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FAST ACCESS, LASTING VALUE: STRATEGIC PATHWAYS FOR URGENT CV CARE

Driving Ambulatory, Value-Based Care

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FACULTY DISCLOSURE

We have no relevant financial relationships with ineligible companies to disclose.

OBJECTIVES

After completing this educational activity, participants will be able to:

- Describe the structure and operational components of an urgent access cardiology clinic
- Discuss how the Ambulatory Specialty Model (ASM) proposed rule aligns with the goals of value-based care and supports implementation of urgent access strategies in cardiology

EXPECTED OUTCOME & EDUCATIONAL NEED/ PRACTICE GAP

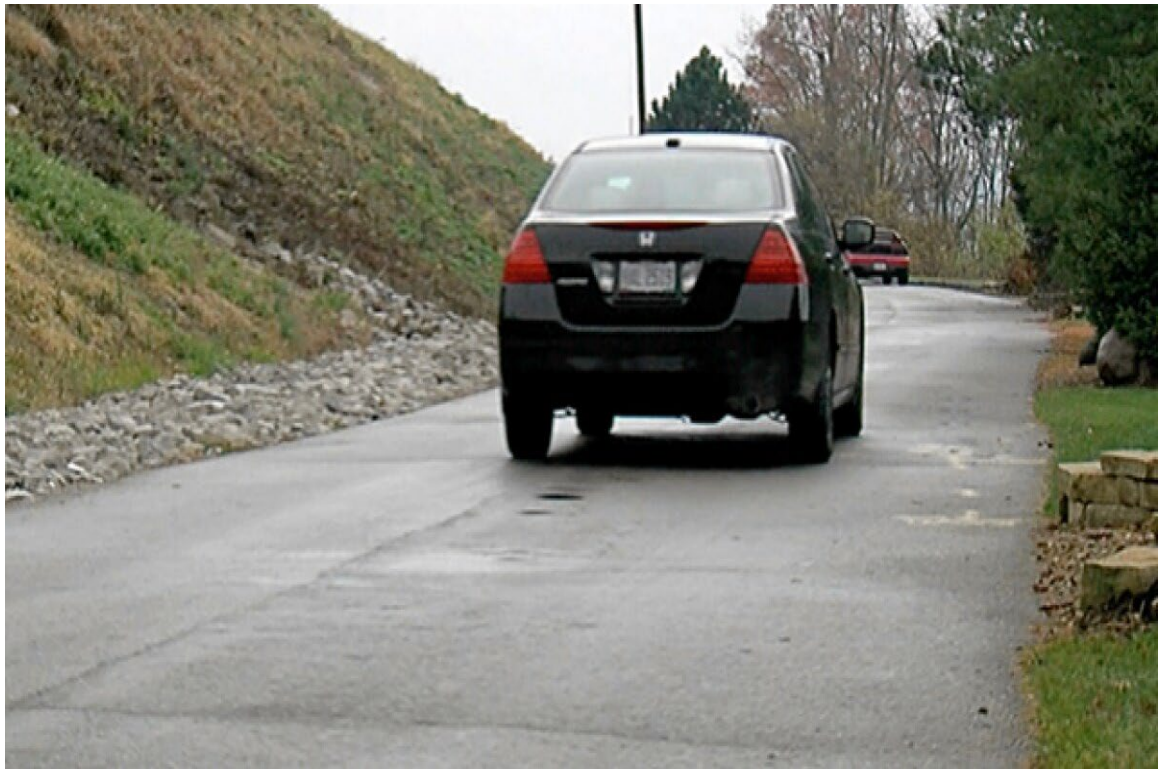
Expected outcome: Participants will recognize how urgent access models reduce hospital utilization and improve outcomes and align with value-based care principles to enhance quality and financial performance.

Educational Need: Cardiology needs practical approaches to design and implement urgent access models that enable early intervention, standardized care, and alignment with value-based payment models such as the ASM proposed rule.

Practice Gap: Patients with heart failure and other cardiac conditions continue to experience preventable ED visits and readmissions due to limited outpatient access, inconsistent triage protocols, and poor care coordination.

FUN FACTS ABOUT KENTUCKY

Kentucky has a mysterious “Magnetic Hill”



In Hopkinsville, there’s a stretch of road where cars appear to roll uphill against gravity when left in neutral. It’s actually an optical illusion caused by the surrounding landscape.

FUN FACTS ABOUT KENTUCKY

Home to one of the world's few "Blue People" communities

In the 1800s, a family in eastern Kentucky, the *Fugates of Troublesome Creek*, carried a rare genetic condition (methemoglobinemia) that turned their skin blue due to reduced oxygen in the blood. It's now a famous case study in genetics and Appalachian medicine.

