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CardioSurve Newsletter

The Voice of U.S. Cardiologists

CARDIOSURVE

ISSUE HIGHLIGHTS

Transforming Health Care: One Process at a Time

"It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change." – Charles Darwin

The processes guiding cardiovascular medicine have developed rapidly in the past decade. From the developments of appropriate use criteria which set a national standard for reviewing patterns of care to the seamless transfer of information across systems to the focus on performance-based maintenance of certification (MOC), the cardiovascular profession continues to advance in areas which support excellence in patient care. Through the insights of our membership, the ACC has been able to more clearly understand the perspective that our clinicians have on some important processes affecting cardiology.

In these times of rapid change, we should never be afraid to look at processes which guide practice excellence with a critical eye, and as ACC President, John G. Harold, MD, MACC, has said, "let us play the hard pieces, rise to our full potential and enrich our country for the good of all of us."

Identifying AUC Usability Benefits and Opportunities for Improvement

By: Steven R. Bailey, MD, FACC; John U. Doherty, MD, FACC; Christopher M. Kramer, MD, FACC; Michael J. Wolk, MD, MACC; Joe Allen, MS; Jenissa Haidari, MPH

The development of ACCF Appropriate Use Criteria (AUC) began in 2005, with the goal of engaging with cardiovascular professionals to be stewards of medical resources in ways that could provide value-added care and preserve physician/patient decision making[1]. These documents sought to define when and how often to do an imaging test or procedure for populations of patients rather than on a case-by-case basis and were developed for a wide range of applications, including detection or exclusion of disease, risk stratification and evaluation of therapeutic benefit.

However, adoption of AUC by clinicians has been slow largely due to several key misunderstandings about AUC including: 1) the methodology for AUC construction, 2) the application of AUC to clinical care, and 3) the category labels of "uncertain" and "inappropriate." In an effort to address these issues, the ACC's AUC Task Force recently conducted a survey of 975 health care professionals, the majority of whom were ACC members, to help gauge current knowledge, use, and potential avenues for improving the understanding-clarity and utilization of AUC.

Overall the survey results showed that the majority of health care providers view improved care delivery, education and cost reduction as the primary benefits of AUC. The most often identified benefit, by 54% of participants, was to improve decision making by practitioners in day-to-day clinical care.

Participants also responded to questions on how to improve AUC use, with the most common responses endorsing increased education and quality improvement programs to improve physician understanding and use of AUC criteria, as well as reporting of AUC compliance across physician groups and/or across a practice over time. Reporting of compliance across patient groups was also noted as useful, however, only 9% preferred per patient case alone as a method of identifying compliance.

The vast majority of participants (92%) felt that professional discretion is intrinsic to clinical decision-making and that AUC are not a substitute for clinical judgment. The preponderance of those surveyed (93%) also felt that the "uncertain" category should be reimbursed all or some of the time, with about 50% incorrectly assuming that an "appropriate" study must be performed most of the time. The intent of the AUC is to allow for clinical judgment across all categories and determine the frequency for which the procedure may be an option, not a requirement for good care.

Prior notification and prior authorization were not viewed as useful methods for improving adoption of AUC, with 46% of those surveyed suggesting that health plan utilization reviews are not consistent with AUC. Almost two thirds (63%) thought that health plan utilization management policies should

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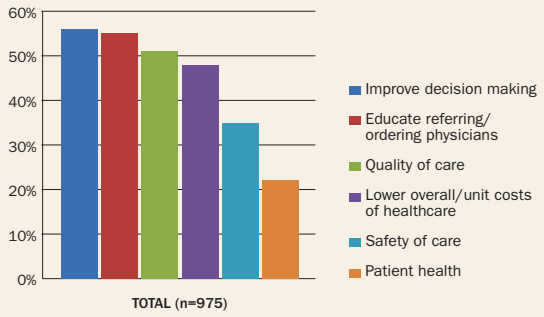
Primary Benefits of Appropiate Use Criteria



Identifying AUC Usability Benefits and Opportunities for Improvement

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be altered to be consistent with AUC.

