

10 Tips

to Improve Appropriate Use Scores for Elective PCI

The ACC-NCDR CathPCI Registry's new AUC scoring system represents a clear opportunity for quality improvement on two fronts. In some instances, analyzing cases that are flagged as inappropriate may reveal problems in clinical decision-making that need to be addressed in a systematic way using, for example, the tools available in the SCAI Quality Improvement Toolkit (SCAI-QIT), which can be downloaded from www.SCAI.org/QIT.

In many cases, however, improving AUC scores may simply be a matter of better communication, documentation, and coding. By filling out the NCDR data sheets more completely – and with AUC in mind – hospitals could see a marked reduction in the number of cases ranked as uncertain or inappropriate. The tips below are likely to help any cath lab to improve its AUC scores.

- ▶ Get more involved in SCAI-QIT by signing up at: www.SCAI.org/QIT.
- ▶ Learn more about the recently revised guidelines for PCI at: www.SCAI.org/QIT-PCI.

Lead the Way in Quality
Improvement at
Your Cath Lab.



1 Study your NCDR quarterly report.

This is the first step to improving AUC scores. Review all cases classified as inappropriate or uncertain to determine why each case was scored the way it was. This type of analysis can be eye-opening, revealing specific targets for improvement at each hospital.

2 Know the AUC.

In order to earn a good AUC score, it's important to be familiar not only with the appropriate use criteria but also with the most common reasons cases are classified as inappropriate. In the recent JAMA article, Chan et al. found that nearly 89% of all inappropriate elective procedures fell into five clinical scenarios. Just over 82% could be described by three scenarios involving, in various combinations, one- or two-vessel disease in combination with few symptoms, a low-to intermediate-risk stress test, and inadequate antiischemic medications.

3 Re-introduce yourself and your team to the NCDR data forms.

Make sure coders understand all of the definitions used in correctly filling out the NCDR data sheets, so that cases are properly categorized. Ask all of the interventional cardiologists in your practice to review the NCDR forms so they know what information the chart abstracter needs. Don't assume that coders can read between the lines and come up with the correct clinical picture. Some are very experienced and knowledgeable, but others have less expertise—and all are very busy.

4 Become class-conscious.

It's important that the pre-procedure work-up or post-procedure case summary includes a clear and concise description of the severity of the patient's angina, including the Canadian Cardiovascular Society class. "As clinicians we tend to blur the clinical distinction between Class II and Class III, but in the AUC, it makes a big difference," said James Blankenship, M.D., FSCAI, who is chair of SCAI's Advocacy Committee and director of cardiology at Geisinger Medical Center in Danville, PA.

5 Open the medicine cabinet.

Be thorough and complete in listing antianginal medications. This can nudge a case from the uncertain category into the appropriate

category by showing that the patient is on maximal medical therapy. Specify whether the patient is taking long-acting nitrates, beta blockers, calcium-channel blockers, and/or ranolazine.

6 Embrace the stress test.

The results of noninvasive testing should be stated concisely and clearly. It's not enough to say the test was positive, negative, or indeterminate. Also indicate whether there is a low, moderate, or high likelihood of future ischemic events.

7 Let the outside in.

Many patients are referred for PCI after having an initial clinical work-up elsewhere. Information on noninvasive stress testing, medications, and clinical history could be housed at another hospital, physician's office, or imaging center. It's essential that this information be included in the cath lab's records and be available to chart abstracters. Otherwise, the NCDR data sheets will be incomplete.

8 Multitask during PCI.

No one likes to finish a case and then sit down to fill out a long form. Instead, assign a tech to fill out the NCDR form during PCI, taking advantage of pauses in the action to clarify questions such as percent stenosis or patient risk level. "There are always slow spots, such as when a balloon is deflating," Dr. Blankenship said. "And the information is never more readily available than during the case."

9 When in doubt, do additional evaluation.

When angiography reveals a stenosis of 70% or less, it's important to document the lesion's clinical significance. Inclusion of flow reserve (FFR) ratios or a lesion's cross-sectional area by intravascular ultrasound (IVUS) helps to do that. This is particularly true if the results of noninvasive stress testing are indeterminate or missing.

10 Get the word out.

Once you've identified the key steps your cath lab should take to improve AUC scores, spread the word. Use a variety of tools, including wall posters, checklists, and cath lab protocols. Incorporate reminders into the electronic medical record if possible.

