Crossing the Quality Chasm

“Don’t be afraid to take a big step if one is indicated. You can’t cross a chasm in two small jumps.” David Lloyd George

Fifteen years ago the Institute of Medicine marked a shift in policy by releasing a series of publications that recommended a fundamental redesign of the American health care system capitalizing on advances in technology and evidence-based medicine to close gaps in quality. Cardiovascular medicine has been at the forefront of the quality charge with its clinical practice guidelines, appropriate use criteria, performance measures, meaningful use, quality initiatives and registries, to name a few. Cardiology has shown great strides in closing the quality gap, yet opportunities for improvement remain.

This issue of the CardioSurve Newsletter focuses on how some of those changes – electronic health record (EHR) utilization, ICD-10 implementation, Accountable Care Organization (ACO) activity and the emerging cardio-oncology subspecialty are impacting cardiovascular medicine in our efforts to cross the quality chasm.

EHR Use Widespread But Challenges Persist

“EHR is probably the most important element in developing the future of medicine. Much can be leveraged from the appropriate acquisition of clinical data in a queryable database.” Cardiologist, CT

Over the last few years, the percentage of practices using electronic health records (EHRs) and the number of cardiologists participating in the federal EHR Incentive Program has grown tremendously. With these developments, clinicians are recognizing some real benefits from their EHRs, however, according to the May CardioSurve survey, much room for improvement still exists for this technology particularly in the areas of interoperability and closing gaps in treatment and care.

Nearly eight out of 10 cardiologists (78%) indicated they have been using EHRs for at least two years or more. More importantly, nine out of 10 cardiologists said they have a fully functioning EHR program or are in the process of implementing one. Popular CV practice EHRs continue to be Epic, Allscripts, NextGen, Cerner, GE Centricity, e-Clinical Works, Athena Clinicals, GEMMS, and Greenway.

Given this increase in usage, as well as opportunities through 2015 to receive financial incentives, it’s not surprising that nearly 80% of respondents also said they are participating in the EHR Incentive Program – up from 58% in 2011. The threat of looming financial penalties...
ACO Participation On The Rise — Impact Uncertain

The number of participants in Accountable Care Organizations (ACOs) has jumped significantly within the past three years, according to the June CardioSurve. Of those cardiologists surveyed, nearly one out of five (19%) are currently in an ACO, up from just 1% in 2011. The largest ACOs in which ACC members participate include Partners Healthcare, Valley Preferred Aetna, Cleveland Clinic Cigna and Carolinas Healthcare System. Additionally, more than 1 out of 3 ACO non-participants indicated a high likelihood of participating in an ACO in the future.

ACOs are defined as a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients with the goal of reducing health care costs. The ACO concept, which initially debuted around 2006, gained traction in 2010 with the passage of the Affordable Care Act and the inclusion of a provision directing the Centers for Medicare and Medicaid Services (CMS) to create an ACO “program” by no later than Jan. 1, 2012. Under the CMS program, each ACO has to manage the health care needs of at least 5,000 Medicare beneficiaries for a minimum of three years.

Given the relative newness of the ACO concept, it’s not surprising that 76% of those surveyed indicated their EHRs are capable of importing lab results with 50% able to import patient medications (92%). In addition, 76% of clinicians noted that EHRs have had the greatest impact on timely access to medical records (86%) and prescription refills (84%), followed by helping to avoid medication errors (60%) and assisting in communication with providers (57%).

However, respondents also highlighted several major areas for improvement. Only a little more than 1 out of 3 cardiologists (35%) indicated they were extremely/very satisfied with their EHR systems overall. While reliability (40%) and sharing of medical information (37%) received the highest satisfaction scores, these results were outweighed by dissatisfaction with interoperability with other software (51%) and integration with medical devices (55%). EHRs also have fallen short in impacting the delivery of care – either preventive or chronic illness. Experts noted that EHRs have had the greatest impact on timely access to medical records (86%) and integration with medical devices (55%).

“...The mandating of EHR has impaired physician practice in a way that nothing before it has done. Job satisfaction, patient satisfaction, professionalism have all suffered.” Cardiologist, TX

EHR Use Widespread But Challenges Persist

is also an impetus for adoption. Physicians and hospitals that had not implemented EHRs and did not participate in the EHR Incentive Program in 2013 had until July 1 to begin participating in order to avoid a penalty in 2015.