Finally, survey participants expressed significant dissatisfaction with the original AUC rating methodology of "appropriate," "uncertain," and "inappropriate." Almost two-thirds of professionals felt that one or more of the terms should be changed, especially "inappropriate" (41%) and "uncertain" (35%). These recommendations for change were grounded in concerns over how the AUC criteria would be applied with respect to the care for individual patients and the potential for misunderstanding about the ethical and legal implication of the current terms.

When asked about the ACC's new terminology, "may be appropriate" was the highest rated alternative to "uncertain" with remarkable consistency throughout the groups. Survey respondents felt the new terminology better reflected the fact that there may be cases in which the suggested management from an individual case scenario might be considered. The community indicated that if the care was labeled as uncertain that it could be misconstrued as unnecessary or should not be performed rather than reflecting a variation in practice or patients. Similarly, the term "rarely appropriate" was the most frequent suggestion to replace "inappropriate" and was felt to convey the sense that, after due consideration of individual patient features, a physician may infrequently choose to suggest the procedure in question.

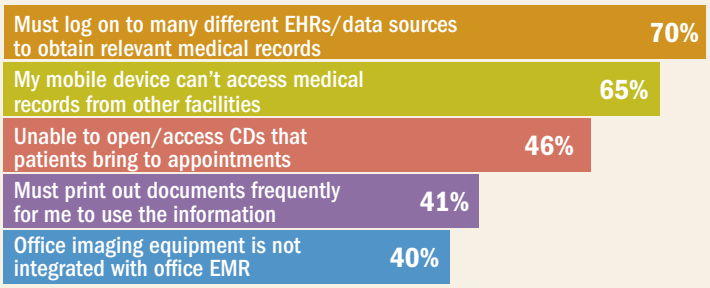
Moving forward, it is clear that most ACC members and health care stakeholders agree with AUC goals. However, there is room for improvement in the understanding of AUC methodologies in certain areas. The new AUC terminology released this past February will hopefully lead to increased use of AUC moving forward. ■

[1] Douglas PS, Wolk MJ, Brindis R, et al. President's Page: appropriateness criteria: breaking new ground. J Am Coll Cardiol. 2005; 26:2143-4.

Health IT: A Path To Minimize Challenges and Maximize Benefits

While health information technology (IT) has been shown to help improve patient safety, increase coordination of care and identify and track areas for quality improvement, there is still room for enhancements, particularly in the areas of interoperability and administrative requirements, according to a CardioSurve survey conducted this past May.

Challenges Experienced With Medical Devices



Q: When working with your medical devices, what are the challenges that you experience in terms of using technology to deliver coordinated care for your patients? (n=149)

The survey revealed that adoption and use of health IT has continued to grow, in part because of the federal Electronic Health Record (EHR) Incentive Program, or "Meaningful Use" program. Nearly one in three cardiologists surveyed (32%) said their technology purchases have been expedited as a result of the program, which provides financial incentives for EHR use, as well as penalties for lack of use.

Cardiologists currently participating in the Meaningful Use program have fared well so far. According to recently released data from the Centers for Medicare and Medicaid Services (CMS), cardiology as a specialty received the largest share of incentive payments under the EHR program as of March 2013, with 12,948 cardiologists, or roughly 50% of the total number of cardiologists in the country, receiving EHR incentive payments.

While this is great news for cardiology, there are still several major challenges associated with using health IT to deliver coordinated care. Cardiologists indicated that the top two challenges involve the need to log on to different EHR/data sources to obtain all relevant records (70%) and the inability to use mobile devices to access medical records from other facilities (65%). Other challenges included incompatibility between different systems and office equipment and administrative burdens, such as the need to frequently print documents in order to use information or the inability to open CDs brought in by patients containing medical records or study results.

"Slow computers, frequent errors, too many scanned documents and duplications," one cardiologist stated. Another noted: "I waste a lot of time day to day navigating electronic and paper records – I would rather use that time doing patient care or research."

