WHAT’S NEW IN ACCREDITATION?
APPROPRIATE USE AND THE NEW STANDARDS
ECHO HAWAII
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DISCLOSURES

MEMBER AND IMMEDIATE PAST PRESIDENT
of THE BOARD OF DIRECTORS of IAC - ECHO
DIMENSIONS OF CARE in IMAGING: WHERE DOES APPROPRIATE USE FIT IN?


Table 2. Quality Goals and Action Items in the “Dimensions of Care” Framework for Cardiovascular Imaging

<table>
<thead>
<tr>
<th>Quality Goals</th>
<th>Action Items</th>
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</thead>
<tbody>
<tr>
<td>Laboratory structure</td>
<td>Mandate laboratory accreditation</td>
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<tr>
<td>Patient selection</td>
<td>Develop physician training and certification requirements</td>
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<tr>
<td>Image acquisition</td>
<td>Support technologist certification</td>
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<tr>
<td>Image interpretation</td>
<td>Develop additional laboratory accreditation processes for all modalities</td>
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<tr>
<td>Results communication</td>
<td>Define key acquisition elements of imaging protocols and sequences</td>
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<tr>
<td>Improved patient care (outcomes)</td>
<td>Develop appropriateness criteria for all imaging modalities</td>
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</tbody>
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DEVELOPMENT OF AUC

- FIRST DEVELOPED FOR NUCLEAR IMAGING (2005)
  - TTE / TEE / SE (2011)
- EXPANDED TO MULTIMODALITY IMAGING BASED ON DISEASES SUCH AS IHD / CHF
  - RECENTLY Acute Chest Pain in the ED
- TERMINOLOGY EVOLUTION
  - USUALLY APPROPRIATE CARE (APPROPRIATE)
  - MAY BE Appropriate Care (UNCERTAIN)
  - RARELY Appropriate Care (INAPPROPRIATE)
Temporal Changes in Appropriateness of Cardiac Imaging (JACC 2015)
59 studies / 103,567 tests (2000-2012)
Trends in appropriateness over time and with new / revised AUC
Some improvement in TTE/TEE
Is this due to improved practice patterns or better AUC classifications?
No improvement in SE
Published reports of effectiveness of education vary
- How long / frequent do educational efforts need to be performed / repeated?

Knowledge of AUC / Guidelines is one of many factors affecting test ordering
- Practice / patient characteristics
- Lab accreditation status
- Financial / other incentives
- Acceptance of guidelines

Lab audits reflect the tests ordered / performed, NOT the ordering process
- Data can be used to educate ordering providers

Fonseca, et al. JACC 2015

The Protecting Access to Medicare Act (passed in 2014) requires ordering providers to consult with “appropriate use criteria through a clinical decision support mechanism (CDSM) for all Medicare patients undergoing advanced imaging (nuclear medicine, CT, MR, PET) starting in January 2017”
- CMS DEFINITION:
  AUC are defined as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decisions for a specific clinical condition.

- Echocardiography is NOT included (at this time)
  - X-ray, fluoro, ultrasound excluded

- APPLIES ONLY TO OUTPATIENT (offices, hospital OP Departments including the ED, ambulatory surgical centers)
APPROPRIATE USE CRITERIA
MEDICARE RULES

TIMELINE

BY NOV 15, 2015: Specification of applicable AUC developed / endorsed by national professional medical societies / other provider led entities

BY APRIL 1, 2016: Identification of qualified CDS mechanisms for AUC consultation

BY JAN 1, 2017: Ordering professionals shall begin consulting with a qualified CDS system, furnish documentation of the consultation to the furnishing professional. CMS will also begin identification of “no more than 5% of the total number of ordering professionals” who are outliers.

