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<https://reachmd.com/programs/cme/utilization-of-risk-assessment-tools-in-the-management-of-pah-a-pah-provider-survey/14832/>

Released: 04/29/2022

Valid until: 04/29/2023

Time needed to complete: 1h 59m

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## Utilization of Risk Assessment Tools in the Management of PAH: A PAH Provider Survey

### Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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### Dr. Sahay:

Hello, everyone. I am Sandeep Sahay from Houston Methodist Hospital, Houston, Texas, and I will be presenting findings from this recent publication from pulmonary circulation; which discussed the utilization of risk assessment tools and management of PAH. It's a survey conducted by the American College of Chest Physicians, Pulmonary Vascular Diseases Network, and targeted to the PAH provider.

In 2015, ESC/ERS guidelines recommended objective risk assessment using risk certification tools. Since then, we are aware of variety of tools, like REVEAL, REVEAL Lite 2, COMPERA has two versions, and the French Registry tools, and Swedish. Most of these risk assessment tools highlight the importance of achieving the low-risk status which is associated with the better survival. However, utilization of these risk stratification tools in day-to-day clinical practice has been low and suboptimal. This survey was targeted to identify these potential barriers to the utilization of these risk assessment tools in daily clinical practice.

ACCP Steering Committee, time 2020 to 2021, designed the survey, reviewed, and approved by a quality improvement initiated via a provider survey comprised of 31 questions assessing PAH patient care. Aim of this questionnaire was to increase understanding of current utilization of various risk assessment tools among PAH care providers; and to identify the potential barriers limiting implementation of risk tools. Survey was sent electronically to PAH specialist worldwide via the clinicians' directory in the Pulmonary Vascular Disease Network of the American College of Chest Physicians and clinicians and research members of the Pulmonary Hypertension Association. Participation was voluntary and participating clinicians were not provided with any incentive for their time and opinion.

The first eight questions were designed to collect demographic information pertinent to the responders. The subsequent questions assessed involvement in PAH outpatient care and queried the number of patients followed, as well as PAH center certification. Only those responding affirmatively to caring for PAH patients advanced to the remainder of the questionnaire. Remaining question surveyed patterns of risk assessment tools used in new and established patients as well as evaluated barriers of implementation of PAH risk assessment routine care. Simple descriptive statistical analysis was performed.

112 clinicians participated in the International CHEST PVD Network and the PAH CR group. Majority of them, 84%, were from the United States, 4% from India, 2% from Mexico and Turkey. And there were one respondent each from Australia, Brazil, Bahrain, Canada, Lebanon, Philippines, Saudi Arabia, as well as Thailand. 99% were physicians while 1% were nurse practitioner or physician assistants. 69% respondents were male. 30% were female. 82% were pulmonologists. 12% were cardiologists. Only 6% were internal medicine-trained doctors. 37% clinicians were having more than 20 years in clinical practice. 27% were between 11 to 20 years. 21% were between five to 10 years. And 10% had less than five years of experience. Of the 101 clinicians who responded, 45% were

providing care to less than 50 patients in their clinical practice, while 55% were caring for more than 50 patients in their clinical practice. If you look at the highlight of this survey, was that the utilization was 83% of the respondents working in PH-certified centers compared to 66% from the non-certified centers.

This table shows the baseline comparison between those who responded to use the risk stratification tools versus those who did not. And as I mentioned earlier, 63% of the clinicians reported the use of PAH risk certification tools in their clinical practice while 24% did not use any risk certification tool, and 13% did not provide any response. Those responded practicing in non-certified centers, 66% used risk certification tools.

When we asked them about the type of tool they're using, as we know that majority of respondents were from the United States, majority of them were using REVEAL 2.0, which is being used by 72% of the responders, closely followed by the ESC/ERS tool by 63% of the respondents.

When we tried to assess the impact of risk assessment tool during the baseline PAH evaluation on the elements of patient care, majority of the respondents suggested that it led to change in the PAH medication. This was followed by the change in the frequency of patients' follow up visit, then followed by prompted additional testing. In smaller percentages, clinicians responded that it triggered transplant referral or palliative care referrals. It also prompted them to have goals of care discussion with their patients. When we discussed about the risk assessment tools in patients' follow-up care, 54% responded to this question. 93% responded favorably to using risk assessment tools during the follow-up visits, and they felt that it did impact their patient management. 51% used these tools on every follow-up visit. 16, that is 26% of them, used only after changing the clinical status. 20% used them at a predetermined interval; that is six months follow up. And 3% used only after a medication change. 67% documented each visit risk assessment score in the patients' medical records, while 33% did not document it in the medical records. 66% felt that it led to change in the PAH medications. 10% felt that it changed frequency of follow-up visits. And 8% reported it prompted additional testing or transplant referral.

When we discussed about the risk assessment tools and EMR, then 54% clinicians responded about the EMR system information. 80% of those who responded believed that having a risk assessment tool incorporated in the EMR would improve patient care by facilitating tracking and comparison of patients' at-risk assessments during patient encounters. On the other hand, 10% were unsure or felt it would not make a difference if risk tools were embedded in their EMR. 68% felt that greatest barriers to the use of risk assessment tools on initial or follow-up visit was availability of risk assessment tool in EMR. 20% clinicians felt that time taken to calculate the risk score during each visit was the most significant impediment to the regular use.

Interventions that clinicians believe may improve utilization of risk assessment tools in PAH patient care. Majority responded that incorporating it into the EMR system would definitely make it more easy to utilize. Then they also believe that using internet-based tools and incorporating that with the EMR would help. And also increasing awareness of the benefits of the risks assessment tools would definitely help. Educating providers and scheduling additional time and follow-up for performing these risk assessment tools would definitely help.

To summarize, only 63% of respondents use risk assessment tools routinely in their clinical practice. A majority of respondents felt that the risk scores influenced initial and subsequent management of medications for PAH. Fewer felt that risk scores informed other aspects of care, such as frequency of follow-up, recommended testing, or referrals or palliative care or lung transplantation. Most respondents felt that lack of integration of risk tool calculators in the EMR impacted their ability to perform these tools.

To conclude, that when employed, these tools are largely used to guide the change in the medical therapy, but not routinely utilized to guide follow-up or referral to palliative care or transplantation. EMR integration appears to be one of the major impediments to implementation of these tools. Educational programs to increase awareness of the clinical impact of formal risk assessment in routine PAH care represent a potential strategy for increasing the utilization of routine risk assessment by PAH providers

Limitations. This survey was intended to target the global PAH clinicians. However, majority of respondents were from the United States. Vast majority of respondents in the survey were pulmonologists reflecting the membership of the ACCP chest; whether practice patterns by other subspecialists who care for PAH patients would've affected the findings, we don't know about that. And inviting by an email for an online survey could potentially introduce a selection bias towards responders with a greater interest in or awareness of PAH risk assessment tools. With that, I would like to thank you for your time and attention. Thank you.

#### **Announcer:**

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