RITE-Size

RIGHT-SIZING TESTING BEFORE ELECTIVE SURGERY

Reducing Low-Value Preoperative Testing

Welcome & Introductions

Lesly Dossett, MD, MPH

Co-Director, Michigan Program on Value Enhancement (MPrOVE);
Associate Professor of Surgery,
Chief, Division of Surgical Oncology,
Michigan Medicine

Hari Nathan, MD, PhD

Director, Michigan Value Collaborative (MVC);
Associate Professor of Surgery,
Division of Surgical Oncology
Michigan Medicine

Disclosures

- Agency for Healthcare Research and Quality R01HS029306
- Dossett & Nathan (co-PI)
- “De-Implementation of Low-Value Testing in Patients Undergoing Low-risk Surgery

Agenda

- What is RITE-Size?
- Why Preop Testing?
- Successes & Barriers
- Material Resources
- Next Steps
- Q&A


RITE-Size
RIGHT-SIZING
TESTING BEFORE
ELECTIVE SURGERY
MSQC
MICHIGAN SURGICAL QUALITY
COLLABORATIVE
MVC
Michigan Value
Collaborative
MPrOVE
MICHIGAN PROGRAM ON
VALUE ENHANCEMENT

Preoperative Testing Collaboration

RITE-Size
RIGHT-SIZING TESTING BEFORE ELECTIVE SURGERY

	MPrOVE MICHIGAN PROGRAM ON VALUE ENHANCEMENT	MVC Michigan Value Collaborative	MSQC MICHIGAN SURGICAL QUALITY COLLABORATIVE
Expertise	• Expertise in identifying areas of low-value care and understanding the reasons for persistent use • Expertise in designing behavioral interventions	• Engagement of statewide site champions in QI • Statewide claims data and quantitative expertise • Reporting structure	• Engagement of statewide clinical champions, hospitals, and key stakeholders to facilitate practice change
Partnership Role	• Lead design of intervention strategies • Support for measure development	• Lead measurement and reporting of testing rates • Integration with MVC P4P and QI infrastructure	• Integration with MSQC P4P and QI infrastructure • Data abstraction

Why Preop Testing?

Making the case for de-implementation of preoperative testing before low-risk surgery

What Does Evidence Tell Us?

- Routine testing in asymptomatic patients does not avoid adverse events
- Tests are costly to the healthcare system
- Cascade events risk patient harm
- Multiple medical societies (e.g., ASA, ACS, AAO, ACP, etc.) recommend against this practice

JAMA Internal Medicine | Original Investigation | LESS IS MORE

Prevalence and Cost of Care Cascades After Low-Value Preoperative Electrocardiogram for Cataract Surgery in Fee-for-Service Medicare Beneficiaries

Ishani Ganguli, MD, MPH; Claire Lupo, BBA; Alexander J. Mainor, JD, MPH; Stephanie Raymond, BA; Qianfei Wang, MS; E. John Orav, PhD; Chiang-Hua Chang, PhD; Nancy E. Morden, MD, MPH; Meredith B. Rosenthal, PhD; Carrie H. Colla, PhD; Thomas D. Sequist, MD, MPH

British Journal of Anaesthesia **110** (6): 926–39 (2013)
Advance Access publication 11 April 2013 · doi:10.1093/bja/aet071

BJA

Effectiveness of non-cardiac preoperative testing in non-cardiac elective surgery: a systematic review

T. Johansson[1*†], G. Fritsch[2†], M. Flamm[1,3], B. Hansbauer[1], N. Bachofner[1], E. Mann[1], M. Bock[2,4] and A. C. Sönnichsen[1,5]

