JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 67, NO. 18, 2016

ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jacc.2016.03.487

LEADERSHIP PAGE

A Call to Action in Changing Times

Richard A. Chazal, MD, FACC, *ACC President*

"These are changing times!" is an overused cliché, especially in a major election year, but is perhaps more germane now than ever in the health care arena, particularly the field of cardiac care.

Advances in diagnostics and therapeutics are being made at a rapid pace, holding promise for breakthrough treatments in heart failure (1), managing hyperlipidemia and hypertension (2,3), and saving and improving the lives of patients who only a few years ago were considered untreatable (4). In addition, the geometric expansion of information technology and communications is enabling widespread clinician access to the latest research, evidence-based guidelines, continuing medical education resources, and point-of-care decision support tools (5). Patients too have greater access to information about healthy living, disease states, treatment options, and even their health care providers (6).

Our professional world is metaphorically becoming smaller as many of these changes make it easier to collect and share information, submit and publish research, stay up-to-date on lifelong learning, and connect with colleagues from around the globe. Looking at the American College of Cardiology alone, a growing number of hospitals and practices in countries like China, Mexico, Brazil, and Saudi Arabia are involved with hospital or outpatient registries that fall under the NCDR (National Cardiovascular Data Registry) umbrella (7). As global registry use grows, so does our ability to track and improve the quality of cardiovascular care around the world.

When it comes to research, nearly 60% of the submissions to the *Journal* are now coming from outside of the United States, with this number only expected to rise. New open access journals are also proving successful in helping researchers broadly disseminate knowledge in a particular field of study. Features like audio summaries make it easier to synthesize and promote research highlights outside of only reading a journal. The opportunity for us to learn from one another is unprecedented.

How we learn and keep up with education requirements is an area of immense change. Online learning opportunities continue to grow and progress. Mobile applications for bedside use in care—and in shared decision making—continue to be developed. Live educational programs have changed over the years to support interactive and virtual learning. Most major physician organizations recognize that, although major meetings bring great value, many professionals are obtaining their information from digital media, or smaller venues. It's important to have lifelong learning offerings that are developed in response to learner needs and to available technology.

The demographics of patients and the profession continue to evolve as well. There is a global increase in the number of patients over the age of 65 years who are living longer with cardiovascular diseases (8). In addition to this aging population, we also face a growing number of patients both young and old with significant cardiovascular risk factors like obesity, diabetes, hypertension, and high cholesterol. The tremendous strides in the treatment of children with complex congenital heart disease has resulted in a new wave of adult congenital heart disease patients for whom many of us are inadequately trained to effectively manage (9). Cancer survivors with cardiovascular disease related to malignancy or treatment present new challenges. We cannot treat all of these patients in isolation, but rather must work with our colleagues in primary care, pediatrics, oncology, and other medical specialty fields.

From the American College of Cardiology, Washington, DC.

Professionally, the care team has grown to span the continuum of care and now involves nurses, nurse practitioners, physician assistants, cardiovascular administrators, pharmacists, emergency medical personnel, and more. Physicians are continuing to learn the value of our colleagues, with complementary skillsets that hold the promise of improved care for our patients. In the face of expanding populations of cardiovascular patients, improved efficiency of physicians and improved access for patients demands that we learn the best processes to work together as a team (10).

Challenges in health care disparities also persist (11). We must better respond. One solution lies within ourselves. Although our profession has grown more diverse in terms of sex, race, and ethnicity, we still have room for improvement in terms of pay equity, work/life balance, and further diversifying our ranks to meet the needs of our diverse patients (12,13). Just like the general population, a large number of practicing cardiologists are also aging, and we face shortages in those who would follow in our footsteps (14).

In the United States, technological and demographic changes are occurring in an environment of changing practice types, increasing scrutiny, burdensome documentation and administrative requirements, and evolving (and often confusing) continuing education processes (15,16). These changes, layered on the need to care for an increasingly ill patient population, present a daunting challenge to simultaneously deliver state-of-the-art compassionate care while fulfilling (often onerous) nonclinical requirements.

The most dramatic systematic changes that we are likely to see in our professional lifetime are on the immediate horizon. The Medicare and CHIP Reauthorization Act of 2015 (MACRA) has the potential to have a bigger effect on U.S. health care than the 1965 creation of the Medicare and Medicaid programs themselves (17,18). MACRA, which permanently repealed the flawed sustainable growth-rate formula used to calculate Medicare physician payment, established a definitive framework for moving Medicare from a volume- to value-based system—a framework that other payers are certain to follow. As with many laws, MACRA was written with broad directions that will be implemented through more specific regulation by the federal agencies over the next few years. Because of the economic underpinnings of the move to a value-based system, repeal or fundamental change is not a political likelihood. Details on implementation are not yet clear. However, the early years of MACRA will likely pose some very real challenges to physicians and patients accustomed to the current system.

A tsunami of information, more challenging patients, rapidly changing technology, increased administrative/nonclinical burdens, and an alteration of practice patterns—all with the backdrop of a likely major overhaul in the U.S. reimbursement model! How do we respond to these changing times? Do our senior experienced practitioners fold their proverbial tents and retreat to retirement? Do our junior colleagues simply accept a new world order and retreat to an hourly job, rather than enjoy a fulfilling and fruitful professional career? What are our options?

