Most of the patients whom I saw in my clinic today did not need to see me. Many of yours probably did not need to see you either. Now, this is not to say that our patients are not ill. They are. They have coronary artery disease, heart failure, valvular heart disease, hypertension, atrial fibrillation, and abnormal lipids, along with a host of other noncardiovascular diseases: diabetes, chronic lung disease, osteoarthritis, and thyroid disease. But most of my patients came to see me for a routine visit that had been scheduled months ago.

One woman may have benefitted from coming to the clinic. She had no significant cardiac symptoms, but mentioned she had been experiencing some fairly severe joint and muscle pain, and I noted that she had some gradual, unintentional weight loss. She had not yet thought to schedule a visit with her primary care physician for evaluation. These symptoms have nothing to do with her hypertension or coronary disease—the diseases for which she sees me regularly—but the in-person visit, with its accompanying review of symptoms, might have uncovered a problem that she might have lived with for a longer time without diagnosis and treatment.

Do not get me wrong, I love my patients. I have known some of them for almost 25 years. I love seeing them, hearing about their families and their concerns, their highs and lows. Their visits are a source of great joy to me, and maybe they feel better just because they have come in and I have again given them the nod. (Some very elderly patients delight in greeting me with, “I’m still here!” as I open the examination room door.) In-person visits help build the patient-physician relationship that is necessary to forge trust and communication.

But notice that the list above is a list of diseases, not a list of symptoms. People with symptoms and signs clearly need to be seen, but do stable cardiac patients need to be seen in person? How often do they need to be seen, and by whom? Our patients sometimes wonder this, too. In fact, they vote with their feet. How many of your stable patients whose insurance plans require a hefty copay from them for each visit cancel visits with you when they are feeling well? In my practice, they tend to.

Pediatricians have some evidence-based guidelines on care and visit frequency. Well child visits, at regular time intervals, have a focus on prevention and include medical history, measurement (height, weight, blood pressure), vision and hearing screening, development/behavioral assessment, physical examination, immunizations, injury prevention, and counseling (1). The in-person examination for babies and children is pivotal in ensuring healthy growth and development. For adult patients, and especially for patients with specific diseases, we have less clear guidance.

Of the more than 1 billion physician office visits in the United States each year, cardiology is behind only orthopedic surgery, ophthalmology, and psychiatry in frequency of specialty physician visits (2). And, there are no firm guidelines to help determine the timing of visit follow-up for specific conditions (3). There is wide variability in how frequently physicians see their patients (4), with 1 study of cardiologists demonstrating a large variation in follow-up intervals for patients with stable angina (5). Our current fee-for-service payment model has probably driven some of the office visit volumes and frequency, and tradition has had an influence as well. An annual visit to a cardiologist for a patient with cardiovascular disease may be the norm in some communities, but there is regional variation in visit frequency (4). The emergence of newer payment models, in particular, accountable care organizations (ACOs), in which health systems assume a share of financial risk for patient costs, presents a new impetus to examine this...
question from an individual and a population health management perspective (6).

Much of what we have heard recently about payment reform has been densely detailed information about changes in the law. In 2010, the Affordable Care Act mandated the creation of ACOs for Medicare beneficiaries. In 2015, the Medicare Access and CHIP Reauthorization Act repealed the Sustainable Growth Rate, established a framework for rewarding clinicians for value over volume, streamlined quality reporting programs into 1 system, and reauthorized 2 years of funding for the Children’s Health Insurance Program. The new Medicare physician payment system is called the Quality Payment Program. Additionally, this past May, the Centers for Medicare and Medicaid Services finalized a January 1, 2018, start date for a new mandatory episode payment model that includes coronary artery bypass surgery and acute myocardial infarction care.

In the wake of all this, most of us, along with our practice administrators, have been busy determining whether we will qualify for the Merit-Based Payment System or an Advanced Alternative Payment Model (see www.ACC.org/MACRA for details). And, with our hospital administrators, we have been examining care processes for our acute myocardial infarction and coronary artery bypass surgery patients. We have heard a great deal about the penalties ahead for the practice of low-value care. Under the Merit-Based Payment System, for example, beginning in 2019, we will receive positive, neutral, or negative payment adjustments to our Medicare reimbursement based on a score calculated from our 2017 performance across 4 categories.

- Quality
- Cost*
- Improvement activities
- Advancing care information (previously meaningful use)

(*The cost category is not included in the performance calculation for 2017 and is proposed to be excluded again in 2018.)

By 2022, we will be at risk for significant payment penalties. This is a zero-sum game. There will be “winners” of the anticipated 9% positive adjustment in a clinician’s base rate of Medicare Part B payment in 2022 and onward, but there will be losers, too. The losers will see a 9% decrease in the same payment.

As we have been struggling to understand this new program, we have not given as much thought to exactly how we are going to transform our practices to succeed under the new rules. How are we going to practice differently as we transition from our current fee-for-service environment? Who do we need in our practices to deliver high-value care? Practice transformation for subspecialists looks a bit different than that for primary care, but it will generally adhere to similar tenants.

- Team-based coordinated care, particularly for the highest-risk patients
- Expanded access
- Transitional care planning
- Preventive care outreach
- Behavioral health care coordination

Under the new models of care, we will all need to work to the top of our licenses. This means that cardiologists need to see sick patients rather than stable ones, patients with multiple morbid conditions and new diagnoses for whom complex decisions need to be made. In my field of heart failure, my talented nurse practitioner colleague is well able to adjust diuretic agents and adjust doses of beta-blockers without my input. My talents are better used evaluating new patients with complex signs and symptoms to help lay out a course and a plan of care for them, including discussing advanced therapies and, sometimes, end-of-life care.

With practice transformation, we will need to work smarter. Systems of care that involve fewer in-person visits, but continue to keep our patients engaged will be necessary. Systems of open-access scheduling, telehealth, navigator models, access through patient portals, and group visits will all be models of care that we need to explore and embrace. Patient education, empowerment, preferences, and values will continue to be crucial as we do not want our patients to feel abandoned in these changing times.

Cardiovascular clinicians are experienced at adapting to change. Our ever-growing evidence base requires that we incorporate new diagnostic techniques and therapeutic approaches once they have been demonstrated to benefit our patients. We may feel buffeted about by all of the changing payment requirements, but we will need to adapt as we have in the past. The new models may well enrich our care of our patients.

ADDRESS FOR CORRESPONDENCE: Dr. Mary Norine Walsh, American College of Cardiology, 2400 N Street NW, Washington, DC 20037. E-mail: president@acc.org.
REFERENCES