Health Services Research

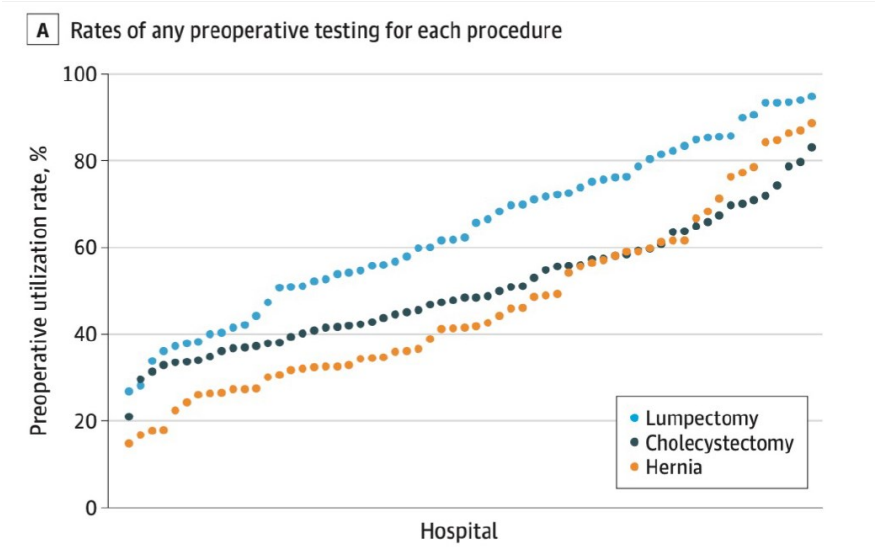
Utilization of Preoperative Laboratory Testing for Low-risk, Ambulatory Urologic Procedures

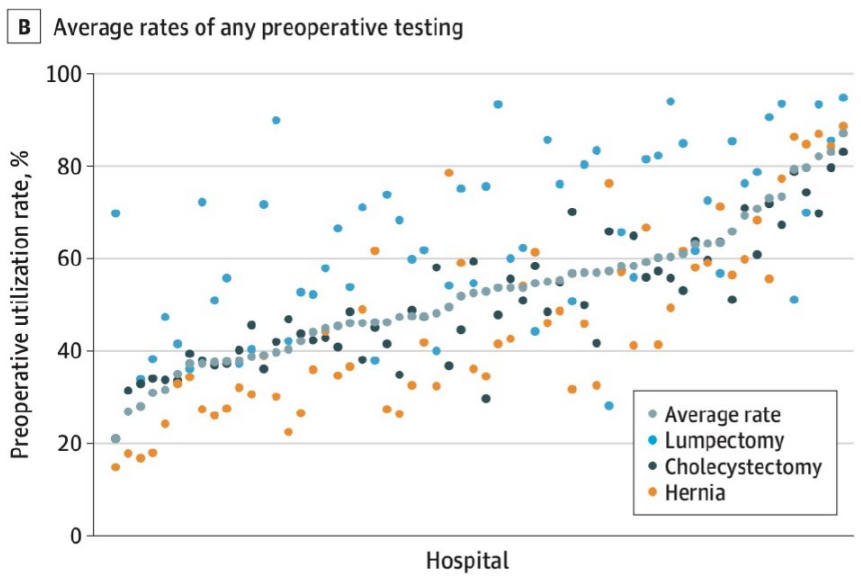
Wilson Sui, Marissa C. Theofanides, Justin T. Matulay, Maxwell B. James, Ifeanyi C. Onyeji, Arindam RoyChoudhury, and Matthew Rutman

Evaluating Compliance with Institutional Preoperative Testing Guidelines for Minimal-Risk Patients Undergoing Elective Surgery

Arunotai Siriussawakul,[1] Akarin Nimmannit,[2] Sirirat Rattana-arpa,[1] Siritda Chatrattanakulchai,[1] Puttachard Saengtawan,[1] and Aungsumat Wangdee[1]

Rates Vary *Between* and *Within* Hospitals





Berlin et al. *JAMA Internal Medicine*. 2021

Identifying areas of opportunity using unblinded data with new MVC preoperative testing cohort definitions

Successes & Barriers

Strategic approaches to de-implementation of low-value testing and common points of resistance

"We all know complications can occur regardless of the preop evaluation, it's better to be safe and just have everyone go through it [preoperative testing]."

"I think one of the big barriers [to de-implementation] would just be making sure that everybody knows that that's the policy."

