Advancing Cardiovascular Care of the Oncology Patient

Why Are We ‘Here?’ The Intersection Between Cardiology and Oncology

Feb 17, 2017

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Our Mission

To Transform Cardiovascular Care and Improve Heart Health
Transforming Cardiovascular Care to Improve Heart Health

Professionalism

Continuous Quality Improvement

Patient-Centered Care

Practice Excellence

Health Policy

Science and Quality

Professional Development

Community
The American College of Cardiology
Strategic Plan

The ACC is the PROFESSIONAL HOME for cardiovascular specialists and the care team.
Current ACC Section Leadership
Councils and Sections

• Academic Cardiology
• Adult Congenital and Pediatric Cardiology
• Cardio-Oncology
• Cardiovascular Care Team
• Cardiovascular Imaging
• Cardiovascular Management
• Cardiovascular Training
• Early Career Professionals
• Electrophysiology
• Federal Cardiology
• Fellows in Training
• Geriatric Cardiology
• Heart Failure and Transplant
• Interventional
• Peripheral Vascular Disease
• Prevention
• Sports and Exercise Cardiology
• Surgeons’ Scientific
• Women in Cardiology
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Financial risk is shifting from payors to providers

Financial Risk Of Care For Provider And Payer, By Payment Method.

- Payer cost risk
- Provider cost risk

Payment method:
- Cost
- FFS
- Per diem
- Per episode (bundled payment)
- Capitation
Payment is transitioning from volume-driven to value-driven healthcare.
A National Transition to Value-Based Reimbursement

CMS Timeline Expects By 2018, 50% of Payments in Alternative Payment Models

- Payments linked to alternative payment models
- Fee-for-Service ("FFS") linked to quality
- All Medicare FFS

Historical Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments linked to alternative payment models</th>
<th>Fee-for-Service (&quot;FFS&quot;) linked to quality</th>
<th>All Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0%</td>
<td>~70%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>~20%</td>
<td>&gt;80%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments linked to alternative payment models</th>
<th>Fee-for-Service (&quot;FFS&quot;) linked to quality</th>
<th>All Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
<td>0%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>90%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Innovation ("CMMI") Center, Bundled Payment Summit, June 2015
THE CURVE

STRADDLE

1. First Curve
   - Fee-for-Service
   - Quality Not Rewarded
   - Pay for Volume
   - Fragmented Care
   - Acute Hospital Focus
   - Stand Alone Providers Thrive

   Revenue Drops
   Minimal Reward for Quality
   Volume Decreases

2. Second Curve
   - Value Payment
   - Continuity of Care Required
   - System of Care
   - Providers at Risk for Payment
   - IT Centric
   - Physician Alignment

PERFORMANCE

TIME
Team Based Care
The Team Will See You Now

 Patients Are Looked After by a Team of Medical Professionals
At Union Square Family Health Center in Somerville, Mass.

**Doctor**
Kirsten Meisinger, supervises the medical team. She also diagnoses patients, performs procedures and prescribes medications.

**Social Worker**
Paula Coutinho assists patients with needs like transportation and financial assistance. She also connects patients to behavioral health services for depression.

**Physician Assistant**
Juliane Liber and handles routine consultations, manages lab results and helps patients with chronic diseases. She is the point person when the doctor isn’t available.

**Pharmacist**
Joseph Falinski advises patients on how to take drugs correctly and possible side effects and interactions. He can adjust dosages and help manage conditions like chronic pain.

**Medical Assistant**
Fabiola Marcelin takes patients’ vital signs and prepares them to see the doctor. A trained phlebotomist, she does blood work and tracks follow-up appointments.

**Registered Nurse**
Amberly Kilmer performs triage and directs some routine patient visits like prenatal counseling. She helps patients adopt healthier lifestyles.