Of these challenges, the need to share clinical data (e.g., ECGs, diagnostic images and patient data from other facilities) across different providers, as well as across different medical devices, was considered most critical. More than 85% of survey respondents believed that it was important for their medical devices to share clinical data on a daily basis, yet 72% of respondents acknowledged that making such sharing happen is difficult.

More than 75% of those surveyed also stressed the need for a solution, with 87% indicating they would be supportive of a standards-based, vendor-neutral solutions approach for connecting clinical devices. The College is considering such a program with Integrating the Healthcare Enterprise (IHE) that would facilitate the integration of clinical devices in cardiology practices and improve device interoperability. The resulting solutions would be provided at no charge to the end users.

The one caveat, however, is that in today's increasingly integrated health care environment only 8% of those surveyed indicated the ability to make any decisions regarding health IT and EHRs on their own. The vast majority of those surveyed (73%) had varying degrees of influence in the health IT decision making process. Any collaboration would need to include comprehensive participation details targeted at all relevant stakeholders.

Unless a change occurs in the current law, eventually cardiologists and other physicians who do not implement EHRs soon will face reductions in their Medicare payments. Specifically, cardiologists who do not complete their first year of participation in the EHR Incentive Program by Oct. 1, 2014 will face a one-percent penalty in 2015, and the penalties will increase to at least three percent in 2017 for those not participating by 2016. While one to three percent may not alone comprise a significant penalty, it can incrementally grow if it is coupled with a decision not to participate in the Physician Quality Reporting System (PQRS) and value-based purchasing programs (where applicable), which also include penalties for those who decline to participate.

Whether collaborating with IHE or joining forces with other medical societies and/or the government on initiatives and tools to aide in EHR adoption and use, the ACC is committed to helping members minimize the challenges of health IT and maximize the benefits. Learn more at CardioSource.org/HealthIT. ■

"I think it makes absolute sense to make relevant information easily accessible and to have standardized formats in the industry"

– Cardiologist in Illinois.

Delivery of High Quality Care Top Need for Clinicians

In May 2012, the American College of Cardiology convened a workgroup to develop ways to better organize its offerings and support the professional needs of its members. The group identified 7 overarching areas of professional focus and 19 supporting statements to better define those needs. The broad-based areas of focus for the cardiovascular professional include:

To validate this conceptual framework, in April 2013 the CardioSurve panel was provided with these overarching areas of focus and statements and asked to evaluate the content of each one. Overall, cardiologists are in agreement that both the areas of professional focus and the needs statements that elaborate those areas are valid and make sense.

The first task of the CardioSurve panel was to determine if they believed that any area was excluded or missing. The majority (77%) said that the current list was complete while 15% felt the list was incomplete. Many of the comments about what was missing from the framework largely centered on advocacy efforts. According to one cardiologist, "I think lobbying on our behalf should be on top of the list, we do NOT have a voice in medicine."

Panelists were then asked to focus on the specific 19 statements that better define the needs of professional focus and to identify any statement that requires additional clarification or if any further statement should be included to make the list complete. Based on the findings, the cardiovascular workgroup successfully identified and summarized the primary list of professional needs of the cardiovascular clinician. Less than one-in-ten panelists felt that the list of needs was unclear and even fewer (6%) indicated that the list was incomplete.

Next, cardiologists were asked to specify which needs were most important in supporting their professional role. Not surprisingly, most were interested in material and content that support clinical care and allow them to stay current and informed. Ensuring the delivery of high-quality care according to the latest clinical standards tops all professional needs with 89% of cardiovascular physicians rating it critically important.

Provide Clinical Care and Interact with Patients	Critically important	Stay Current and Informed	Critically important
Ensure delivery of high-quality care according to the latest clinical standards	89%	Remain current on latest developments in care, practice, and research	83%
Make more informed decisions at the point of care	83%	Identify and adapt to changes in the industry and regulation	73%
Increase my patients' understanding and compliance	82%		

Cardiologists also identified performance improvement activities and new care methods as important to their professional needs, particularly the ability to address gaps in knowledge and skills.

