Applied Clinical Cardiology

EDITORIAL

Value-Based Collaboration

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EDITORIAL

Cardiologists have been on the forefront of catheter-based vascular intervention for years. Ever since vascular surgeons began performing catheter-based interventions there has been a turf-war between interventional cardiologists and vascular surgeons. Interventional cardiologists certainly have the historical and numerical advantage. There are nearly three times as many interventional cardiologists as vascular surgeons in the United States.[1,2] And when it comes to a prospective patient pool and referral base, the enormous number of US cardiologists (over 23,000) [3] ensures that the interventional cardiologists will not be short of business.

Value is an increasingly hot topic in medicine today. Not only are patients striving for higher quality care, but payers are rewarding it, or even demanding it. The Centers for Medicare and Medicaid Services (CMS) have developed value-based programs with the goal of better care for individuals and populations-all with lower costs. [4] Programs such as these will reward those providers and facilities providing the most value to patients and payers. There programs are a great impetus to begin work collaboratively instead of fighting the same old turf-wars.

No one argues that interventional cardiologists reign supreme in coronary interventions and vascular surgeons have mastery over open aortic surgery. There are other vascular territories that invite more competition, such as lower extremities, endovascular aneurysm repair, or renal and carotid arteries. Cardiologists have superb catheter skills to offer in these areas and vascular surgeons have surgical experience that cardiologists do not get. Patients stand to benefit from the two specialties working together to achieve the best outcomes for the patients. At times this may require simultaneous intervention from both specialties. This is increasingly true in areas such as TAVR or with Impella-support during coronary intervention. Vascular surgeons can offer valuable assistance with these larger sheaths and catheters.

As procedures increase in complexity and sicker patients are offered more interventions, we should not fear the competition between specialties but rather embrace the opportunity to work collaboratively. I suspect we will soon see that teams of interventional cardiologists with vascular surgeons provide better outcomes at lower costs than either specialty working alone. And those teams will be rewarded by CMS and other payers at a level that negates anything lost to relinquishing some common ground in the turf-war.

References

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