JAN 1, 2020: CMS shall apply prior authorization for applicable advanced imaging services ordered by outliers

DELAYED

The Ohio State University
Wexner Medical Center
CMS IMPLEMENTATION DELAYED NOT RESCINDED

- DELAYED TIMELINE (as of Oct 2015) but NOT RESCINDED
  - FINAL RULE IN LATE 2016 (FOR CALENDAR YEAR 2017)
  - REITERATED THE DELAYS / ISSUES
    - PLE / FOCUSED DIAGNOSES IDENTIFIED

- NEED A PROCESS FOR SPECIFYING AUC, followed by rules regarding CDS mechanisms

- CMS EXPECTS TO HAVE CDS MECHANISMS BY MID 2017

- NOVEMBER 2017 FINAL RULE FOR 2018 PFS RELEASE

- Probable delay in implementing CDS until 2018 at the earliest

- CARDIOLOGY IS WELL SITUATED WITH A VARIETY OF AUC DOCUMENTS
  - SOME AUC DOCUMENTS CONFLICT
    - e.g. THE RECENT AUC for IMAGING FOR CP PATIENTS IN THE ED

NEW IMAGING IN ED AUC NOT UNIVERSALLY ENDORSED

JACC 2016

SPECIAL ARTICLE

APPROPRIATENESS USE CRITERIA IN THE ACCREDITATION PROCESS

Developed from Stainback MDCVJ 2014; X (3):178

APPROPRIATE USE IN ACCREDITATION

- STANDARDS (required) /GUIDELINES (suggestions)

- REVIEWED / REVISED PERIODICALLY
  - ONGOING PROCESS
  - CURRENT STANDARDS FOR ASSESSMENT OF APPROPRIATENESS RECENTLY REVISED

- PATIENT SELECTION
  - MULTIPLE CONSIDERATIONS
PATIENT SELECTION
The Right Test for the Right Patient?

AUC
PATIENT PREFERENCE
PROVIDER EDUCATION

OSU Heart Center

APPROPRIATE USE AND ACCREDITATION

- GUIDELINES FIRST REFERENCED AUC IN 2010
- AUC REQUIREMENTS INCORPORATED IN TO IAC STANDARDS IN 2012
- WHAT IS CURRENTLY REQUIRED / EXPECTED
  - MEASURE
  - REPORT
  - EDUCATE
- WHAT RECENTLY CHANGED?
  - NEW STANDARDS
  - NEW QI TOOL
    - ALLOW LABS TO COMPARE THEIR DATA WITH OTHER ACCREDITED LABS
MEASURE

DOCUMENTATION OF APPROPRIATENESS FOR EACH MODALITY

- % OF Appropriate / May be Appropriate / Rarely Appropriate

INITIAL SAMPLING OF YOUR PRACTICE

- Baseline statistics for adherence

IAC HAS TOOLS TO HELP

- NEW QI TOOL
- SAMPLE DOCUMENTS TO ASSIST WITH AUC DOCUMENTATION

IAC STANDARDS HAVE CHANGED

Old Standard:
Test Appropriateness

- The facility must evaluate the appropriateness of the test performed for a minimum of 30 consecutive TTE, TEE and SE examinations annually and categorize as:
  - appropriate/usually appropriate;
  - may be appropriate; or
  - rarely appropriate/usually not appropriate

New Standard (Effective Jan 1, 2017):
Test Appropriateness

- A minimum of two cases per modality (TTE, TEE, SE) per quarter must be evaluated for the appropriateness of the test performed and categorized as:
  - appropriate/usually appropriate;
  - may be appropriate; or
  - rarely appropriate/usually not appropriate
APPROPRIATE USE AND ACCREDITATION: PUBLISHED JUNE 8, 2016

2.1C Facilities must have a process in place to evaluate the QI measures outlined in sections 2.1.1C through 2.1.5C. A minimum of two cases per modality (TTE, TEE, SE) per quarter must be evaluated and the same cases may be used for the first four measures.

2.1.1C Test Appropriateness

A minimum of two cases per modality (TTE, TEE, SE) per quarter must be evaluated for the appropriateness of the tests performed and categorized as:

i. appropriate/usually appropriate;
ii. may be appropriate; or
iii. rarely appropriate/usually not appropriate.