Learn and Improve My Performance	Critically important	Conduct and Publish Research	Critically important
Address gaps in my knowledge and skills	76%	Identify and test new approaches to care	65%
Monitor and improve my quality of care	69%	Evaluate the impact of existing care methods	64%
Earn and maintain my certification(s) (MOC/CME)	64%	Share my knowledge, findings, and advances	54%

Other areas of professional needs were less individual and extended to the cardiovascular community in terms of teaching, information exchange and networking.

Teach and Inform Others	Critically important	Engage with the Cardiology Community	Critically important
Effectively instruct others in the practice of cardiology	65%	Drive thought leadership and dissemination of cardiology knowledge	61%
Help others in my office learn and use our tools and workflows	55%	Exchange insights, support, and advice with peers	60%
		Identify & respond to new career opportunities	41%

The final area of professional need that was important to clinicians, although less so in comparison to other needs, was the management of the business aspects of cardiology.

Manage the business aspects of cardiology	Critically important
Align my work to improve efficiency and profitability	58%
Respond effectively to business-related challenges	57%
Shape policies that affect how I work	57%

Clearly this overarching framework will provide the ACC with a good infrastructure for the organization of content and material to align with the professional needs of the cardiovascular community particularly as the changes in the requirements for maintenance of certification take effect in 2014. This core foundation will serve to enhance the development of tools and resources that best support the delivery of optimal clinical care for patients.

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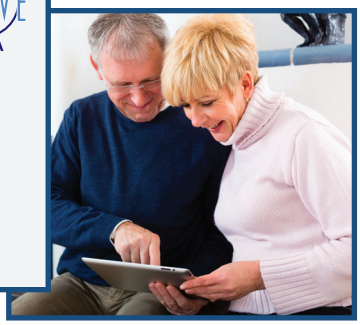
CardioSurve™ is a unique, insightful panel of 300-350 cardiologists which provides an in-depth perspective of what U.S. cardiologists think.

For additional information about this report or CardioSurve™, please contact Paul Theriot at 202-375-6357 or ptheriot@acc.org.



Closing the Gaps in Care Among ACHD Patients

Congenital Heart Disease (CHD) is the number one birth defect in the U.S., affecting nearly 40,000 of the nearly 4 million live births each year[1]. Thanks to advances in treatment in care, more and more children with CHD are living into adulthood, and the number of adult CHD patients has now surpassed the number of pediatric patients and is expected to exceed one million.

The increasing number of adult CHD patients requiring life-long specialized care due to their complex anatomic and physiologic outcomes poses new challenges for cardiovascular professionals. According to results from the HEART-ACHD Trial published in the *Journal of the American College of Cardiology,* gaps in cardiology care for adult CHD patients are common, particularly in patients who are around 19 years of age and transitioning to adult services.[2]

In an effort to better understand the challenges and opportunities associated with caring for CHD patients, in recent months CardioSurve research has explored topics ranging from referral practices to desired tools and educational programs for the cardiovascular team.

The results uncovered that while two out of three congenital specialists said they transfer their pediatric patients to an adult CHD specialist, nearly half (48%) indicated that the CHD community does a below average or poor job transferring patients to an appropriate adult CHD setting.

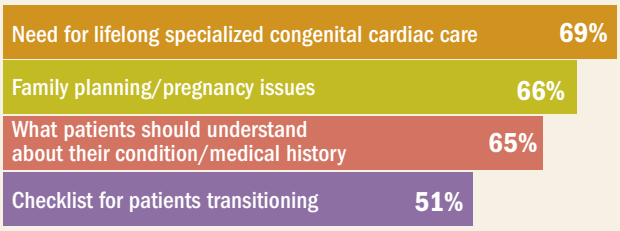
In terms of talking to patients about their need for lifelong care and the importance of communicating with their health care providers about their current medications, doses and side effects, and medical history, nearly 40% of survey respondents said the CHD community does a below average or poor job educating patients about the need for long-term care. Many of the respondents noted that they make efforts to discuss the need for lifelong care with their patients, but lack of time is a primary barrier to these discussions.