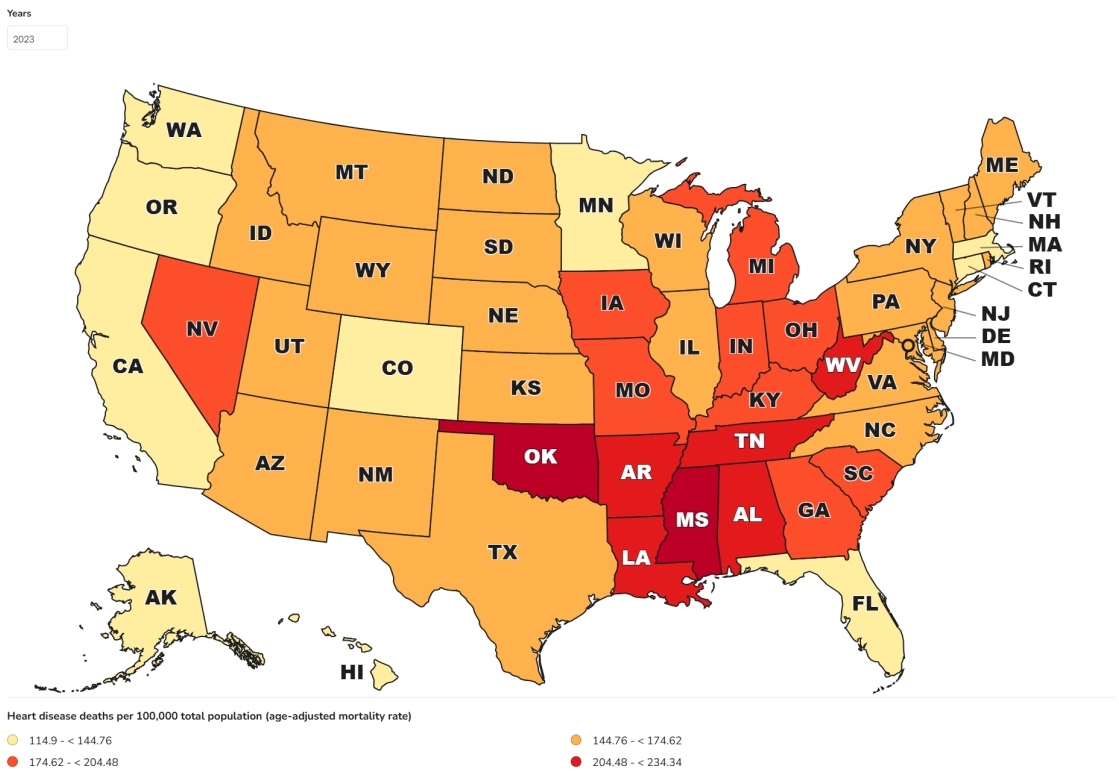
FUN FACTS ABOUT KENTUCKY

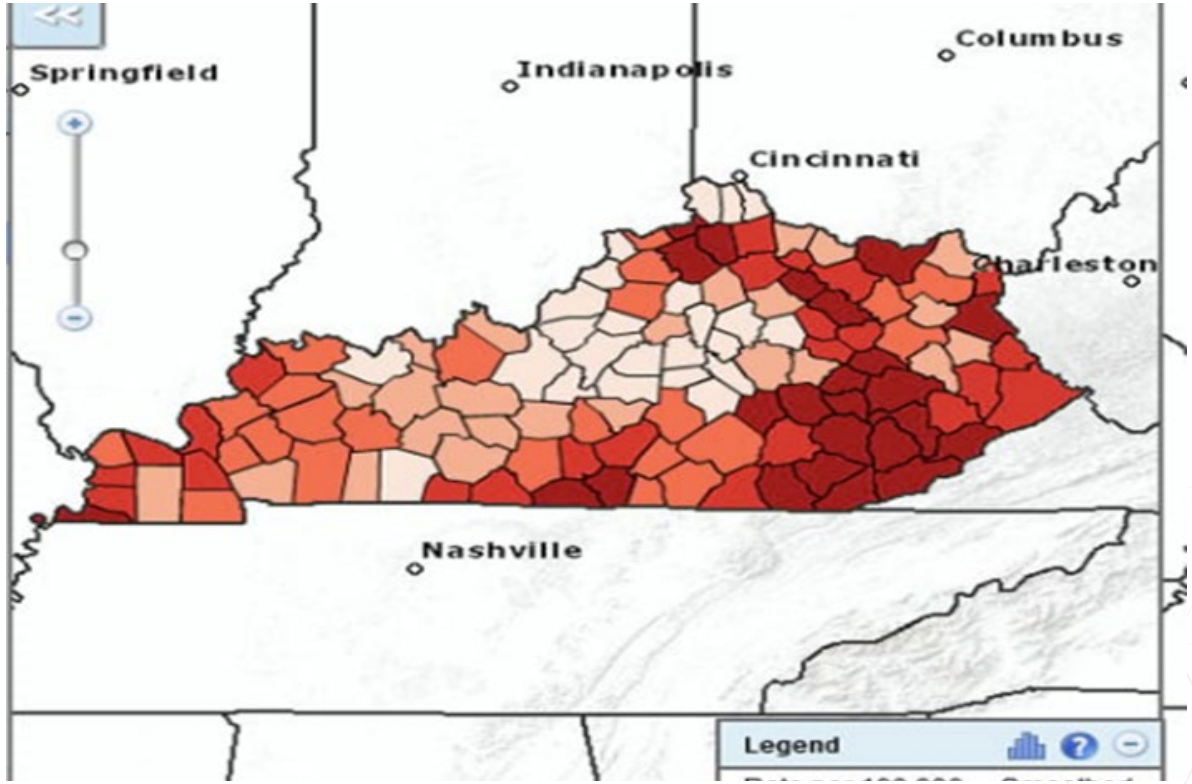
Has more caves than any other place on Earth

Mammoth Cave is the longest, but few realize Kentucky has **over 130 recorded cave systems** — more than any country. Entire underground rivers and endangered species exist only there.

NOT SO FUN FACT ABOUT KENTUCKY

The leading cause of death in the state is CV Disease





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STATE OF CARDIOLOGY

HEALTHCARE IS UNDER ATTACK

Our political landscape has created uncertainty

- ✓ Big Beautiful Bill
  - ➢ Anticipated to leave many people without healthcare coverage
- ✓ Tariffs
  - ➢ Cost of medical devices and medical supplies is anticipated to go up
- ✓ Visas
  - ➢ There are many practicing foreign-trained physicians in the US that will be affected by new immigration policies

HOT OFF THE PRESS

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2025

CARDIOVASCULAR
PROVIDER COMPENSATION
& PRODUCTION SURVEY

2025 HIGHLIGHTS

Advanced Practice Provider (APP) Deployment Trends: APPs continue to play a critical role in cardiovascular care. Cardiology programs increased their APP-to-physician ratio to 0.75, while cardiac and vascular surgery programs saw declines in APP support per surgeon.

APP Productivity Growth: Cardiology APPs posted an 8% increase in median wRVUs, reaching 1,987 in 2024. Private practice APPs significantly outperformed their integrated peers, producing a median of 2,743 wRVUs, underscoring differences in billing independence and productivity expectations.

Access Challenges: Access to cardiology care showed signs of strain in 2024 as larger patient panels, nearly 2,000 per physician full-time equivalency (FTE), coincided with the first drop in new patient office visits reported in several years. The percentage of new patient visits to total office visits dipped to its lowest point in five years at 15.4%.

