



Commentary

Cardiology Workforce Crisis: Team-Based Care as a Solution

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In September, the “ACC 2009 Survey Results and Recommendations: Addressing the Cardiology Workforce Crisis” was published in the *Journal of the American College of Cardiology (JACC)*. This document is the product of work done by the ACC Board of Trustees Workforce Task Force chaired by **George Rodgers, M.D., F.A.C.C.** Since 2001, under the leadership of **Bruce Fye, M.D., M.A.C.C.**, the ACC has drawn attention to the looming workforce crisis in our specialty. Some contributors to this crisis have been identified as:

- Increase in the incidence and prevalence of cardiovascular disease (CVD)
- Decrease in CV mortality and resulting increase in size of patient population
- Greater number of adults with congenital heart disease
- 20 percent decrease in number of CV specialists in training during the 1990s due to erroneous predictions of diminished demand
- Resultant decrease in the size of CV training programs and in the number of cardiologists trained

In 2006, the Workforce Task Force was formed to explore these workforce issues and to develop recommendations or solutions. The newly released paper in *JACC* is the result of some of their work. The ACC and ACCF then contracted with The Lewin Group and the Association of American Medical Colleges (AAMC) to conduct an analysis of factors affecting the cardiology workforce. One of the areas examined was the practice of team-based care in the form of employment of non-physician practitioners.

Practice Efficiency

It is clear that the current and anticipated shortage of cardiologists calls for a careful analysis of methods to provide patient care more efficiently. In order to better define current practice efficiencies, the task force surveyed adult CV private practices, pediatric practices and academic practices. Several areas were explored; two of which were —

- Clinical staffing models (e.g., number of physicians, use of part-time physicians and/or non-physician practitioners)
- Practice operation and management (e.g., multi-specialty versus single specialty, number of offices, use of part-time or outreach offices, ownership type, practice setting)

Data from these surveys were then analyzed to determine the effects of the various practice characteristics on clinical productivity.

Employment of Non-physician Practitioners

All practices were asked whether or not they employed non-physician practitioners (non-physician professional providers). Although state regulations differ regarding the scope of practice of non-physician practitioners — and this may have influenced practices’ employment of these individuals — data were not stratified according to state.

Overall, larger private practices were more likely to have nurse practitioners (NPs) or physician assistants (PAs) with 90 percent of practices of more than 10 cardiologists reporting employment of non-physician practitioners. However, among practices using NPs and PAs, the ratio of non-physician practitioners to physicians was much higher in the smaller practices.

In the larger groups, non-physician practitioners were often employed as part of a niche clinic (heart failure, device or anticoagulation) whereas smaller practices were more likely to use the skills of these providers in general practice, thus achieving substantial efficiencies.

All practices were asked to report either the number of relative value units as a standard metric of work per full-time equivalent (FTE) physician or gross revenues per FTE physician. Of the groups who employed non-physician providers, some groups found that non-physician providers generate one-third of the relative value units of an FTE cardiologist, and that NPs and PAs generate gross revenues three to four times greater than their incomes. Such favorable economics suggest that greater use of non-physician practitioners can enhance practice efficiency.

Solutions/Recommendations

Best practice sharing — The results showed a lot of variability regarding employment of non-physician providers among the practices. Many practices reported no employment of non-physician practitioners, and on average, larger practices had lower ratios of non-physician practitioners per physician than smaller practices. This variability suggests an opportunity for sharing best practices. Successful models of partnership between cardiologists and NPs and PAs may be valuable to those practices that have not yet integrated non-physician practitioners into their practices.

Advocacy — On the advocacy front, the task force underscored the fact that along with the cardiology workforce crisis comes a need for more non-physician practitioners. As such, increased funding is needed to train more NPs and PAs to meet these demands.

Education — It is clear that education is the cornerstone of the development of effective models of team-based care. The ACC has initiated an educational program to assist NPs in gaining more proficiency specific to cardiology care and developed a core curriculum specific to this group. This program should serve to accelerate the availability of cardiology-trained non-physician practitioners.

Equally important is the development of education around team-based care. The practice surveys found that non-physician practitioners are underused in many practices. Our CCA colleagues will no doubt be able to lead us in the development of best practices in optimal multidisciplinary team-based care.

Walsh, who is on the ACC Board of Trustees, is a member of the Workforce Task Force. She also sits on the CCA Committee.



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support comparison of competing methods of diagnosis or treatment in determining meaningful outcomes.

Reimbursement: Sudden and dramatic reimbursement cuts (up to 40 percent) threaten to destroy specialty practice and, therefore, patient access. Pay-for-performance initiatives may be outlined in H.R. 3200, yet CMS sets actual reimbursement schedules in a separate process, and the two should not be confused.

Medical-legal environment: The absence of tort reform may be acceptable to some physicians — a bitter pill that must be swallowed to advance reform of an ailing system. For others, it will not be acceptable, no matter what else is contained in the bill. Where one falls on this continuum remains a personal decision, based on a balance between patient rights on one hand and protecting physicians' freedom from defensive medicine and frivolous lawsuits on the other.

While we must overcome the notion that all things government are inherently inefficient and ineffective, it must also be noted that overzealous government intrusion can be deeply harmful, whether it arises from conservative or liberal agendas. Health care may be too complex and medical decisions based too often on fear and emotion rather than logic to assume that a predominantly free market approach would be affordable.

The health care bill may be necessarily vague in terms of detail; however, it serves as a conceptual tree on which to hang the ornaments later. It appears that the majority party will likely pass some form of this legislation. Of major concern is the possibility that as various special interests, the minority party included, exert their influence, the resulting bill will be incomplete and unbalanced. After we have a final version of a health care bill, true advocacy from physicians will need to occur to optimize patient care within financial and regulatory constraints and to preserve the essential worth of a career in medicine.



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