THE NEW QI TOOL IS NOW AVAILABLE

COMBINES APPROPRIATENESS, TECHNICAL QUALITY, INTERPRETIVE QUALITY, REPORT COMPLETENESS / TIMELINESS AND CORRELATION IN TO ONE CASE
REPORT / EDUCATE

- REVIEW FINDINGS AT QI MEETINGS
  - Rates of adherence
  - Patterns of adherence
  - Goals for improvement
  - Measure your progress

- EDUCATION OF LAB STAFF AND REFERRING PROVIDERS
  - Interpreting providers / tech staff
  - Ordering physicians / Practices
    - Report on patterns of adherence
    - IAC sample letter
  - Only 65% of interns are aware of AUC (Bhatia et. al. JACC Img 2013)

APPROPRIATE USE IN ACCREDITATION: HOW DO WE EFFECT CHANGE?
CHALLENGES IN (Referring) PROVIDER EDUCATION

- EFFECTIVENESS OF VARIOUS EDUCATION EFFORTS VARIABLE
- CHANGING TEST ORDERING PATTERNS CHALLENGING
  - “MY PATIENTS ARE DIFFERENT”
- AUC DISSEMINATION SHOULD HELP
  - TEST PROVIDERS SEEM MORE AWARE THAN REFERRING PROVIDERS
- COMMUNICATION FROM LAB TO PROVIDERS
  - IAC HAS SAMPLE LETTERS
- NEW CMS RULES MAY HELP
A CDS TOOL FOR STRESS ECHO

Levitt JASE Dec 2015

ST. MICHAEL’S STRESS ECHO CDS TOOL

APPROPRIATENESS PRE / POST INTERVENTION

- 256 SE PRE AND 159 SE POST INTERVENTION
- INTERVENTION
  - 60 MINUTE TAILORED LECTURE (CARDIO / FP / VASCULAR) ON AUC
  - UPDATED SE REQUEST FORM
  - IMPLEMENTATION OF THE POINT OF ORDER TOOL
    - INCLUDED ONLY Appropriate / May be Appropriate Indications
    - Rarely Appropriate Indications not listed, could free text

NO TESTS WERE CANCELLED HOWEVER TEST NOT DONE IF FORM NOT COMPLETED

APPROPRIATE SE INCREASED FROM 65% TO 76%
RARELY APPROPRIATE SE DECREASED FROM 31% TO 19%

- CARDIOLOGY PERFORMED BEST, VASCULAR SURGERY WORST
Think Before You Order

Table. Questions Physicians Should Ask Themselves Before Ordering Tests

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<tr>
<td>Did the patient have this test previously?</td>
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<tr>
<td>If so, what is the indication for repeating it? Is the result of a repeated test likely to be substantively different from the last result?</td>
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<tr>
<td>If it was done recently elsewhere, can I get the result instead of repeating the test?</td>
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<tr>
<td>Will the test result change my care of the patient?</td>
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<tr>
<td>What are the probability and potential adverse consequences of a false-positive result?</td>
</tr>
<tr>
<td>Is the patient in potential danger over the short term if I do not perform this test?</td>
</tr>
<tr>
<td>Am I ordering the test primarily because the patient wants it or to reassure the patient?</td>
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<tr>
<td>If so, have I discussed the above issues with the patient? Are there other strategies to reassure the patient?</td>
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- WHAT DO I ALREADY KNOW?
- WHAT WILL THE TEST ADD?
- ARE THERE ADVERSE CONSEQUENCES OF DOING or NOT DOING THE TEST?
ACCREDITATION AND MOC: A NEW BENEFIT OF ACCREDITATION

- NEW MOC PROGRAM JUST RELEASED
- CAN BE DONE BY INDIVIDUALS OR THE LAB
- EMPLOY A MODIFICATION OF THE NEW QI TOOL

SUMMARY

- AUC / IMPLEMENTATION IS HERE TO STAY
- IAC REQUIREMENT
- CMS ROLL OUT MAY / MAY NOT IMPACT ECHO
  - WILL IT IMPROVE APPROPRIATE ECHO USE?
    - ORDERING PHYSICIANS MORE USED TO UPFRONT DECISION MAKING
  - WILL IT WORSEN INAPPROPRIATE (STRESS) ECHO USE?
    - ECHO IS (CURRENTLY) EXCLUDED
    - EASIER TO ORDER A STRESS ECHO (vs a Nuclear Stress)

- EDUCATION OF REFERRING / ORDERING PROVIDERS IS KEY
- POINT OF ORDERING TOOLS MUST BE DEVELOPED / USED
  - We need to put the horse before the cart, NOT the cart before the horse
THANK YOU