Declining Cath Lab Volumes: Catheterizations and PCIs per 1,000 active cardiology patients continued their downward trend, reflecting shifts in care delivery and the growing use of advanced imaging to guide interventions.

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ADDING TO THE STRAIN

Figure 23: Shortage of Cardiologists

1 IN 4 CARDIOLOGISTS (25%) IS NOW OVER THE AGE OF 61

7,563 MEDIAN

wRVUs per FTE over age 61 (10,355 overall)

There's a whole FTE missing here

U.S. CARDIOLOGY PROJECTIONS

Practicing Cardiologists[1]	32,000
Over the Age of 61[2]	8,320
Estimated Annual FTE losses[3]	(1,650)
Current Total U.S. Fellows[4]	4,302
Annual Number Entering Workforce[4]	1,156
Net Annual Workforce Impact	**(494)**

[1] Source: Joint American College of Cardiology (ACC)/MedAxiom calculations
[2] Source: MedAxiom Cardiovascular Provider Compensation & Production Survey
[3] Source: MedAxiom projections based on both wRVU production reductions and physician departures
[4] Source: Accreditation Council for Graduate Medical Education, 2018 - 2019

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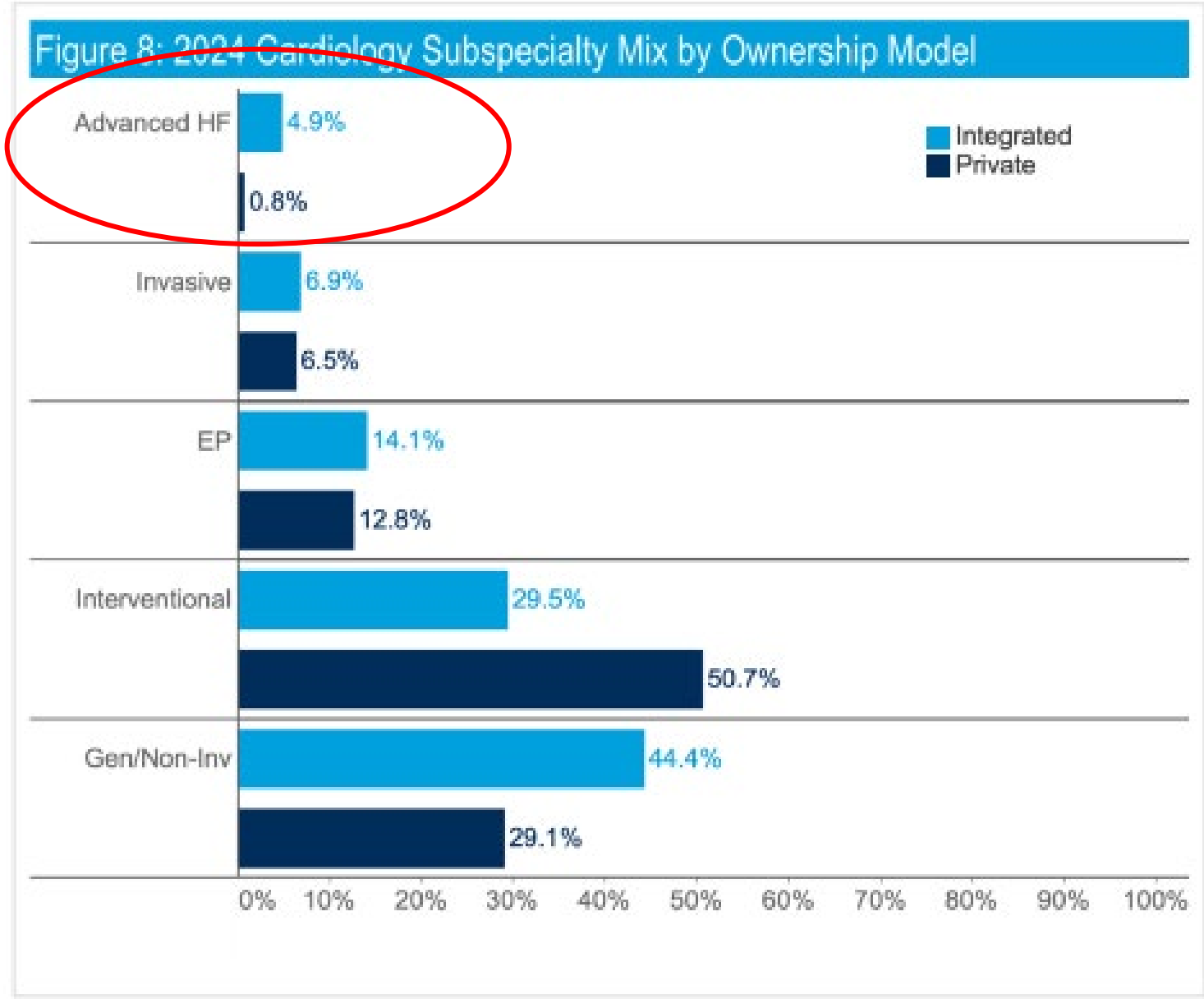
THERE AREN'T ENOUGH HEART FAILURE PHYSICIANS TO TAKE CARE OF OUR AGING POPULATION