This uptake in EHR adoption has also resulted in several tangible improvements in patient safety, quality care and medication adherence. Nearly all cardiologists said their EHRs allowed for patient/clinical notes (95%) and electronic tracking of patient medications (92%). In addition, 76% of those surveyed indicated their EHRs are capable of importing lab results with 50% able to import imaging results. Because of these features, clinicians noted that EHRs have had the greatest impact on timely access to medical records (86%) and prescription refills (84%), followed by helping to avoid medication errors (60%) and assisting in communication with providers (57%).

Moving forward, the survey data suggest there is still a large amount of work to be done if EHRs are to play a true role in improving delivery of care – either preventive or chronic illness. Finding ways to help physicians meet guideline-recommended care and improve communication with patients should be key areas of focus. EHR features that allow for easy import of hospital data feeds, include reminders for ordering tests, and track patient medication adherence were less common among survey respondents and could also be a good place to start.

As the ACC moves forward with implementing its Strategic Plan, partnering with EHR vendors and other health IT stakeholders to make EHR use more streamlined, interoperable and conducive to improving patient outcomes and care is a leading priority. The College intends to use the survey results to inform these actions.

For more information about EHRs, as well as the EHR Incentive Program, visit CardioSource.org/HealthIT.

EHR Satisfaction – Overall and Specific Elements

Q:  How familiar are you with Accountable Care Organizations (ACOs)? (CardioSurve n=129)

- Very familiar, but not participating
  - 2011: 1%
  - 2014: 19%
- Somewhat familiar, but not participating
  - 2011: 6%
  - 2014: 14%
- Not familiar with ACOs
  - 2011: 38%
  - 2014: 46%
- Not at all familiar with ACOs
  - 2011: 16%
  - 2014: 33%
- Have not heard of ACOs
  - 2011: 22%
  - 2014: 5%

Q:  How satisfied are you with each of the following aspects of your EHR system? (CardioSurve n=149)

- Overall
- Reliability
- Sharing of medical information
- Ease of use for direct patient care
- Integration with other software
- Integration with medical devices
- Not all satisfied
- Not sure/N/A

Q:  How satisfied are you with the EHR system at your practice? (CardioSurve n=149)
With ICD-10 Transition Looming, More Education Needed on Requirements

With the transition from ICD-9 code sets used to report medical diagnoses and inpatient procedures to ICD-10 codes looming, a recent CardioSurve survey indicating that nearly 65% of cardiologists are unclear about the new requirements suggests greater provider education is needed.

The transition deadline, which was initially slated for October of this year, was delayed until Oct. 1, 2015 as part of the Protecting Access to Medicare Act that passed in April. The transition, which does not affect CPT coding for outpatient procedures and physician services, will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims.

Given that the number of ICD-10 diagnoses codes will grow by nearly five times the number of ICD-9 diagnoses codes to 69,099, the Centers for Medicare and Medicaid Services (CMS) has urged health care organizations, from large national plans to small provider offices, laboratories, medical testing centers, and hospitals to allocate six to nine months for the transition. The shift will require significant changes to the way coding is done and organizations need to allow time to identify impacts; develop an implementation plan and timeline; work with vendors on new software and/or systems to accommodate the new codes; and coordinate with vendors, payers and other business partners to test transactions and processes.

The good news, according to the CardioSurve survey, is that nearly three out of four cardiologists have taken action to prepare for ICD-10. Furthermore, almost half (46%) have an ICD-10 implementation plan that they are about to enact or have already begun.

However, the details of the ICD-10 changes may require additional education since the majority of cardiologists indicated a poor understanding of the new requirements. The ability of clinicians and coding staff to select the appropriate diagnosis code was cited as the area of greatest difficulty in relation to ICD-10, followed closely by concerns about documenting the patient encounter (58%) and the ability to compare ICD-10 data to ICD-9 data (56%). The survey also suggests concerns about the financial impact of ICD-10, with 40% of cardiologists indicating the transition will likely have a negative financial impact and the remaining majority noting uncertainty.

The ACC is closely following CMS and industry efforts surrounding ICD-10 implementation and has developed several tools to help members both understand the ICD-10 requirements and plan accordingly. Additional resources will be posted as they are available. For more information, visit CardioSource.org/Coding.