Clinicians specializing in congenital care stressed a clear need for patient tools that reinforce the importance of lifelong specialized congenital cardiac care (69%), family planning/pregnancy issues (66%), basic educational material to improve their patient's understanding of CHD (65%), and a checklist for patients transitioning (51%). Additionally, two-thirds of clinicians would be interested in an ACC-sponsored program that supports CHD patients by providing a series of web-based, age appropriate education modules that provide guidance on care and life-stage transitions.

Additionally, approximately two out of three congenital specialists indicated that publications about the transition/transfer from pediatric to adult care would be helpful, while nearly half of respondents said they would be interested in CME/CE webinars and/or special programming at the ACC's Annual Scientific Session.

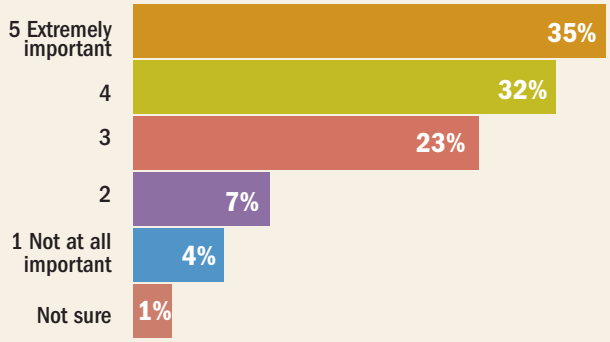
In terms of the tools currently available for clinicians, 25% of respondents were not aware of any tools, including the Adult Congenital Heart Association (ACHA)/ International Society for Adult Congenital Heart Disease (ISACHD) ACHD clinic directory, ACHA personal health passport, and others. Additionally, a separate CardioSurve survey found that slightly more than half (57%) of cardiologists are "sometimes" accessing the ACHD clinical guidelines, while 1 out of 4 are "never" accessing the ACHD guidelines.

Most Valuable Tools To Support CHD Patients



Q: Which of the following would you find most valuable to support CHD patients? (n=248)

Likelihood to Utilize ACC CHD Tools



Q: How likely would you be to utilize these web-based age appropriate education modules at your practice? (n=248)

This research highlights a number of opportunities for the ACC and its partners to not only raise awareness about existing patient and clinician tools and educational forums, but also to create new programs and resources aimed at educating the broader medical community. This is even more important now that the American Board of Medical Specialties (ABMS) has created a new adult CHD cardiovascular subspecialty.

"Establishing a nationally recognized training pathway and a certification will ensure adult CHD patients seeking adult CHD care will be able to seek out care from a specialty trained cardiologist," said Kathy Jenkins, MD, MPH, FACC, chair of the ACPC Council and Section

Closing the gaps in care for ACHD patients is a main focus of the ACC's Adult Congenital Pediatric Cardiology (ACPC) Council and Membership Section. The ACPC council and membership section will use the results of the survey to help inform their work with ACC Chapters across the country and the ACHA patient advocacy group on education and advocacy efforts, as well as through programs aimed at educating general cardiologists like the Provider Action for Treatment of Congenital Heart disease (PATCH) program.

"As the number of CHD children surviving into adulthood has increased over the past four decades, these gaps will continue and likely increase if we don't work together to address these gaps," said Gerard R. Martin, MD, FACC, senior vice president of Children's National Medical Center, and immediate past chair of the ACC's Adult Congenital Pediatric Cardiology (ACPC) Council. ■

[1] Hoffman JL, Kaplan S. The incidence of congenital heart disease. *J Am Coll Cardiol*. 2002;39(12):1890-1900.

[2] Gurvitz M, Valente A, Broberg C, et al. Prevalence and Predictors of Gaps in Care Among Adult Congenital Heart Disease Patients : HEART-ACHD (The Health, Education, and Access Research Trial). *J Am Coll Cardiol*. 2013;61(21):2180–2184.