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ACC NEWS

President's Page: Taking Up the Challenge and Continuing the Charge

W. Douglas Weaver, MD, FACC
ACC President

This past year we have had to confront the possibility of many changing scenarios that will affect our health care system and, consequently, our profession and the American College of Cardiology (ACC). As the reality of these scenarios has grown, the College has taken a proactive approach in guiding possible reforms to our health care system. We have also taken on the difficult task of preparing members for the very likely changes to come. Central to all our efforts has been a clear mantra—quality of patient care must guide change, and practitioners need to be the ones defining quality.

In his first President's Page one year ago, James T. Dove, MD, MACC, put forth a vision of electronic health records (EHRs), describing their value in assisting cardiovascular professionals to improve patient care on a case-by-case basis. Used to their fullest potential, EHRs potentially offer more than just accuracy and timeliness of patient records and cost-effective recordkeeping. The EHRs systems that include practice guidelines, performance measures, and appropriateness criteria in their database, enable practitioners to immediately reference information for an individual patient's care. Such systems, however, are currently uncommon and information technology, which has revolutionized American business and our own personal lives, is on par with the tube radio in U.S. health care.

Quality, particularly its importance in guiding health care reform decisions, continued to be the underlying message of 2007. Now, as we face 2008, an election year, it becomes more and more apparent that health care system reforms will happen. It is also apparent that the ACC's decision to take a proactive role in reform discussions has been a good one. We are seated at the table in discussions with payers, the government, and other providers, and our quality message is being heard.

As an organization and a profession, we face a daunting task. What will reform look like? Will we really be able to define "quality of care" or will payers use their past approaches and define quality as cost-effectiveness instead? How will reform affect our reimbursement fees? After all, we have spent years attempting to enact a correction of the sustainable growth rate (SGR) formula. Where will that stand?

Will we really be able to define "quality of care" or will payers use their past approaches and define quality as cost-effectiveness instead?

At times, we may feel ill-prepared to address these challenges, yet we are far ahead of many other organizations and medical specialties and even the payers. The ACC's quality agenda, which includes practice guidelines, performance measures, appropriateness criteria, and the National Cardiovascular Data Registry (NCDR™) and its multiple databases, is having an impact in health care reform discussions.

Still, many of us may question the need for health care reform and feel that the ACC should follow the actions of other societies and fight any change, rather than work within the system to guide change. When we have our moments of doubt, we need only to look at the bigger health care issues faced by us and our society.

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- The rising cost of health care threatens to make insurance unaffordable for a large portion of our middle class; it threatens people's wages as businesses use increases in total compensation to pay higher health care premiums.
- Primary care is becoming a specialty that is off the radar screen for new physicians, the average of whom enters practice with $120,000 to $160,000 of debt. We have all seen patients shuffled among subspecialists when what they needed was a physician who could put all of their problems into perspective. A solid primary care infrastructure is paramount if we are to deliver the greatest "value" and truly meet the needs of our patients.
- This year, we sit in limbo until June or July, not knowing whether we will be victims of a 10% pay cut, yet we know that permanently fixing the SGR formula under our current structure would require an impossible sum, which means it just will not happen.
- The current payment reconciliation process with insurance companies has become unbelievably complex, angering both physicians and patients and resulting in excessive overhead costs that add little if any value to a patient–physician encounter.

How did medicine get so messed up? How will we cope with all of this?

Understanding Our Responsibilities

We can take great pride in the many advances in cardiovascular diagnostics and therapies that have occurred in recent years. The death rate from cardiovascular disease has declined another 26% in just the past few years. Yet, although Congress and our patients recognize these advances, both question whether we always use these new tools appropriately. For example, how can we explain the 5- to 6-fold geographic differences in procedure use that is not attended by superior outcomes for patients? In fact, recent data show that the U.S. has slipped in the Western world to number 19 in reducing preventable deaths. Some skeptics suggest that as much as one-third of the diagnostic testing performed is unnecessary and adds no value. They say that all the required funding for universal coverage could be financed by controlling this factor alone. Some patient coalitions view professional societies as self-serving guilds rather than organizations concerned about attenuating the cost of health care and increasing the value of health care to patients.

We cannot change all of the issues surrounding health care and reform on our own. However, we need to concentrate on what we can control or change. To begin, I believe that we as practitioners need to be more accountable for the dollars spent in cardiovascular care. For example, the College has been out front with its evidence-based practice guidelines and recently with the appropriateness criteria for cardiovascular imaging. We need to implement the guidelines, appropriateness criteria, and quality tools more consistently in our day-to-day practices. Simply put, we need to put our energies into improving quality and patient safety.

We must consistently choose what works best at the lowest cost and consistently apply that concept—until we have found something better that replaces it. We need to advocate for payment aligned around quality and uncouple payment strictly for volume and complexity.

We also need support for information technology expansion and a fix for the payment reconciliation process. To lower costs and provide more value, we must make health care more convenient, rely more on self service and self care, and use technology more effectively.

This past year, Jim Dove challenged us all—both the organization and the profession—in a call to action on quality and health care reform. I am carrying that challenge forward in 2008. Talk with your colleagues, ask them to come and join our charge into the future. Threats of reducing care and/or demanding more payment for the status quo are nonstarters.

We need to find ways to improve the quality of care that you deliver to your patients—join the NCDR™ registries, particularly our new IC^3 Program™, Improving Continuous Care, a program aimed at providing quality assessments for your outpatient practices.

The next couple of years will be riddled with change. We must approach them by putting patients first and concentrating on quality. Ultimately, we will be rewarded. At the ACC, we have chosen the high road—let us all step up to the challenge to continue on that road.

Address correspondence to:
W. Douglas Weaver, MD, FACC
American College of Cardiology
2400 N Street NW
Washington, DC 20037