### More Education Needed on Requirements

<table>
<thead>
<tr>
<th>Current Planning Process Status for Implementation of ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just starting to plan</td>
</tr>
<tr>
<td>Implementation plan begun</td>
</tr>
<tr>
<td>Plan in place, but not yet implementing</td>
</tr>
<tr>
<td>No plans as of yet</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Not sure</td>
</tr>
<tr>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Q: Where are you currently in your planning process regarding implementation of ICD-10? (CardioSurve n=177)

- Implementation plan begun: 23%
- Just starting to plan: 28%
- Plan in place, but not yet implementing: 23%
- No plans as of yet: 12%
- Other: 1%
- Not sure: 11%
- Not applicable: 2%

### ICD-10 Impact on the Difficulty of Practice Activities

- Ability to compare ICD-10 diagnosis data with ICD-9: 58%
- Ability to document patient encounter: 65%
- Ability of coding staff to select appropriate diagnosis code: 54%
- Ability of clinician to select appropriate diagnosis code: 64%
Clinical Spotlight: The Growth of National Cardio-Oncology Services

Cardio-oncology has become an increasingly hot topic over the past several years as an increasing number of patients with cancer and cancer survivors are living with cardiovascular disease. According to a recent CardioSurve poll of 106 adult and pediatric cardiology division chiefs, fellowship training directors and specialists, two out of three hospital centers across the nation have added cardio-oncology services to help cancer patients maintain their heart health during and after treatment, with even more centers planning to add cardio-oncology services within the coming year.

The survey was conducted to gain a better understanding of the nation’s cardio-oncology field and to see what challenges and opportunities exist for the College to provide tools, resources and education in this area.

Of the cardio-oncology services provided, respondents noted that a pre-operative consultation conducted by a cardiologist and an established consultation with multiple clinicians are the most popular services (35% and 27% respectively).

Most chiefs and training directors expressed the importance of considering cardiovascular implications before, during and after the treatment for cancer patients, and two-thirds of respondents believe specific training or access to specialized consultants provides an advantage in caring for patients who suffer from cardiovascular complications from anti-cancer treatment.

Although cardio-oncology services continue to grow, there are still several challenges facing the field such as limited resources and lack of funding, national guidelines, overall interest, infrastructure and education. Notably, nearly 1 out of 5 institutions (18%) do not offer cardio-oncology and have no current plans to add the service.

In terms of education for physicians providing cardio-oncology services, unfortunately, many programs currently do not offer dedicated cardio-oncology training (43%) and any kind of cardio-oncology education is typically performed during usual clinical rotations (43%) or through lectures (11%). Further, there are only a handful of cardio-oncology fellows (1%) or programs offering elective training in oncology (3%).

Additionally, when asked to rate themselves on their knowledge of the impact that cancer treatment and cardiovascular management have on each other, cardiologists give themselves an average rating on understanding the impact that cancer treatment for a CV reason has on cancer outcomes and give oncologists an average rating on understanding the impact of a slow involvement of a specialist when a CV problem develops in an oncology patient. Clearly, there is room for improvement and a need for additional training.

Support for increasing education is evident since seven in 10 cardiologists noted that they are likely to encourage staff or fellows to complete educational materials in cardio-oncology, and over half (52%) agreed that a dedicated cardio-oncology service would improve the care of oncology patients.

“To address some of these challenges, the College recently formed a Cardio-Oncology Working Group within the Early Career Professionals Section to identify priorities and items in diverse areas of need, including clinical practice approaches, educational programs and curriculum, as well as research development and interdisciplinary collaborations,” said Andrew Freeman, MD, FACC, chair of the ACC’s Early Career Professional Section, and Ana Barac, MD, PhD, FACC, chair of the Cardio-Oncology Working Group.

“The group intends to create a foundation that will allow for the development of a full set of cardio-oncology offerings within the College.”

Current Clinical Cardio-Oncology Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-operative consultation</td>
<td>35%</td>
</tr>
<tr>
<td>Established consultation and evaluation service</td>
<td>27%</td>
</tr>
<tr>
<td>Single cardiologist with experience</td>
<td>16%</td>
</tr>
<tr>
<td>Not at present and do not plan to add</td>
<td>15%</td>
</tr>
<tr>
<td>Not at present but plan to add these services within a year</td>
<td>12%</td>
</tr>
<tr>
<td>Not sure what cardio-oncology is</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
</tbody>
</table>

Q: Please indicate which description most accurately defines your current clinical cardio-oncology services: (n=106)