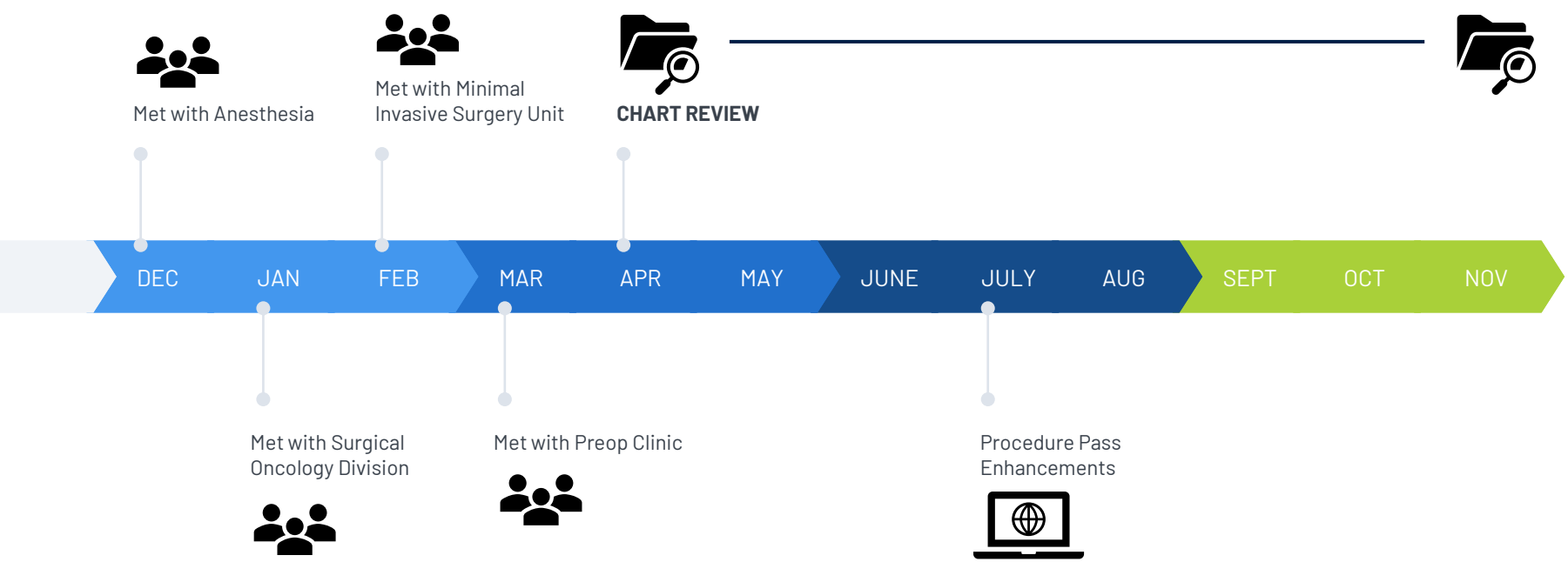
Common Barriers Observed

- Concerns for safety
- Testing culture / Current policies
- Provider habits and workflows
- Conflicting EMR processes
- Communication breakdowns between providers
  - Testing triad: Anesthesiologist, Surgeon, PCP

MM Pilot Interventions

BARRIERS	INTERVENTION STRATEGIES				
	Consensus guidelines 	*Provider education* 	Audit & Feedback 	*Clinical decision support* 	*Financial incentives* 
Different beliefs & attitudes about pre-op testing		X	X		
Different surgeon, anesthesia, & other staff perspectives about pre-op testing	X			X	
Unequal awareness of evidence-based guidelines/standardization	X	X			
Cultural norms	X	X		X	
Fear of adverse events, Concern for medico-legal risk		X	X		
Facilities are not motivated to reduce over testing overtreatment since it leads to lower reimbursement					X

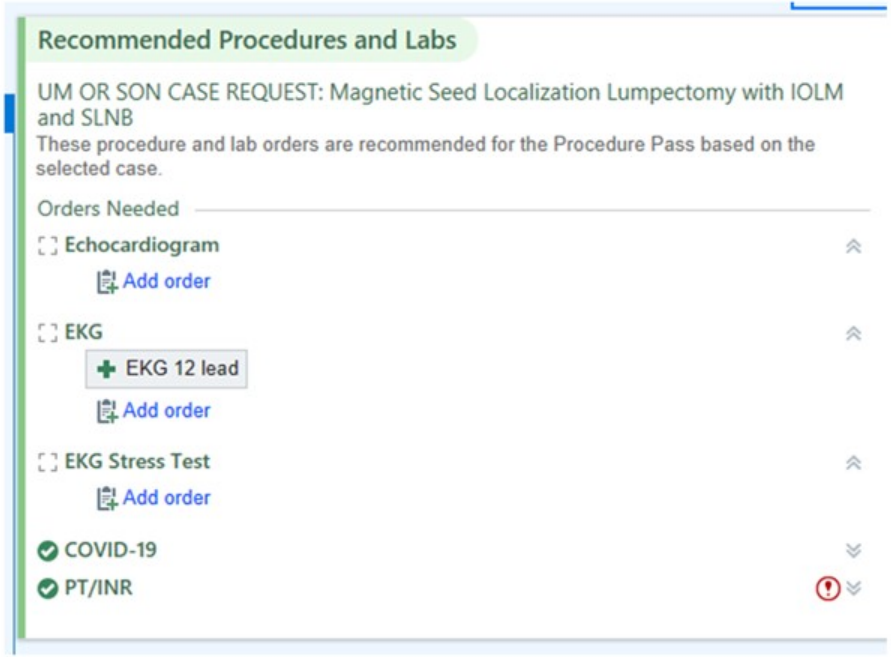
MM Pilot Timeline



EHR Enhancements: Procedure Pass

Here is an example: low risk lumpectomy

COVID and INR default order (COVID is no longer necessary for outpatient surgery). ECHO, EKG and stress test as options.