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CLINICAL OPPORTUNITY

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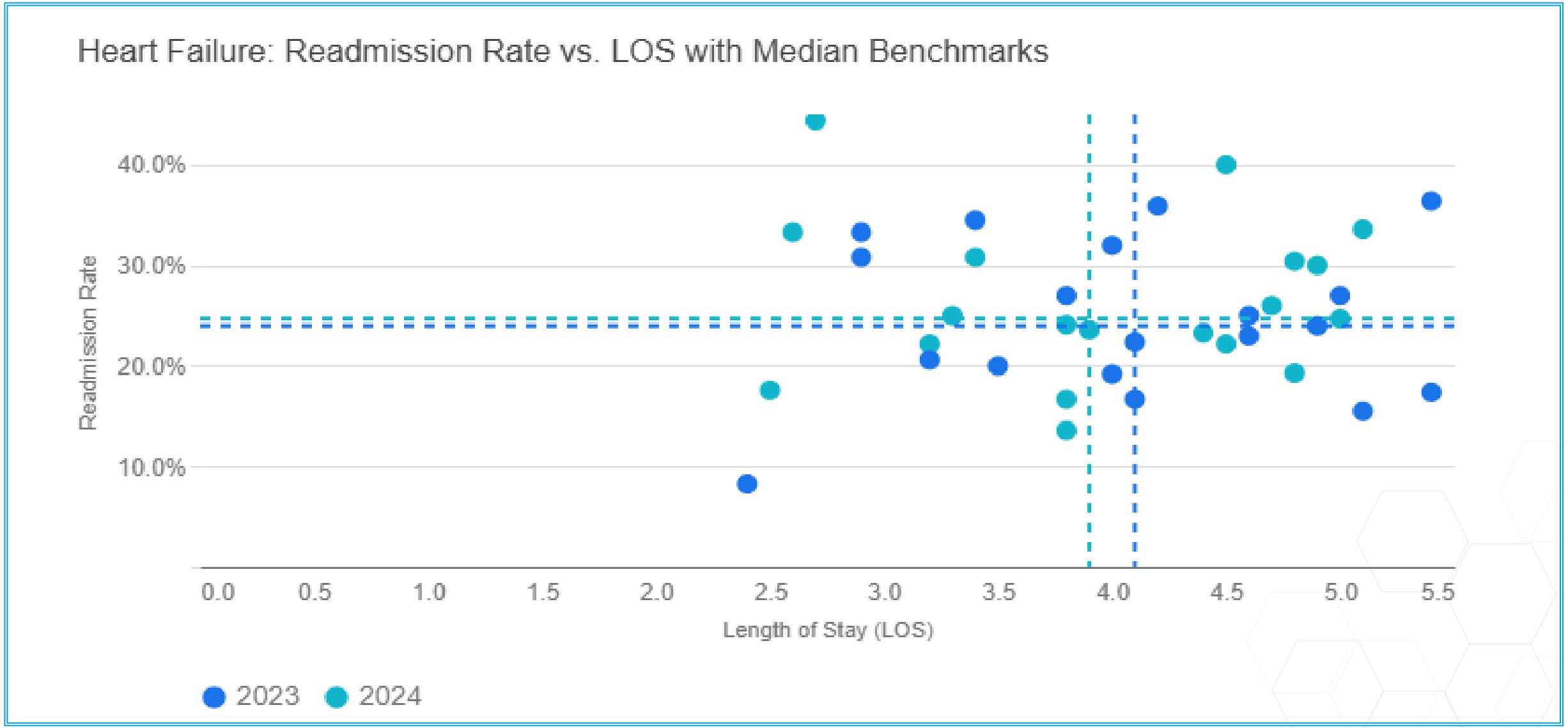
GILL AFFILIATE NETWORK DATA - HF



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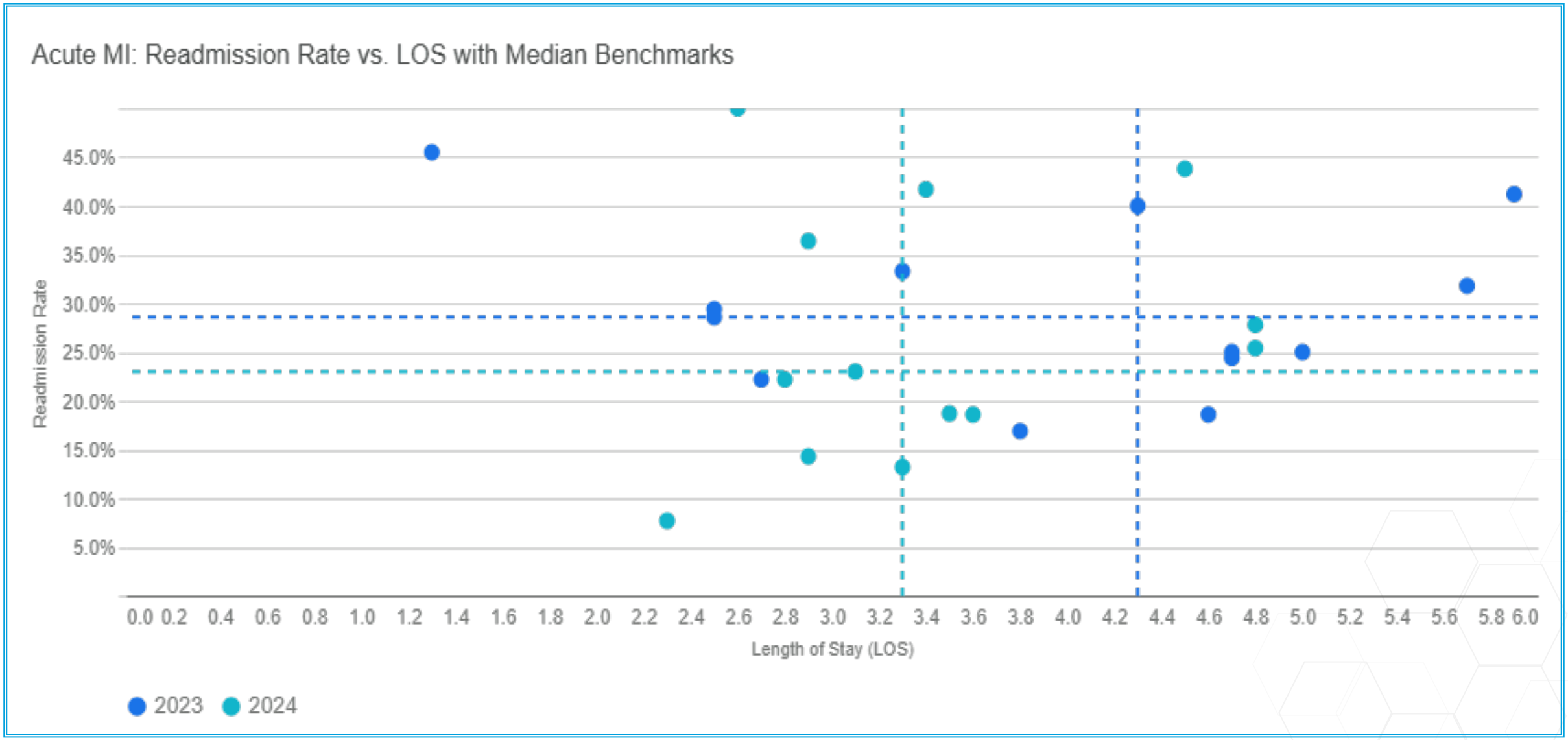
GILL AFFILIATE NETWORK DATA- ACUTE MI



