

Work Group 1 - Regional Care

Summary of Forum Dialogue: Key points and Insights

Pros/advantages of proposed regional approach:

- Goal of coordinated system which strives to provide access to care at all levels
- Concept of “hub and spoke” model
- ACHA’s role as “voice of patient”/outsider will help overcome politics/institutional barriers/lack of will

Cons/concerns of proposed regional approach:

- Focus on urban centers rather than regions is problematic
 - Many patients live outside urban areas; can’t/won’t travel far
 - Many strong ACHD programs are outside urban areas - particularly academic centers
 - Not all urban centers have existing centers of ACHD expertise

Conflicting views expressed re: single center model

- Disadvantages of single center/single hub approach
 - Many areas have multiple potential hubs in single region
 - Offering patients choices better than one choice - many patients will be seen in private practice/locally
 - Given large volume of patients, large urban areas should have multiple hubs
- Disadvantages of multiple center/hub approach
 - Multiple leaders can result in chaos/absence of leadership
 - Effort will need strong leader-champions who are rewarded for their engagement
 - True hubs should be high-volume, good outcome, congenital heart centers
 - Unlikely to be more than one in a given region

Barriers to implementation

- Barriers to institutional engagement
 - Perception of ACHDers as high need, high cost patient group
 - Lack of awareness of ACHD care as an issue
- Barriers to collaboration
 - Insurance/reimbursement system -Competitive system
 - Potential lack of will/interest to collaborate
- Barriers to transition
 - Pediatric cardiologists may want to “hold” patients
 - Pediatric cardiologists may not be able to identify ACHD program which offers adequate care.

Suggested Approaches for Consideration

- Empower patient voice
 - Disseminate standards, let patients choose
- Create chapters/regional groups affiliated with ACHA to identify regional needs and key partners
 - Engage/empower patients in this effort on the regional/chapter level
 - Engage CHD parent’s groups in efforts
- Identify and partner with major pediatric cardiac centers in each region
 - Promote focus on transition, patient education as part of the regional approach
- Identify major insurance players and potential insurance barriers in region
- Address geographic barriers and mental mapping – i.e. where will patients drive?
- Be inclusive
 - Include private practice, academic, IM cardiologists, Pediatric cardiologists, ACHD specialists
 - Invite all hospitals in area – some may not participate
- Hold in-person regional meetings/forums
- Promote resource sharing and education
 - Use technology - Remote case sharing, teleconferencing
- Run regional training sessions on ACHD for ‘regular’ cardiologists
- Look at potential models
 - Existing de facto hub and spoke systems – ex: New England
 - Military medical system
- Individual cardiologists can help start now by
 - Reach out to governing bodies of own institutions – begin discussing issue
 - Reach across to pediatric cardiology or IM cardiology
 - Each forum participant can be a leader at one’s individual centers

Working Group 2 – Program Accreditation

Summary of Forum Dialogue: Key Points and Insights

Pros/advantages of proposed accreditation model

- Accreditation will
 - Help patients make informed choices
 - Drive improvement in the field
 - Allow organizations to identify gaps, leverage resources
 - Engage attention of administration/adult cardiology institutions
 - Provide needed standards/metrics to assess quality
 - Use by insurers may drive appropriate referral

Cons/fears re: proposed accreditation model

- Might be too exclusive, create fears on part of small programs of being left out and/or not having enough resources to achieve the standards
- If volume is used as quality indicator, high-quality small programs will be left out
- If consensus standards are used, could lead to standards which articulate the “lowest common denominator” as opposed to high standards
- Nature of accreditation may be too onerous and cost staff time, money
- Use by insurers may exclude good programs, create ill will and exclusivity
- If accreditation brings attention from administration, programs may lose autonomy

Barriers to Implementation

- Currently we lack hard outcomes/quality metrics
- Differing opinions about how to define/measure quality in absence of outcomes data
 - volume, structure, resources, process all discussed
- All current guidelines consensus based (no evidence)
- Even basic clinic data currently lacking
- Cost will be a barrier for ACHA to conduct the accreditation process if site visits are expected to 70+ national sites

Suggested Approaches for Consideration

- First step – establish better, standardized data reporting for all ACHD programs
- Create a credentialing system that is:
 - Transparent
 - Patient-centered
 - Inclusive and brings people along
 - Communicates high standards
 - Starts with vision of “perfect program”
 - staged approach to move toward vision
 - start in with less difficult standards, get harder as higher levels reached
 - Engages hospital administrators from the beginning
 - Builds in collaboration and research to generate the outcomes data needed to move this forward
- Standards should be real/attainable while articulating high quality
- Clear timelines should be given
- Educational assistance should be built in – ex: regional mentorship programs
- Accreditation may dovetail into “pay for performance” reform models currently under discussion

Identified areas of disagreement:

- Multiple models for accreditation proposed
 - Tiered systems
 - Based on surgical expertise/capacity
 - Based on documented structure/resources
 - Alternate model – start with single tier that all can attain
 - documented CME in ACHD
 - small number of low-level markers
 - Source of criteria
 - Guidelines
 - Patient-generated quality markers
- Whether/how to exclude programs
 - Some expressed wish to create initial markers that all could achieve
 - Others expressed opinion that to be meaningful, not meeting standards must be a possibility

Working Group 3 – Business Models

Summary of Forum Dialogue: Key Points and Insights

Pros/advantages of proposed business models/approaches

- Acquired heart disease dropping – need new revenue sources
- New ACHD Guidelines should make building case easier
 - Signal need for ACHD care, can use as tool
- Addressing coding offers potential easy opportunity to improve revenue
- Better trained docs/programs typically use less resources and cost less

Cons/concerns of proposed business models/approaches

- Concern that revenue emphasis could drive overuse of resources/interventions/testing
- Some centers just starting out, not yet at level to focus on these issues
- Drawing administrative attention may reveal poor payer mix, cut off “back door” access strategies

Barriers to Implementation

- ACHD is not on radar of adult cardiology world
- Getting administration to notice/engage with ACHD program can be difficult/takes time
- Administration may be unwilling to share data
- Pediatric centers lose dollars when they transfer – in tough financial times may resist ACHD transfer more
- Reality is that ACHD programs lose money when viewed in isolation
- Even when you show value, funding may not follow

Suggested Approaches for Consideration

- Quality as well as volume must be measured
- Encourage documentation of downstream revenue
 - Ex: 10% of total intervention; surgical volume from one FTE ACHD doc
- Must demonstrate that ACHD is lucrative
- Use Data tracking via Congenerate
- Address coding/not coding issues and understand that proper coding is a revenue source
- ACHD docs/programs/fellows need education on coding
- ACHA could educate on successful business models
- Business model needs to support what is right for patients
- Engage other professional societies around ACHD reimbursement issues
- Centers of excellence can be shown to save money
 - Prevent wasteful spending on bad studies, need to repeat studies
- Engage pediatric cardiology to highlight
 - medical investment in peds patients (i.e. \$\$\$ for previous surgeries)
 - Need to “capitalize” on this investment by helping maintain life-long care
 - Need to do the right thing (even if it means spending money/losing money)
- Copy pediatric strategies for getting staff funded – public funding options may be available
- Administrators can share strategies to optimize coding
- Business models should reflect and reward collaboration

Identified Areas of Disagreement

- Payer mix/insurance status
 - Some described ACHDers as having positive payer mix
 - Others described poor payer mix
- Viability of RVU models that span institutions
 - Some recommended models that can “share” revenue across institutions

Others stated such models are illegal in current system

Working Group 4 – ACHD Workforce Planning **Summary of Forum Dialogue: Key Points and Insights**

Pros/advantages of proposed workforce models

- Rising patient populations will push greater workforce creation
- New guidelines offer starting place
- Subspecialty certification in progress - Joint ABIM/ABP petition

Cons/concerns re: proposed workforce models

- Formal ACHD training programs may be too burdensome
 - Exclude participation by skilled/interested providers
 - Worsen supply chain issues

Barriers to Implementation

- Patients at ACHD centers getting more numerous, more complex
- Adult cardiology not interested/engaged - Poor fit with competitive, salary-driven model
- ACHD Training and positions not funded
- Current state/size of ACHD work force unknown
- Length of ACHD training major barrier
 - 10-12 years
 - Substantial debt
 - Supply gets “backed up”

Suggested Approaches for Consideration

- Need to involve/engage interested excellent adult cardiologists
- Can use Web technology to consult remotely, create learning/mentorship
- Change ACHA survey to ask about FTEs rather than/in addition to % of time
- Addressing/improving transition will drive workforce investment
 - ACHA should promote formal transition plans -Allows projection of #s of upcoming patients
- Recapturing “lost” will drive workforce investment – ACHA single focus should be capture
- ACHA could lobby for debt forgiveness programs for ACHD professionals
- Expedited ACHD training options should be provided
- Models should allow for non-traditional training
- Should require CME
- ACHA should encourage ACHD mentorship
- Look to Heart Failure/Transplant model - database, outcomes, moving towards subspecialty
- Models will only work if paid for realistically
- Strength of ACHA model is having administrators, providers, patients work together
- Institutions currently send staff to get skills sets they perceive as lucrative
 - ACHA might encourage this type of 3-6 month training visit
- Health care reform likely to have instant major impact
 - Likely to move from pay for procedures to pay for performance
 - May adopt some kind of medical home model
 - ACHA should plan for these potential changes
- Workforce needs will be predicated on models of ACHD care proposed by other work groups

Identified Areas of Disagreement

- Importance of on-site expertise/services
 - Some stressed possibilities of remote access to experts
 - Others stressed importance of having expertise at site of care
- Training models
 - Some stressed formalizing training
 - Others stressed importance of allowing non-traditional models
 - Various options stressed re: importance of engaging, training peds versus adult fellows
 - Proposed evaluation models included testing, demonstrating competencies, and demonstrating volumes/“time on task”