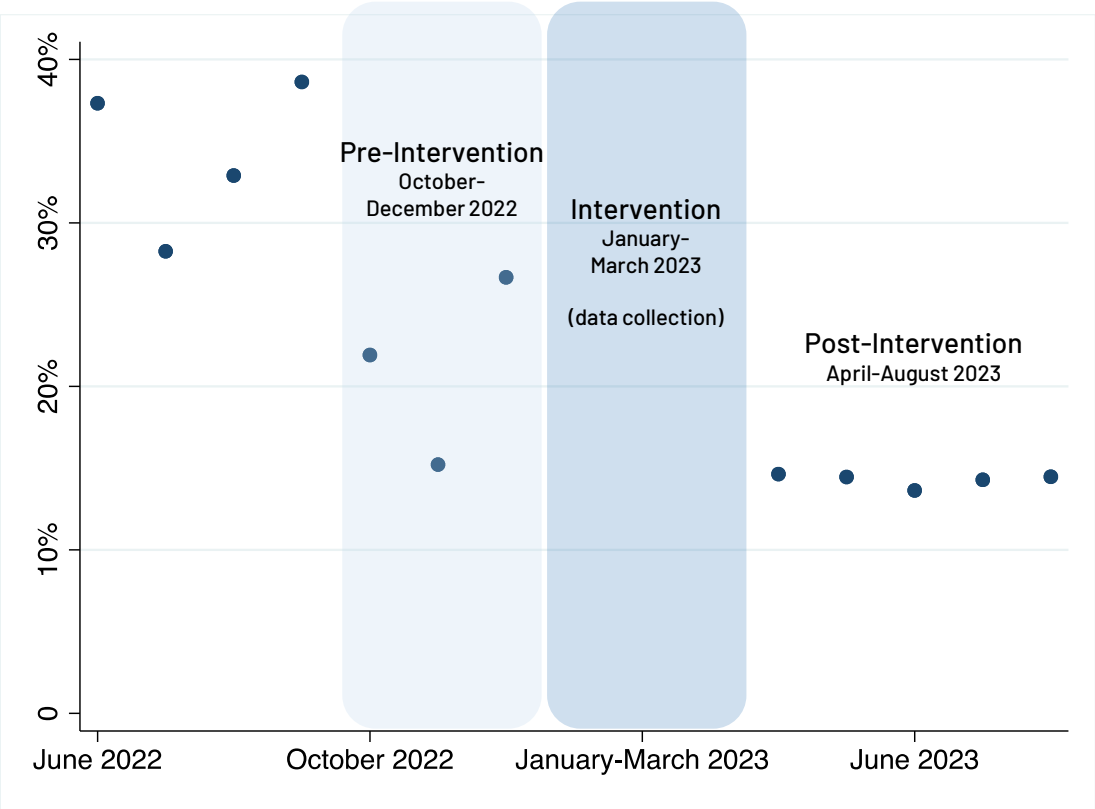
Studies / Findings

Laboratory studies ordered: none indicated.

EKG: Does not require EKG per updated anesthesia guidelines July 2020.

Unnecessary Preoperative Testing Decreased Overall

Proportion of patients receiving at least one unnecessary test



Material Resources

Decision Aid, Testing Chart, PCP Package, and more

Announcing ritesizetesting.org

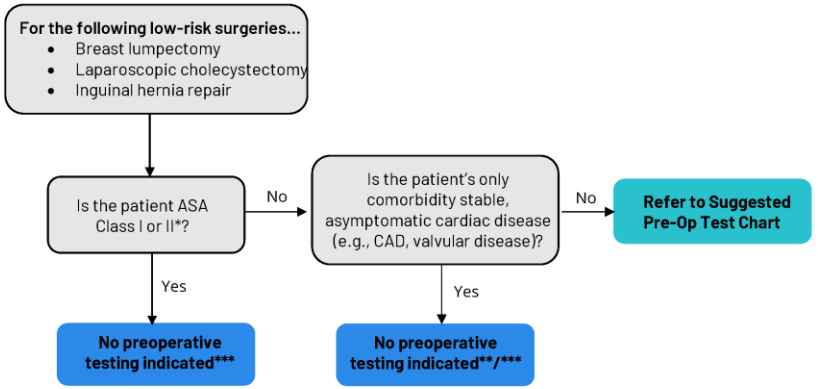
New domain name and redesigned web pages to support preop testing initiatives

