Adapting to a Changing Health Care Environment

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I feel very honored and privileged to assume the chairmanship of the American College of Cardiology Imaging Council (ACC), and would like to congratulate Dr. Neil Weissman on a job superbly done last year!

The Cardiovascular Imaging Section of the ACC was formed in 2011 and is one of its largest (3,800 members as of May 31, 2014), the fastest growing (110% growth since 2012), and certainly the most diverse given its structure, comprising the imaging subspecialties. In a rapidly changing health care environment the section and under its mandate, the Imaging Council have a critical role in re-evaluating the structure and delivery of cardiovascular imaging services to ensure the continued relevance of imaging to the care of patients with heart disease.

Central to this question is the perception of value. There are strong indications of impending changes in the paradigm of health care delivery in this country that make it highly likely that more emphasis will be placed in the future on value-based utilization than incentive for quantity. Such a change could empower physicians, who are the best positioned party to devise cost-effective management strategies that are also safe and expedient. However, in an environment of accountable care, imaging laboratories will be “cost centers” rather than “revenue centers,” and the demonstration of cost-effectiveness and a positive impact on patient outcome will dictate utilization. The value of imaging to the care of patients with heart disease should be self-evident, given that few clinical episodes of cardiac care are devoid of an imaging component. But formal explorations of factors contributing to the cardiovascular health of the nation have failed to define the role of imaging (1). Traditionally, it has been difficult to show a direct relationship between the outcome measure of mortality and the use of cardiac imaging tests. But the concept of mortality as a “hard” event is based primarily on statistical convenience rather than clinical relevance, especially in an aging population. Alternative and more creative measures must be devised for proving value-based imaging.

In this context, the promotion of appropriate use will be important for the continued relevance of imaging to clinical care. A recent analysis revealed a marked reduction over the past 2 decades in the proportion of single-photon emission computed tomographic myocardial perfusion imaging results that are abnormal, decreasing from 40.9% in 1991 to just 8.7% in 2009 (2). Although some percent of test normality is consistent with the “gatekeeper” philosophy of noninvasive testing, these data suggest that lower risk populations are increasingly being tested. In addition to inviting regulatory scrutiny and reimbursement cuts, inappropriate use also adversely affects the performance characteristics of imaging tests (3).

There are also changes in the internal milieu of the field of cardiac imaging that merit mention. It is no longer the exception that trainees finish cardiology fellowships with some degree of experience in multiple imaging modalities. A working knowledge of the strengths and weaknesses of all modalities is central to the concept of the “imaging consultant,” who will be charged with devising imaging strategies to answer specific questions posed by the referring physician. How then does one define the multimodality imaging expert? If indeed, one were to define level 3 expertise on the basis of a philosophy of being able to lead an academic laboratory, is the goal of acquiring and maintaining advanced expertise in all 4 imaging modalities even realistic? How does one advocate a balance between breadth of knowledge and the focus required to drive innovation in the individual imaging subspecialties? These are some of the questions that will be addressed in the “Future of

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CV Imaging” initiative of the Imaging Section, being led by Drs. Meryl Cohen and Pamela Douglas.

And finally, on a lighter note, I wonder whether we should rethink our designation as “noninvasive” cardiologists. It is, I think, a term that defines us by what we don’t do. Perhaps it is time to re-establish our identity more specifically with a designation such as “Imaging Cardiologist” or “Cardiologist Imager.”

I look forward to a dialogue in the months to come with the imaging community on several of these issues. With the mandate of the Cardiovascular Imaging Section, the Imaging Council will strive for the continued relevance and vibrancy of the field.

REFERENCES

