ACC.15

TCT@ACC-i2 | innovation in intervention

64th Annual Scientific Session & Expo

How to Incorporate High Value Care in Education

Faisal Latif MD, FACC & Chittur A. Sivaram, MD, FACC
University of Oklahoma, Oklahoma City, OK

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SAN DIEGO
CALIFORNIA

HVC Education in Fellowship Training

- Cardiovascular fellowship training uniquely prepared
  - Curricular competencies well defined (COCATS 4)
  - Several clinical practice guidelines and updates
  - Appropriate use criteria (AUC)
  - Point of care use of Apps

Choosing Wisely- Cardiology

ABIM

Five Things Physicians And Patients Should Question

1 Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary "screening." Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

2 Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients' outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

3 Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient's clinical management or outcomes and will result in increased costs.

4 Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

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5 In response to new science showing that complete revascularization of all significantly blocked arteries leads to better outcomes in some heart attack patients, the American College of Cardiology (ACC) has withdrawn its *Choosing Wisely* recommendation that patients and caregivers examine whether this practice is truly necessary.

To read the complete statement from ACC on this recommendation please visit:
http://www.cardiosource.org/news-media/media-center/news-releases/2014/09/choosing-wisely-statement.aspx

More relevant to Primary Care Providers?

Appropriate use Criteria for Echocardiography

APPROPRIATE USE OF ECHOCARDIOGRAPHY

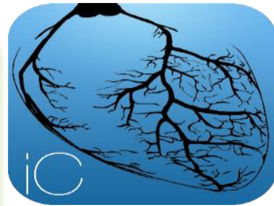
ACCF/ASE/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography

A REPORT OF THE AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION APPROPRIATE USE CRITERIA TASK FORCE, AMERICAN SOCIETY OF ECHOCARDIOGRAPHY, AMERICAN HEART ASSOCIATION, AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY, HEART FAILURE SOCIETY OF AMERICA, HEART RHYTHM SOCIETY, SOCIETY FOR CARDIOVASCULAR ANGIOGRAPHY AND INTERVENTIONS, SOCIETY OF CRITICAL CARE MEDICINE, SOCIETY OF CARDIOVASCULAR COMPUTED TOMOGRAPHY, SOCIETY FOR CARDIOVASCULAR MAGNETIC RESONANCE AMERICAN COLLEGE OF CHEST PHYSICIANS

(J Am Soc Echocardiogr 2011;24:229-67.)

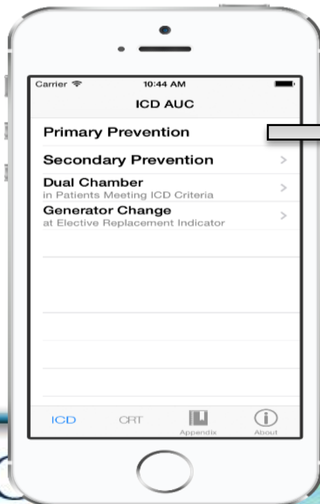
Appropriate Use Criteria for iOS

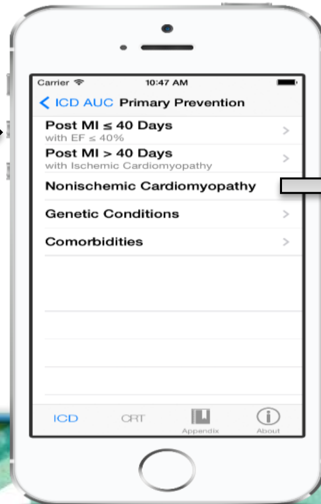
Developed by
Weston Hickey MD
OU Cardiology Fellow

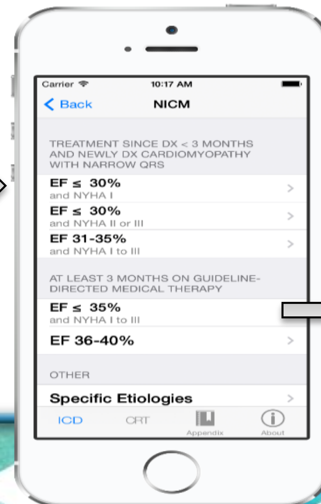


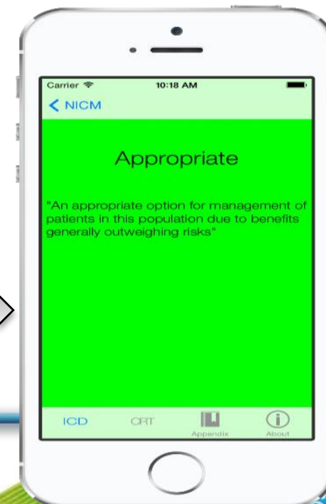
iCath

iImplant









HVC Types

- High Value Test ordering (particularly imaging)
- High value prescribing
- High value consultation
  - Proper indication
  - Pre-consult testing
  - Post-consult coordination of care

Reducing Readmissions for HF and AMI

Some Resources

- www.choosingwisely.org
- www.healthcarebluebook.com or
- www.clearhealthcosts.com

Cost of test and services

- http://www.acponline.org/education_recertification/education/curriculum/
- Cardiology specific resources:
  - ACC/AHA Practice Guidelines
  - Appropriate Use Criteria (AUC)
  - Choosing Wisely (ABIM-ACC)

Challenges in HVC Education & Practice

- Physicians' unease with clinical uncertainty
- Inability to assess the downstream impacts of testing in real time
- High level of variability of cost of services across the country & within same geographic areas
- Lack of transparency of cost
- Lack of expertise of physicians in economic issues
- Culture of medicine & resistance to change

Alliance for Academic Internal Medicine

- Curriculum for Fellowship in development
    - Incorporates ACP basic modules on High Value Care
    - Use specialty specific cases for each learning point
- Expected to be ready by this summer

Untapped Resource for Teaching HVC

- Documentation of Clinical Reasoning forces us to make rational treatment choices & aids in HVC in practice
- Chart Stimulated Recall
- High Value Care Rounds (discuss patient care using real billing data)

Talking to patients about NOT doing things

Principles of patient-centered discussions

- Find out where the patient is coming from (chief complaints versus chief concerns)
  - "What are you afraid we will find?"
  - "What do you think is going on and what are you worried about?"
- Explain your reasons
  - "The good news is that you don't have any worrisome symptoms"
- Make it clear that you are on the patient's side
  - "I wish more testing would help you, but it could actually make things worse"
- Contract for a clear follow-up plan and review red flag signs and symptoms
  - "I want to see you in 2 weeks, but call sooner if you have leg weakness"

Increasing Relevance of HVC

- Bundled payment
- Value Based Purchasing