



The Society for Cardiovascular Angiography and Interventions

President's Page

Professionalism in Interventional Cardiology and the New Value-Based Payment System

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"I just want someone to know that Dr. F. is the most wonderful and caring doctor you have on staff. My son is autistic with a life-threatening heart condition. Dr. F.'s bedside manner with him is incredible. I can reach out to him day or night and he never hesitates to return my messages. He has gone out of his way to help my son with a particularly difficult situation even when he was on vacation. You will never find a doctor like that." This comment recognized Dr F.'s professionalism, "hard to measure but you know it when you see it" [1].



James C. Blankenship

MEDICAL PROFESSIONALISM: IS IT THREATENED?

"Medical professionalism" has been poorly defined [2], poorly taught [3], and sometimes poorly performed [4]. The public's view of physicians' professionalism has been threatened by allegations of fatal medical errors [5], accusations of procedural overuse [6], availability of data about industry payments to physicians [7], and assertions that individual physicians have excessive complication rates [8]. The fee-for-service payment system is another challenge for medical professionalism. It is a far too common perception that volume-based payments tempt providers to put their own financial interests ahead of the interests of patients.

Recent developments in payment reform may reduce these concerns, but may also offer new challenges to professionalism.

NEW VALUE-BASED PAYMENT SYSTEMS

In January 2015 the U.S. Department of Health and Human Services (HHS) announced a goal of tying 30% of fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016, and tying 50% of payments to these models by the end of 2018. HHS also set a goal of tying 85% of all traditional

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Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs [9].

Furthermore, the 2015 Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) replaced the SGR reimbursement formula with annual 0.5% payment increases over the next five years [10]. Beginning in 2019, physician compensation will be adjusted based on performance under the new law's Merit-Based Payment Incentive System (MIPS), consisting of existing CMS payment incentive/penalty programs (e.g., the Physician Quality Reporting System (PQRS), EHR/Meaningful Use Incentive Program, and Value-Based Payment Modifier (VBPM)). Under the new law, the MIPS will be based on four categories of annually developed metrics: [1] quality, [2] resource use/efficiency (using measures similar to the current VBPM program), [3] meaningful use of electronic health records, and [4] clinical practice improvement activities. The metrics will be designed to address the quality domains in clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. Payments to doctors with low MIPS scores will be reduced in proportion to their scores. Negative payment adjustments will be capped at 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022. Professionals with scores above the threshold will receive payment increases.

It is unclear what ethical challenges these new payment systems will offer to interventional cardiology teams. As the payment systems evolve, it is crucial that practitioners and societies such as SCAI participate in shaping these policies and regulations. In uncertain times, lawmakers and judges rely on the United States Constitution for guidance. A similar document exists for us - the Charter on Medical Professionalism [11], published in 2002 and endorsed by over 130 societies. Let's examine how the Charter on Medical Professionalism should guide Interventional Cardiology teams.

FUNDAMENTAL PRINCIPLES

The Charter describes 3 fundamental principles of medical professionalism. Together these principles can serve as our moral compass as we advocate for our patients and policies that appropriately value the services we provide.

Beneficence

Our first concern is patient welfare. Doing good for the patient takes priority over what is good for other stakeholders. For example, the primary angioplasty of

an uninsured patient with ST elevation myocardial infarction is performed at 2:00 AM without thought of reimbursement to the physician or the hospital.

Autonomy

Physicians empower patients to make decisions and respect those decisions within the bounds of reasonable medical care. If, for example, conservative medical therapy for coronary disease is a reasonable option, then the physician should respect an informed patient's preference for it, even when the physician's own opinion favors intervention [12].

Social Justice (Distributive Justice)

Medical professionals should advocate for the fair distribution of resources. For example, some ethnic groups are less likely to receive catheterization [13]. Cardiologists should be aware of these disparities and seek to prevent them in their own practices.

PROFESSIONAL RESPONSIBILITIES

The Charter describes 10 professional responsibilities. These responsibilities, originally articulated in a fee-for-service environment, remain equally relevant in value-based payment systems.

Professional competence

Individuals commit to lifelong learning, maintaining old skills and learning the new skills needed to provide the best possible care to their patients. Societies, such as SCAI, commit to providing members with education and tools (e.g., SCAI Quality Improvement Toolkit [SCAI-QIT]) to maximize their professional performance.

Honesty with patients

The physician advises patients about risks and alternatives of treatment and expected results. After a procedure, results are disclosed, including less than optimal results and complications. For example, last night when a wire tip broke off and we had to seal it against the vessel wall with another stent, I explained the event in detail to the referring doctor, the patient, and the family.

Confidentiality

Patients often trust health professionals with information they would never provide to their closest friends or relatives. The basis for this trust is confidentiality. Social media, digital communication, and inter-

connected electronic medical records all pose challenges to confidentiality. Providers must be diligent and accept this responsibility to the patient.

Maintaining appropriate relations with patients

In dealing with their health care providers, patients are very vulnerable. Medical professionals must recognize this and avoid any perception of impropriety or exploitation of their patients.

Improving quality of care

Members of the entire interventional team commit to continuously improving the quality of the care they provide, individually and as a team [14]. Professionals work with other disciplines and stakeholders in the hospital to improve institutional quality, and as part of a professional society to raise the quality of care provided by the entire profession. SCAI does this through educational courses (e.g., Cath Lab Bootcamp), guidelines and expert consensus documents, and the SCAI-QIT.

Improving access to care

Patients' access to care can be limited by financial, geographic, social, or racial factors. Physicians have individual and collective responsibilities for minimizing these barriers. Examples include valve clinics that allow the frail elderly to have a 1-stop visit with the cardiologist, surgeon, and social worker. Dr. F, mentioned above, is famous at our institution for his home visits to elderly patients.

Just distribution of resources

Lack of access to health care may affect cardiology patients who lack financial resources. Interventionists should advocate for patients whose socioeconomic status precludes optimal care. On the other hand, excessive or unnecessary services and procedures are bad for both patients and the U.S. health care system.

Appropriate use of scientific knowledge

Physicians have a responsibility to grow scientific knowledge and advocate for its appropriate use. Not all interventional cardiologists conduct world-famous research, but all of us can implement quality improvement projects to assess and improve patient care in the local setting. All members of the interventional team can teach colleagues and students. Societies can advocate against the mis-use of scientific knowledge, as SCAI has done on numerous occasions [15].

Managing conflicts of interest

The potential for conflicts of interest increasingly confronts the medical profession. The physician's responsibility is to put the patient's interests first when a potential conflict of interest exists, and to fully disclose these potential conflicts.

Self-regulation and governance

Fundamental to the public's trust in health care professionals is the ability of the profession to regulate itself [16]. On an individual level, this may mean participating in peer-reviews and reciprocal blinded angiographic reviews among colleagues. At an institutional level, it may mean participating in hospital quality and governance committees. At a national level, the profession has a responsibility for determining training standards, establishing standards of professional behavior, ensuring the competency of its practitioners, and assisting individuals who fail to meet those standards.

FINAL THOUGHTS

The U.S. health care system is going through a period of unprecedented change. Patients are becoming less passive and more engaged; public scrutiny is intensifying. Challenges to interventional cardiology teams to "do the right thing" arise almost daily. In this fluid health care environment, holding ourselves to the highest standards of professionalism has never been more important than it is today. Membership in SCAI and fellowship status (FSCAI) should represent our individual commitments to understand and maintain these standards of professionalism. The leadership of SCAI is dedicated to making our Society the standard-bearer for medical professionalism in our field. As changes in health care systems offer new challenges to our professionalism, SCAI will identify them and shine a guiding beacon to its members.

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