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CMS AMBULATORY SPECIALTY MODEL (ASM)

- Proposed July 2025- would begin January 2027
- Mandatory value-based model
- Ties cardiologists' reimbursement to quality, cost and coordination of care for HF
- Requires Collaborative Care Arrangements (CCAs) with primary care, interoperability, and measurable performance on HF metrics (GDMT, BP, readmissions)
- Two-sided risk: ±9 % payment adjustment over time

PROPOSED CMS AMBULATORY SPECIALTY CARE MODEL (ASM)

Implications

- ✓ Encourages structured ambulatory HF management
- ✓ Supports team-based care models: APPs, RNs, pharmacists
- ✓ Data-driven performance targets

Strategic Considerations

- ✓ Invest in EMR-integrated HF pathways and analytics
- ✓ Formalize HF clinic infrastructure and team training
- ✓ Prepare for risk-sharing and quality-linked reimbursement

THE NEED

HF remains the number 1 cause of CV hospitalizations

1

Chest pain is the number 2 cause of ED visits nationwide

2

Many low-to-intermediate risk patients are admitted unnecessarily, increasing cost and delaying care

3

Opportunity for better triage & faster access

4

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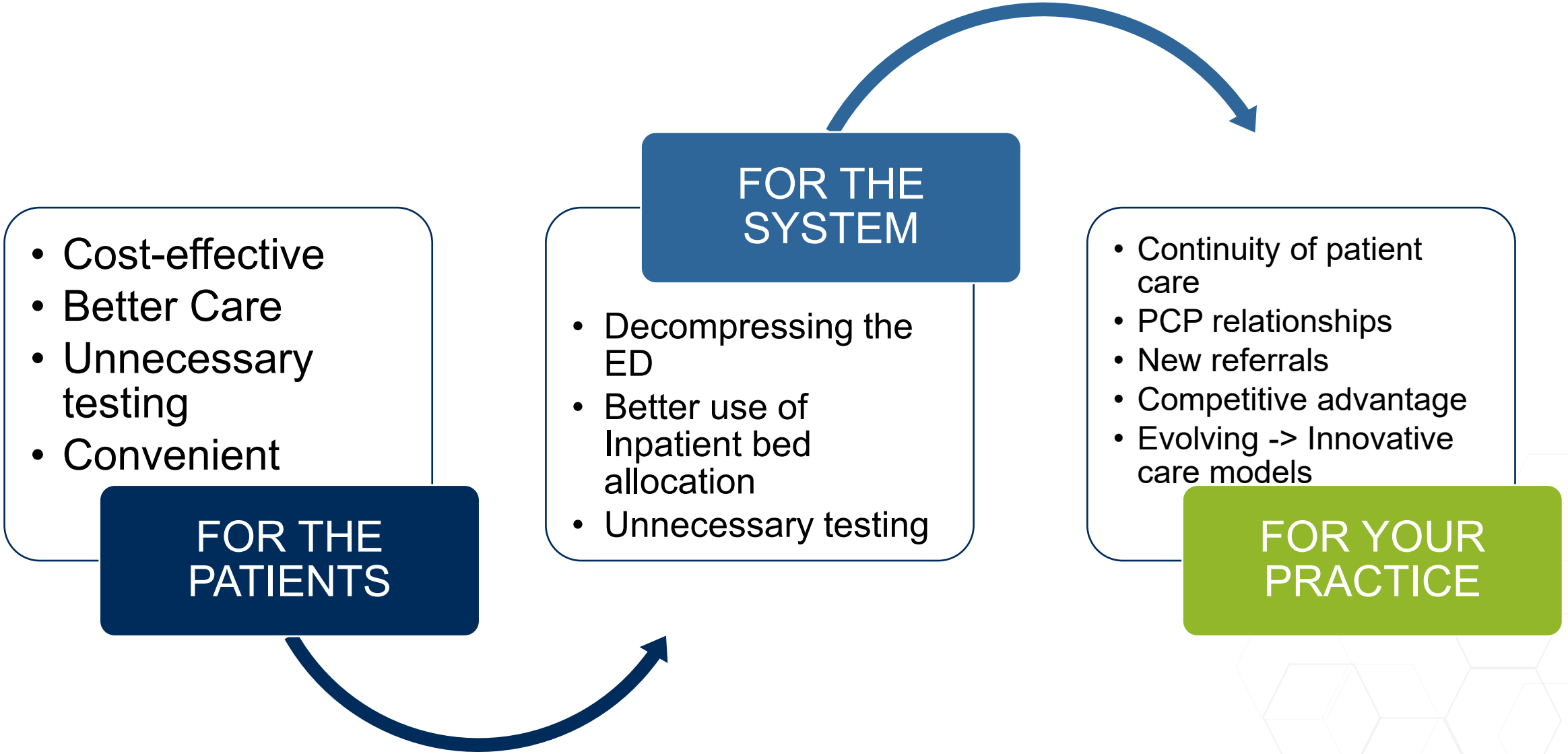
What we know: ACCESS is the strategy



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PATIENT POPULATIONS

Chest Pain

50% of chest pain-related ED visits **do not result in a diagnosis of ACS** highlighting a clear opportunity for outpatient triage and evaluation.

Source: Emergency Department Cardiac Risk Stratification With High-Sensitivity Troponin

Atrial Fibrillation

~600,000 ED visits/year in the U.S. due to AFib; **>60% result in admission**.

