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Closing the Gaps in Cardiac Care With Technology, Collaboration

By Christina Mattina

CARDIOVASCULAR DISEASES REQUIRE ongoing care and management across providers and settings to support patients in adhering to treatment and lifestyle changes. This makes the cardiology space ripe for implementation of value-based care arrangements and remote technologies, according to speakers at an Institute for Value-Based Medicine event held in Phoenix, Arizona, on November 12, 2024. The event, held by *The American Journal of Managed Care* in partnership with Banner Health and Banner | Aetna, featured faculty from those organizations as well as primary care and specialty practices and digital health companies.

Event cochair Robert Groves, MD, then the executive vice president and chief medical officer of Banner | Aetna, began the evening by noting the inherent challenges of cardiac care from the patient perspective: With so many details to remember and

the stakes so high, patients might not be sure of their next step or who to ask. In this fraught and fragmented setting, continuous remote care presents a solution allowing for better coordination, he said.

“When your life is on the line, things slip through the cracks. You don’t remember everything being said to you,” Groves said. “So I not only believe that we have a lot that we can do for our patients, [but also that] we haven’t even begun to tap the potential available today through technology.”

To illustrate technology’s potential, he introduced the first speaker, Spencer Kubo, MD, chief medical officer at CareCognitics, who presented insights from an experiment that leveraged a novel technology application to reduce 30-day cardiology readmissions. The experiment, using CareCognitics technology, was conducted at the Cardiac Solutions practice in the Phoenix area. The idea was to proactively reach out



GROVES



KUBO



CLARKE



CAPLAN



GREGORY



GURULE



PATEL

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to the patient, reduce barriers to care, enhance activation, and reward adherence, rather than waiting for the patient's condition to worsen and require readmission.

"If we're able to reach out and connect with the patient so that the patient feels special, we feel that the patient who feels special is activated, engaged, and will actually do the things that will help them, rather than being passive along the way," Kubo explained, defining what his team calls the VIP care experience.

In this pilot experiment, which had a control group but was not randomized or blinded, patients being discharged from the hospital with a diagnosis of heart failure could choose to receive text or email messages, which included elements such as educational videos on dietary tips or knowledge quizzes. There were also symptom monitoring questions and check-ins to ask whether the patient was concerned that an emergency visit might be needed or whether they would like to be connected with their care team. If they answered yes to either question, the system automatically called the triage line for them. Also, for engaging with these reach-outs, patients received tickets for sweepstakes with the chance to win a cash prize.

The findings presented by Kubo encompassed a patient population of 375 individuals with a mean age of 76 years and a typical mix of comorbidities. Sixty-two percent were men, and 61% had heart failure with reduced ejection fraction. Within 30 days, the overall readmission rate for those receiving the intervention was 15.5%, which is much lower than the historical average of 24%. An even greater difference was seen when breaking the data down further into patients who were considered activated vs those who enrolled but did not engage with the program, Kubo said. For those who were "watching the videos, doing the surveys, [and] following the directions, their readmission rate was only 7.7%, so a marked reduction. [It's] very gratifying to see that the plan worked as well as it did," he said.

He attributed this success to the early intervention by the triage line and the seamless linkage to the care team, which he called "a case where digital technology accentuates the human connection." Potential next steps for this model could include refinement with artificial intelligence and partnerships with payers to waive co-pays for engaged patients.

Next, event cochair Ed Clarke, MD, vice president and chief medical officer of Banner Health Plans & Networks at Banner Health, introduced the evening's panel discussion, which brought together primary care physicians and cardiologists to share their thoughts on value-based

care in cardiology. First, he asked the participants to discuss how third-party vendors can help bring the element of value to cardiac care.

According to Joseph Caplan, MD, FACC, a cardiologist at Cardiac Solutions, one key advance has been in the arena of home monitoring to distinguish patients whose blood pressure measures high when they are in the office vs those who have hypertension.¹ Joseph Gregory, MD, chief medical officer for care transformation at Banner Medical Group, agreed that home blood pressure monitors are a huge time-saver because the data from the readings are automatically uploaded to providers who can help manage uncontrolled hypertension.

"If you had a third-party payer who was vested in that plan and could provide larger rewards where it became more meaningful, and [if you could] leverage that across a larger population, rather than what we just see at Cardiac Solutions, that would be huge. The second big one would be shared savings to incentivize doctors to do the right thing, whether it's utilization of technology or clinical programs or whatever your favorite jam is."

—Joseph Caplan, MD, FACC, cardiologist, Cardiac Solutions

Tech solutions are just one example of a tool used to align care as more practices take on financial risk for patient outcomes. That value-based transformation was discussed further by Charlotte V. Gurule, MD, a family medicine specialist at Oak Street Health. Oak Street's structured care model takes an integrated approach to caring for patients' needs, from behavioral health to social determinants to transportation, Gurule said, and tools including clinical decision support and specialist

consultation platforms are key to proactively managing patients' conditions.²

Practicing medicine in a small town adds another layer of challenge, Gregory noted, with many patients unable or unwilling to travel the 30 minutes to the hospital for an echocardiogram, so he and his colleagues try to do as much as possible in their office. When that's not possible, and primary care physicians and cardiologists need to work together, it's "critical that we help our patients understand that we're sending that information and that we're coordinating and collaborating together to do it," Gregory said.

"If we were to have a good relationship with a set of specialists, where we can have a conversation easily and we can partner together, where we can handle the majority of things, as long as we have the care plan established by the specialists of what to do, what to look for, when to call us, and easy access to call them, that would be ideal."

—Charlotte V. Gurule, MD,
family medicine specialist, Oak Street Health

Communication is also key from the cardiologist's perspective, according to Rishi Patel, MD, a cardiologist at Banner Health. "For all of us, it's bidirectional because I need to have the primary care doctor's number," he said. "Being able to speak directly with a primary care doctor is, I think, equally important to the specialist...."


From the primary care viewpoint, "If we were to have a good relationship with a set of specialists, where we can have a conversation easily and we can partner together, where we can handle the majority of things, as long as we have the care plan established by the specialists of what to do, what to look for, when to call us, and easy access to call them, that would be ideal," Gurule said.

Clarke asked the panel to opine on what payers need to do to advance the journey along the value-based care continuum. According to Caplan, who worked with Kubo on the technology pilot, the program's results demonstrate the power of financial rewards as a motivator.

"If you had a third-party payer who was vested in that plan and could provide larger rewards where it became more meaningful, and [if you could] leverage that across a larger population, rather than what we just see at Cardiac Solutions, that would be huge," Caplan said. "The second big one would be shared savings to incentivize doctors to do the right thing, whether it's utilization of technology or clinical programs or whatever your favorite jam is."

Using the example of compensation for delivering intravenous diuretics, Patel suggested that the "ability to have plan-sponsored, plan-collaborative infrastructure for that, I think that would be really helpful to the patients, helpful to the plan, and helpful to the practice, because they're getting that support to help do better by the patients."

In response to an audience question about the interest among cardiologists in engaging in value-based models with payers, the panelists agreed that the power of momentum is behind value, so practitioners will need to get on board or be left behind. Patel noted that culture change and the publication of provider-specific metrics for cross-network comparison can be powerful motivators of transformation.

"It is really refreshing to hear so many people dedicated to showing up in a broken system every day and trying to make it better," Groves concluded. "I think there is hope for our system, and I think you're seeing a lot of it today." 

Author Information: Ms Mattina is an employee of MJH Life Sciences, the parent company of the publisher of *Population Health, Equity & Outcomes*.

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