Insert your hospital logo here

Decision Aid & Testing Chart Updated

Version 1.4 has been modified slightly and now also endorsed by ASPIRE/MPOG

Suggested Preoperative Testing Decision Aid for Low-Risk Surgeries



***American Society of Anesthesiologist (ASA) Physical Status Classification System:**

ASA Class I: Normal healthy patient. Non-smoking, no or minimal alcohol use, no acute or chronic disease, normal BMI.

ASA Class II: Mild systemic disease without substantive functional limitations. Current smoker, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease.

ASA Class III: Severe Systemic disease with substantive functional limitations, poorly controlled DM/HTN, COPD, morbid obesity (BMI ≥ 40), active hepatitis, alcohol dependence or abuse, pacemaker, moderate reduced EF, ESRD on dialysis, prior MI, CVA, TIA, or CAD/stents > 3 months ago

**May consider EKG if none available within the past ~6 months

***Except recent (3-6 months) potassium if on diuretic

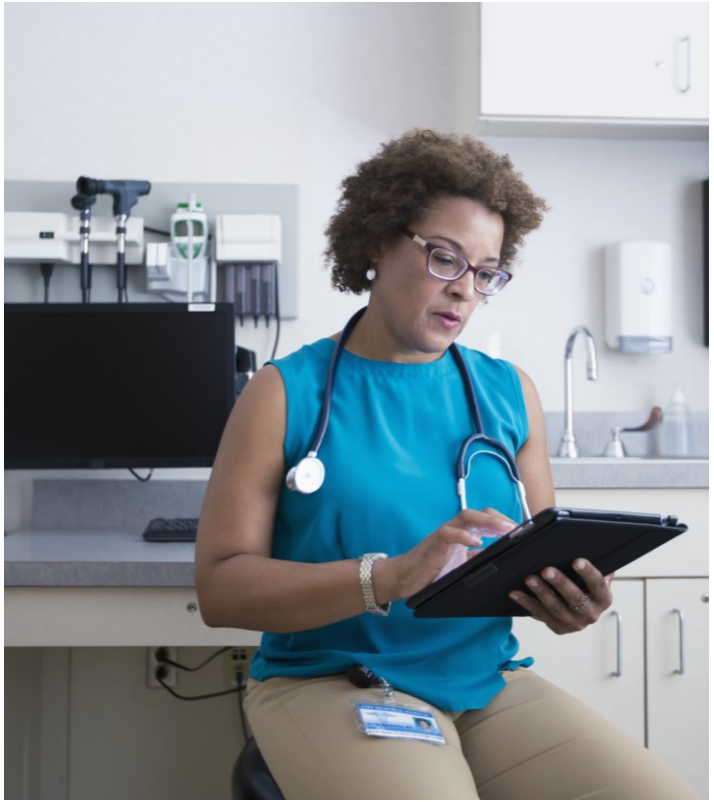
All recommendations in this document pertain to non-pregnant, adult patients undergoing low-risk procedures. They do not replace clinical judgment and are intended as guidance only.

Version 1.4 February 2024

Engaging Primary Care Physicians

Sites with experience reducing preop testing commonly cite PCPs as the source of test orders

- We recommend engaging PCPs as partners, and are developing a PCP Package to engage them



INPUT REQUESTED: Our team will reach out for feedback on these materials after the meeting

Connect with RITE-Size & Hospital Peers

CURRENT:

- Leverage resources on ritesizetesting.org
- Attend MVC preop testing workgroups
  - May 14, 12-1pm
  - Aug. 6, 12-1pm
  - Nov. 5, 12-1pm

RSVP and event details available at https://michiganvalue.org/upcoming-events

FUTURE:

- Select preop testing for future MSQC and/ or MVC P4P cycles
- Contact RITE-Size team about joining study program in 2025

Thank You!

Any questions?

You can reach us at:

- drnathan@umich.edu
- ldossett@med.umich.edu