Helping Cardiovascular Professionals

WSJ Feb 18, 2014
### Need for Team-Based Care

**Table 6. Average U.S. Staffing by Practice Size: Role Composition**

<table>
<thead>
<tr>
<th>Role</th>
<th>Total (%)</th>
<th>Small Program (&lt;4 staff) n=107 (%)</th>
<th>Small-Medium Program (4–10 staff) n=86 (%)</th>
<th>Medium Program (11–20 staff) n=45 (%)</th>
<th>Large Program (&gt;20 staff) n=14 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO FTEs</td>
<td>28.0</td>
<td>29.6</td>
<td>25.5</td>
<td>29.4</td>
<td>28.4</td>
</tr>
<tr>
<td>NP/PA FTEs</td>
<td>23.3</td>
<td>29.2</td>
<td>23.6</td>
<td>20.6</td>
<td>24.0</td>
</tr>
<tr>
<td>RN coordinator FTEs</td>
<td>27.6</td>
<td>21.4</td>
<td>24.4</td>
<td>29.3</td>
<td>33.0</td>
</tr>
<tr>
<td>Financial consultant</td>
<td>3.1</td>
<td>0.2</td>
<td>3.6</td>
<td>3.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Social worker</td>
<td>5.2</td>
<td>2.8</td>
<td>6.1</td>
<td>5.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Exercise physiologist</td>
<td>2.2</td>
<td>3.2</td>
<td>2.9</td>
<td>1.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>3.8</td>
<td>5.1</td>
<td>4.9</td>
<td>3.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2.7</td>
<td>2.8</td>
<td>3.2</td>
<td>3.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Pharmacologist</td>
<td>4.1</td>
<td>5.6</td>
<td>5.8</td>
<td>3.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Total no. of staff</td>
<td>2,386</td>
<td>298</td>
<td>762</td>
<td>826</td>
<td>500</td>
</tr>
</tbody>
</table>

DO indicates doctor of osteopathy; FTE, full-time equivalent; MD, medical doctor; NP, nurse practitioner; PA, physician assistant; and RN, registered nurse.
Working to the top of your license

Pre-visit chart review

N= 55

- MD: 12%
- RN: 28%
- LPN/LVN: 2%
- MA: 48%
- No Clinical Credential: 12%

Patient self-management support

N= 55

- MD: 23%
- NP: 4%
- RN: 25%
- LPN/LVN: 2%
- MA: 2%
- No Clinical Credential: 2%
- Off-Site Service: 18%
ACC in **2000** (26,000 Members)

ACC in **2016** (52,000+ Members)

Source (Right): Data compiled from 2015 Year End Official Member Count

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Crude Death Rates for Leading Causes of Death in the United States from 1900 to 1950

Figure 1. Number of deaths due to heart disease and cancer: United States, 1950–2014

NOTES: Leading cause is based on number of deaths. Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/cb254_table.pdf#1.
The figure presents the percentage of adults in each state who were current smokers in 2015.³
Current Smoking: NHIS

Figure 8.1. Prevalence of current cigarette smoking among adults aged 18 and over: United States, 1997–2015

NOTES: Data are based on household interviews of a sample of the noninstitutionalized population. Current cigarette smokers were defined as those who had smoked more than 100 cigarettes in their lifetime and now smoke every day or some days. The analyses exclude persons with unknown cigarette smoking status (about 2% of respondents each year). See Technical Notes for more details.

DATA SOURCE: NHIS, National Health Interview Survey, 1957–2015, Sample Adult Core component.
Maps of estimated hypertension, diabetes mellitus, and current smoking prevalence among whites and blacks, adjusted for age and sex.

Number of Chronic Conditions in Medicare FFS Beneficiaries 2010 by Age

Figure 1.2b  Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions and Age: 2010

- Less than 65 years
- 65 to 74 years
- 75 to 84 years
- 85+ years

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>0 to 1</th>
<th>2 to 3</th>
<th>4 to 5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 65 years</td>
<td>47%</td>
<td>34%</td>
<td>27%</td>
<td>9%</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>37%</td>
<td>33%</td>
<td>29%</td>
<td>9%</td>
</tr>
<tr>
<td>75 to 84 years</td>
<td>28%</td>
<td>29%</td>
<td>29%</td>
<td>9%</td>
</tr>
<tr>
<td>85+ years</td>
<td>17%</td>
<td>17%</td>
<td>18%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Palliative Chemotherapy Does Not Improve Quality of Life

Chemotherapy Use results in worse Quality of Life Near Death

JAMA Oncology

Chemotherapy Use, Performance Status, and Quality of Life Near Death
This multi-institutional, longitudinal cohort study finds that palliative chemotherapy did not improve quality of life near death for cancer patients with moderate or poor performance status and...

View on web

RETWEETS 2  FAVORITES 4
Patient Centered Care