Source: Management of Atrial Fibrillation in the Emergency Department

Hypertension

ED visits for hypertensive urgency/emergency are **increasing**, yet many **do not require admission**.

Source: The Management of Elevated Blood Pressure in the Acute Care Setting

Heart Failure

A leading cause of hospitalization in older adults; early outpatient intervention can significantly **reduce admissions**.

Source: 2023 Focused Update of the 2021 ESC Guidelines for the Diagnosis and Treatment of Acute and Chronic Heart Failure

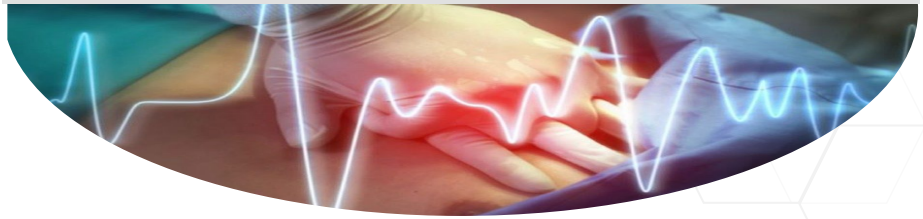
DEFINE TARGET POPULATION(S)

INCLUSION

- HF exacerbation w/o distress
- Low/moderate risk chest pain (non-STEMI)
- New/uncontrolled hypertension
- Stable atrial fibrillation/flutter
- Palpitations, syncope, suspected arrhythmia

EXCLUSION

- High-risk acute coronary syndrome (ACS)
- Cardiogenic shock or unstable arrhythmias
- Severe heart failure requiring hospitalization



WHAT'S THE FORMULA

Early Intervention + **Protocol driven care** + **Defined disposition criteria** = **Improved outcomes & reduced cost**

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PROTOCOL-DRIVEN MANAGEMENT

Consistent care in high-throughput clinic

HYPERTENSION

✓Rapid BP control with oral or IV agents

AF

✓Rate control with beta-blockers or calcium channel blockers

✓Anticoagulation decision per CHA_2DS_2-VASc score

HF

✓Diuresis

✓Monitor status

✓GDMT titration

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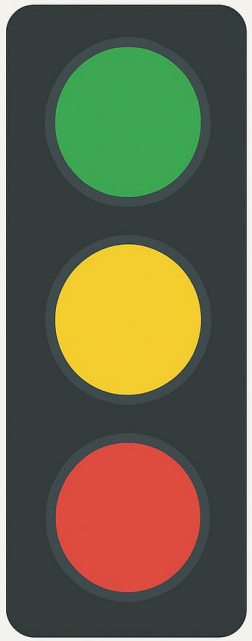
DISPOSITION CRITERIA

- ✓ The decision to discharge or escalate care should be guided by:
  - ✓ Clinical stability
  - ✓ Diagnostic findings
  - ✓ Follow-up availability
- ✓ Coordination with primary care and cardiology ensures continuity of care



DISPOSITION AND FOLLOW-UP PLANNING

Discharge with Close Follow-Up

Mild hypertension, stable atrial fibrillation, minor palpitations

Urgent Specialty Referral

Moderate risk cases requiring monitoring but no immediate admission

ED Transfer for Higher Acuity Cases

High-risk chest pain, unstable arrhythmias, hemodynamic instability

CASE STUDY – SHORTNESS OF BREATH

Presentation

72 year-old Male

C/o difficulty breathing with activity

6# weight gain in 2 days

No CP

PMH: chronic HFrEF, CAD, HTN

Assessment

BP 132/82

HR 88, regular

RR 24

O2 sat 96% on RA

Alert and oriented

Mild bibasilar crackles, 2+ pedal edema, No S3 or murmur

Diagnostics

BNP elevated

CMP, CBC normal

ECG: NSR

Last Echo- 35%, > 1 year ago

Management

IV loop diuretic

Good urine output (1.5 L in 2 hrs)

