans to expand to other procedures such as PCI. The accreditation lasts for two years, and then hospitals must be reviewed again. Both the ACC and the SCAI believe that the ACE initiative, combined with our appropriate use criteria implementation for coronary revascularization and imaging, will be invaluable in addressing the state of Maryland's recent concerns of alleged inappropriate PCI in their state. Professional societies have the expertise to best evaluate and advise stakeholders related to these concerns, particularly if we respond to these challenges as knights rather than as knaves or pawns.

To quote President Barack Obama's January 2009 inaugural address: "We understand that *greatness* is never a given. It must be earned. Our journey has never been one of shortcuts or settling for less. It has not been the path for the fainthearted . . ." (4). We are definitely in the middle of a storm, and at times it appears that we are stuck in shark-infested waters, but we have the tools and the ability to successfully navigate and even help shape the landscape on the other side. My challenge to all ACC members: join me in the knighthood of professionalism. Let us not settle for being knaves or pawns, but let us lead the charge in transforming health care from the inside out.

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