Although we cannot control external events, we can control our reactions to said events and thus influence our future and the future of others, especially our patients. We can decide whether to emphasize the inherent challenges or the inherent opportunities presented to us.

Cardiovascular medicine has traditionally attracted among the best and brightest in the medical and research fields. In a changing environment where some will embrace and leverage change (and flourish), others may find the challenges overwhelming. It is my belief that the best and the brightest are also most likely to be those flexible and adaptable enough to find great success (professionally and personally) in this environment. Further, the move toward a value-based system presents the potential for a better model than one based solely on volume without heed to demonstrable quality. Those well-educated, dedicated physicians and team members who are practicing evidence-based medicine in a cost-effective manner will likely (and hopefully) be the same persons who best succeed moving forward. Implementation of change is going to be difficult and the transition fraught with anxiety—but few real accomplishments are achieved without angst.

I challenge ALL of us to meet these changes—and the challenges and opportunities they present—head on. We cannot make them go away. We are unable to go back to a “simpler time.” We can only decide how we choose to respond.

We need to continue to find ways to best utilize the technologies and communications at our disposal to meet our professional needs and those of our patients, both present and future. We need to help develop and use new diagnostic and therapeutic drugs and devices in a responsible and evidence-based manner, making certain that we keep value to patients as our guide star. We need to embrace colleagues with varying backgrounds and viewpoints and learn from one another. We need to engage in respectful discourse that focuses not just on problems

and challenges, but also on workable solutions. We need to reserve the energy spent on anger and frustration for more meaningful, productive endeavors.

Those of us in clinical and research medicine (and cardiovascular medicine in particular) have all been given a great gift: to individually and collectively improve the lives of our patients. Few are so fortunate as to have such an opportunity. Let us not squander our chance to truly "transform cardiovascular care and improve heart health," as directed by ACC's mission statement. Let us take advantage of these changing times to do better for ourselves and, more importantly, for the patients whom we serve.

ADDRESS CORRESPONDENCE TO: Richard A. Chazal, American College of Cardiology, 2400 N Street NW, Washington, DC 20037. E-mail: president@acc.org.

REFERENCES

1. Owens AT, Brozena SC, Jessup M. New management strategies in heart failure. Circ Res 2016;118:480–95.

2. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol 2014;63 25 Pt B:2889–934.

3. The SPRINT Research Group. A randomized trial of intensive versus standard blood-pressure control. N Engl J Med 2015;373:2103–211.

4. Reardon MJ, Kleiman NS. Watching a procedure evolve: sequential findings from the TVT registry. J Am Coll Cardiol 2015;66:2824–6.

5. Ortiz E, Clancy CM. Use of information technology to improve the quality of health care in the United States. Health Serv Res 2003;38:xi–xxii.

6. Laugesen J, Hassanein K, Yuan Y. The impact of internet health information on patient compliance: a research model and an empirical study. J Med Internet Res 2015;17:e143.

7. O'Gara PT. Tackling population health: leaving a meaningful mark on the world. J Am Coll Cardiol 2014;64:1061–3.

8. National Institute on Aging and World Health Organization. Global Health and Aging. Publication 11-7737. 2011. Available at: http://www.nia.nih.gov/sites/default/files/global_health_and_aging.pdf. Accessed March 13, 2016.

9. Warnes CA, Liberthson R, Danielson GK, et al. Task force 1: the changing profile of congenital heart disease in adult life. J Am Coll Cardiol 2001;37:1170–5.

10. Brush JE Jr., Handberg EM, Biga C, et al. 2015 ACC health policy statement on cardiovascular team-based care and the role of advanced practice providers. J Am Coll Cardiol 2015;65:2118–36.

11. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep 2003;118:293–302.

12. Jagsi R, Biga C, Poppas A, et al. Work activities and compensation of male and female cardiologists. J Am Coll Cardiol 2016;67:529–41.

13. Rodgers GP, Conti JB, Feinstein JA, et al. ACC 2009 survey results and recommendations: addressing the cardiology workforce crisis: a report of the ACC Board of Trustees Workforce Task Force. J Am Coll Cardiol 2009;54:1195–208.

14. Heidenreich PA, Trogdon JG, et al. Forecasting the future of cardiovascular disease in the United States a policy statement from the American Heart Association. Circulation 2011;123:933–94.

15. Jaskie S, Rodgers G. Current trends in U.S. cardiology practice. Trends Cardiovasc Med 2014;24:350–9.

16. Laslett L, Anderson H, Clark B III, et al. American College of Cardiology: environmental scanning report update 2015. J Am Coll Cardiol 2015;66 Suppl 19:D1–44.

17. Ginsburg PB, Rivlin AM. Challenges for Medicare at 50. N Engl J Med 2015;373:1993–5.

18. Oberlander J, Laugesen MJ. Leap of faith–Medicare's new physician payment system. N Engl J Med 2015;373:1185–7.