A National Program Promoting Evidence-Based Medicine

USPHS Symposium 2017

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Two Parts of the Talk

- Overview of the program
  - What
  - Why
  - How
  - Who
- How the program fits into healthcare reform, past, present and future.

Overview of the program

What

- Implements section 218(b) of PAMA 2014
- Clinicians must consult AUC through a clinical decision support (CDS) tool when ordering advanced diagnostic imaging services (CT, MRI, nuclear medicine)
- Applies to Fee For Service Medicare only
  - Physician Fee Schedule (PFS)
  - Outpatient Prospective Payment System (OPPS) for hospital outpatient department services
  - Ambulatory Surgical Center (ACS) payment systems

- Applies to these settings only:
  - Physician's office
  - Hospital outpatient department (including an ED)
  - Ambulatory surgical center

So no in-patients. No Medicare Advantage (Part C)

Impact

- The impact of the program is enormous
  - Most physicians in the US
  - Most of 50+ million Medicare beneficiaries
  - >38 million imaging studies and >$3B in physician payments annually
  - Private payers, health systems, DoD?
  - Other clinical spaces (?)

Why

- This is a quality improvement program
  - Goal is to improve health outcomes of Medicare beneficiaries
  - Potential to improve quality and reduce costs
  - Appropriate use criteria or guidelines are the backbone
  - So what exactly is “Appropriate Use”?

Mark Fendrick's "top 3" list for low-value procedures:

1. Coronary stents
2. Colonoscopies
3. MRI for low-back pain

Guess what is his "top 3" list for high-value procedures.

1. ?
2. ?
3. ?

Example of AUC

- CPM – IHC (website or earliest memo fall 2014)

AUC – Working Definition

- Are a set or library of individual criterion
  - each criterion is an evidence-based guideline for a particular clinical scenario
  - each scenario starts with a patient's presenting symptoms and/or condition
  - Example: "Headache and fever in an immunocompromised adult"
- AUC are evidence-based to the extent feasible

Many stakeholders believe AUC will become increasingly clinically rich, integrating individual and eventually population-based data.

How

- Through rulemaking AND consultation with physicians and other stakeholders
- Four major milestones:

  (1) CMS qualifies Provider-Led Entities (PLEs) and the AUC they develop

  (2) CMS qualifies CDS tools that house the AUC

  (3) “Ordering professionals” consult the AUC, and “furnishing professionals” report AUC info on claims

  (4) CMS identifies “outlier” ordering professionals who will be subject to prior authorization

Who

- Qualified Provider-Led Entities (PLEs) are the engine as they generate the AUC
  - Professional medical societies, health systems, hospitals and collaborations of these, like the High Value Healthcare Collaborative or the National Comprehensive Cancer Network
  - Only qualified PLEs can develop, modify or endorse AUC

AUC Development Process

A qualified PLE must have at least one autonomous, physician-led multidisciplinary team, which:

- performs an extensive literature search;
- reads and formally grades the evidence coming from trials, observational studies and consensus statements;
- designs a product that's useful and fast at the bedside, and regularly updates it

AUC team composition

At least 7 members, 5 of which are specified. So at a minimum:

- 1 practicing physician with expertise in the clinical topic;
- 1 practicing physician with expertise in the associated imaging studies;
- 1 PCP;
- 1 expert in clinical trial design; and
- 1 expert in quantitative analysis (e.g., a biostatistician or epidemiologist)

* Participation of a QI expert and an informaticist highly recommended.

Priority Clinical Areas

- QI doesn't try to boil the ocean. It leverages the Pareto Principle: identify the few things that have the largest impact.
- We wanted everyone – qualified PLEs, the CDS tool vendors, care delivery teams – to focus on a few things, do them well, and move forward
- The examples of Intermountain, Mayo, Geisinger . . .
- So what is the right number to start with? It has to be something humans can digest
  - Remember the "span of control" theory in OBC?
  - When Don Berwick launched his campaign too save 100,000 lives in 1 yr, how many QI/Safety topics did he pick?
  - How many digits in a phone number?
  - So how many PCAs did I propose ???

8

- We proposed an initial list of 8 PCAs, then modified these based on public comments
- The **final PCA list**:
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic or non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff injury)
  - Cancer of the lung (primary or metastatic, suspected or diagnosed)
  - Cervical or neck pain
- We can add to this list in the future

CDS Tools

- These are the portals through which clinicians consult AUC. Every qualified CDS tool must contain the PCAs.
- The tools are preferably integrated into an EHR
- We want enough CDS tools (and EHR systems) to maintain a competitive market
  - But not so many that standards never emerge
  - "Meaningful use" gave rise to 400+ standards, and to this quote:

"The good thing about standards is that there are so many to choose from. And if you don't like any this year, you can just wait for next year's models."

Appropriate Use in the Context of Healthcare Reform – Past , Present and Future

- Additional Slides -

Exceptions to AUC Program

- Emergency services for individuals with “emergency medical conditions” defined in Sec. 1867(e)(1) of the SSA
- Inpatients with payment under Medicare Part A
- Ordering professionals granted a hardship exception under the Medicare EHR Incentive Program (but without categorical specialty exceptions)
  - However this program goes away after 2018 . . .

Emergency medical condition

- The ER is not carved out, only true “emergency medical conditions” are exempt.
  - Defined in law under Sec 1867(e)(1)

  The term “emergency medical condition” means –

  (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

  (i) placing the health of the individual … in serious jeopardy,

  (ii) serious impairment to bodily functions, or

  (iii) serious dysfunction of any bodily organ or part

Priority Clinical Areas

- The CY 2016 rule said:
  - All clinicians must consult AUC for every advanced imaging study in order for a claim to be processed (reflecting the "comprehensive" approach)
  - But when determining, down the road, the not more than 5% "outliers" of ordering clinicians, who will be subject to "prior authorization," the denominator would reflect only the PCAs, not the universe of potential AUC (reflecting the "focused" or "stepping stone" approach)