DIAGNOSTIC BUNDLES
MOVING THE SPECIALIST TO VALUE

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DISCLOSURES

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COMMON CAUSES OF CHEST PAIN

Cardiovascular
Acute coronary syndrome
Unstable angina
Myocardial infarction
Aortic dissection
Pericarditis, cardiac tamponade
Arrhythmia -
Stable angina pectoris
Myocarditis
Mitral valve prolapse syndrome
Aortic aneurysm

Respiratory
Bronchitis
Pulmonary embolism
Pneumonia
Hemothorax
Pneumothorax, Tension pneumothorax
Pleurisy
Tuberculosis
Tracheitis
Lung malignancy

Gastrointestinal
Esophageal rupture
Gastroesophageal reflux disease & heartburn
Esophagitis
Hiatus hernia
Achalasia, nutcracker esophagus, diffuse esophageal spasm and other motility disorders of the esophagus
Functional dyspepsia

Chest wall
Costochondritis or Tietze's syndrome - form of osteochondritis often mistaken for heart disease
Spinal nerve problem
Fibromyalgia
Chest wall problems
Radiculopathy
Precordial catch syndrome - sharp, localized chest pain often mistaken for heart disease

Breast conditions
Herpes zoster commonly known as shingles
Tuberculosis
Osteoarthritis
Bornholm disease

Psychological
Panic attack
Anxiety
Clinical depression
Somatization disorder
Hypochondria

Others
Hyperventilation syndrome often presents with chest pain and a tingling sensation of the fingertips and around the mouth
Da costa's syndrome
Carbon monoxide poisoning
Sarcoidosis
Lead poisoning
High abdominal pain may also mimic chest pain
Prolapsed intervertebral disc
Thoracic outlet syndrome

Source: Wikipedia.org
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Source: Wikipedia.org
WHAT PEOPLE THINK IT LOOKS LIKE

WHAT IT REALLY LOOKS LIKE
Differential Diagnosis:
- Ticks
- Fleas
- Dry Skin

Pick the one best Cause -
Real Cause -

All of them

(None of them)
Historical Focus to Reduce PCI (Costs)

“Standard Care”
(Historical)
1000 patients

1000 patients

Non-invasive Evaluation
30% proceed to invasive

300 patients

Invasive Evaluation
20% proceed to PCI

75 patients

PCI

High Patient Deductible and Co-pay

Use of Other Patient Management Techniques

Control Clinician’s Use - Prior Authorization

Adjust Payment (reduce clinician payment)

Align Payment Clinician and Systems Payment with Value

Utilization Must Go Down for Every Stage in Care
What happens if focus on “Value”

PCP and Cardiologist → Unnecessary Stress Tests → False Positive Results → Unnecessary Angiograms → Unnecessary Stents

Patient

PCP and Cardiologist → Appropriate Stress Tests → Appropriate Angiograms → Appropriate Stents
History and Development of SMARTCare

- Collaborative effort convened by the American College of Cardiology and funded by the Centers for Medicare and Medicaid Innovation (CMMI)

- Stands for Smarter Management And Resource Use for Today’s Complex Care Delivery

- Used by nine cardiology practices in Florida and Wisconsin

- Supported by the Florida and Wisconsin chapters of the ACC

- Developed by physicians with the input of patients and the business community
The SMARTCare Design

- Support Physician Decision-Making
- Incentivize Patient-Centered Care
- Performance Reports to All Stakeholders
- Patient Engagement in Treatment Choice
What Problem Does SMARTCare Solve?

- Clinical decision-making is complicated, involving three critical decisions:
  - Appropriateness of non-invasive and invasive cardiac imaging
  - Treatment choice between medical therapy, stenting, and CABG
  - Optimization of medication therapy and health behaviors

- Patients’ roles in decision-making are just as critical:
  - Needs, preferences and values have implications for adherence
  - Patients generally choose less invasive, less costly options when given clear and unbiased information about all options

- FFS discourages interactions necessary for high-quality, patient-centered decision-making

*SMARTCare is designed to support better decision-making by addressing appropriateness of care for stable ischemic heart disease*
Shared Savings and Risk-Based Payment Aren’t Adequate Solutions

- Appropriateness of care has both quality and cost implications so cannot be treated only as a cost driver

- Dis-incentivizing unnecessary care may not adequately cover cost of care if payment still based largely on FFS model

- New payment models must both dis-incentivize unnecessary care and incentivize appropriate use of tests and treatments
# Proposed Model

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<th>Problem with Current Payment System</th>
<th>Goal of SMARTCare Payment</th>
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| Appropriateness not considered in payment | • Pay more for patients for whom evidence indicates that testing and procedures are appropriate.  
• Do not pay more for more tests or because more expensive tests or procedures are used. |
| Payment does not cover fixed costs of providing care when volume of services goes down | • Calculate payment amounts based on revenues needed to cover cost of adequate capacity for expected volume of appropriate tests and procedures.  
• Adjust payment amounts based on marginal costs, not average costs, when volume changes |
| Time required to make better decisions is not compensated | • Ensure adequate payment to cover costs of decision support tools and shared decision-making for both PCPs and cardiologists. |