Vitals stable

Breathing improved with ambulation

Discuss “urgent” or red symptoms

Disposition Plan

Discharge home

Follow up in HF Clinic in 48-72 hours

Medication optimization

Education: diet, daily weights, medication

Schedule ECHO in 1-3 days

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OPERATIONAL BLUEPRINT

High-performing CV programs

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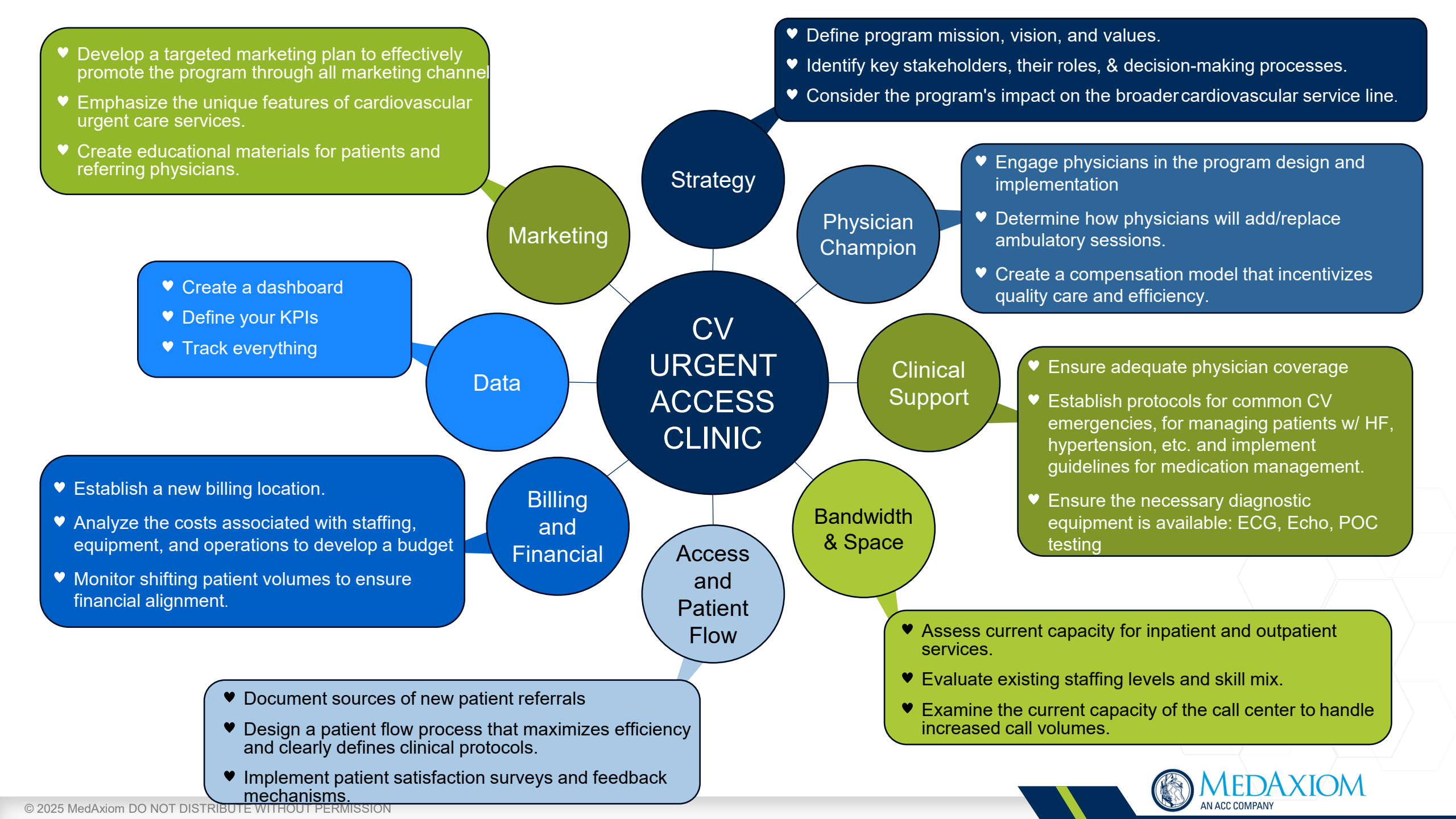

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CHECKLIST

- STRATEGIC PLAN
- PHYSICIAN CHAMPION
- CLINICAL SUPPORT
- PRACTICE BANDWIDTH & SPACE
- ACCESS AND PATIENT FLOW
- BILLING & FINANCIAL SET-UP
- DATA
- MARKETING

DASHBOARDS

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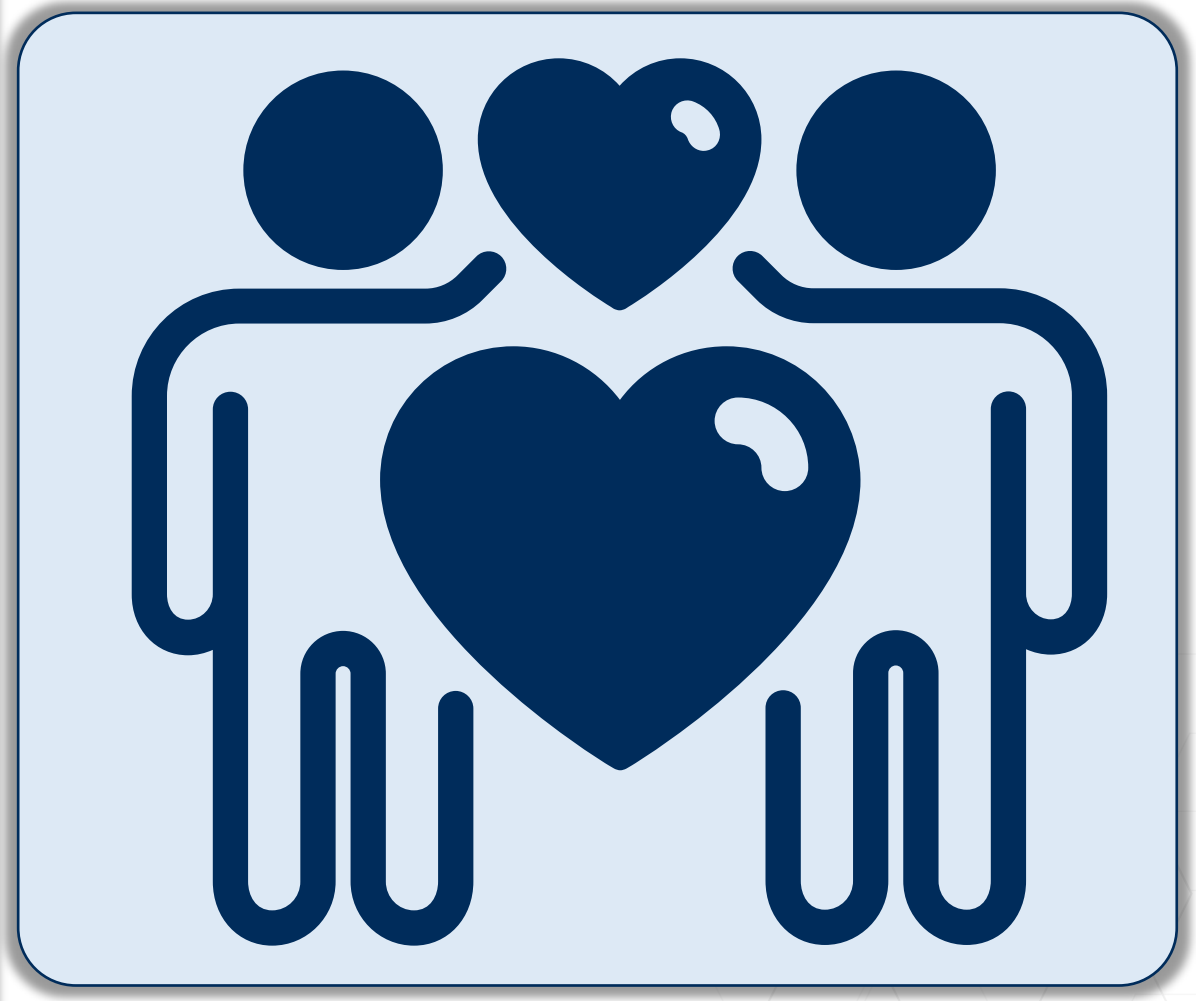
STAFFING

- Create opportunities for existing staff
- Evaluate existing staffing levels and skill mix
- Rotate the clinical staff to avoid burnout



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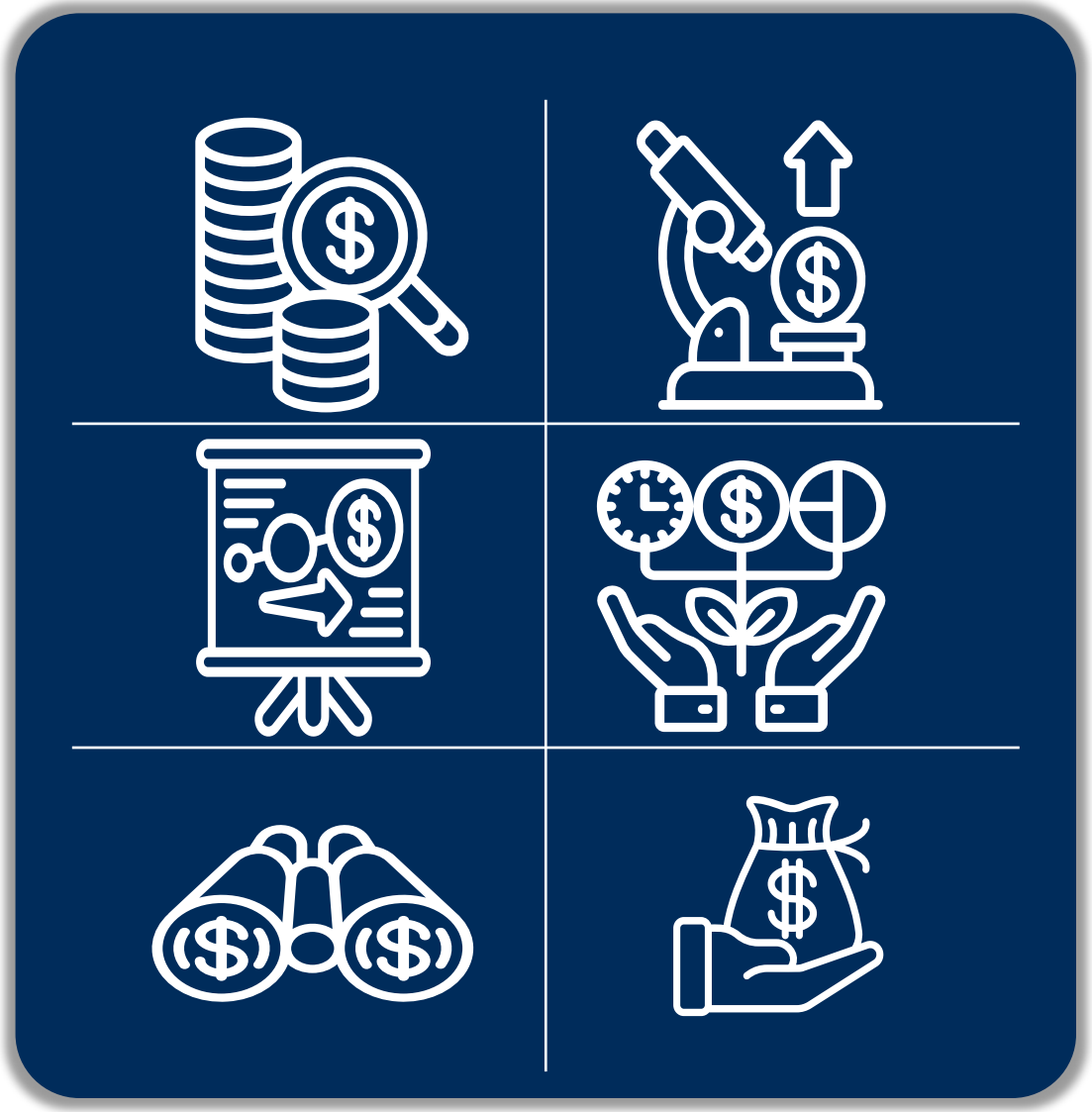
COMPENSATION



The physician champion is an important ally in this conversation.

It's crucial to be transparent and to clearly communicate.

Compensation options

- $ Part of the standard salary structure
- $ Bonus
- $ RVUs
- $ Program growth

DASHBOARDS

A tool that consolidates and displays essential data metrics and KPIs in a single, user-friendly interface.

- Worth the extra effort
- Understand your audience
- Let the data speak for itself

QUALITY METRICS (KPIS)

ED return visits

Unnecessary admissions

Time to diagnosis

Patient satisfaction

Cost savings

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STRATEGIC & FINANCIAL IMPACT

- Cost avoidance for health system
- Diagnostic testing revenue stream
- ED throughput improvement
- Stronger cardiology service line growth

URGENT ACCESS: THE BRIDGE TO VBC

➡️ Together, these redefine how cardiovascular care is delivered and reimbursed — moving from volume to value, from reactive to proactive.

1 Urgent Access Model

- Rapid triage & early intervention
- Protocol-driven management
- Post-discharge stabilization

2 Value-Based Outcomes

- Lower readmissions
- Reduced total cost of care
- Improved patient experience

3 ASM Proposed Rule

- Recognizes team-based, site-flexible care
- Rewards timely, outpatient management
- Aligns payment with performance

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THE FUTURE OF CV CARE

- Is rapid-access, protocolized, and team-delivered
- Know your state's burden
- Align with the ASM rule
- Build urgent access pathways the deliver measurable value
- Do not let perfection be the enemy of good
- Be creative!

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CARDIAC CARE INNOVATION

EASING THE ED BURDEN, BUILDING NEW REFERRAL NETWORKS

Download at
MedAxiom.com/UrgentCareCases

Q&A

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