

Cardiology: Appropriate Percutaneous Coronary Intervention (PCI)

Rank: 13 (highest adoption)

Adopted January 2013 | X months from adoption to survey

Read our Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals		
<ul style="list-style-type: none"> • PCIs are performed for non-acute indications, with limited or no evidence of appropriateness • Patients experience excess costs and added risks due to unnecessary care • There is variable measurement of PCI procedures meeting American College of Cardiology’s Appropriate Use Criteria 	<p>Hospitals participate in the Clinical Outcomes and Assessment Program (COAP)</p>	<ul style="list-style-type: none"> • Medical therapy and PCI occur based on current evidence of appropriateness • Hospital tracks and reports to COAP measurement of appropriate PCI procedures • Utilization and costs for PCI are significantly reduced across the state

Background

Recommendations for Appropriate Percutaneous Coronary Intervention (PCI), also known as coronary angioplasty, focus on documentation of appropriate use of the procedure as part of the Clinical Outcomes Assessment Program (COAP), a program of the Foundation for Health Care Quality. COAP tracks multiple cardiac surgery measures in addition to appropriate PCI. PCI is considered appropriate when the expected benefits exceed the expected negative consequences of the procedure, in terms of survival or health outcomes (e.g., reduction of symptoms, improvement in the quality of life, etc.). Currently, all state hospitals that perform PCI procedures report their data to COAP. The detailed clinical information used to measure appropriate use is complex and some hospitals had difficulty in submitting complete data. As a result, a large proportion of PCI tests were determined to have insufficient information. As such, appropriateness cannot be fully measured.

The recommendations included an aggressive timeline

- Step 1: Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the COAP website.
 - Completed August 2012.

Read the full Roadmap here: www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf

Bree Collaborative Implementation Roadmap | Cardiology

- Step 2: COAP provides feedback and tools to hospitals to reduce insufficient information in data.
 - Completed August to December 2012.
- Step 3: Updated appropriate use insufficient information report based on 4th Quarter 2012 data only, by hospital, given to Collaborative and hospitals to review. Hospitals had the option not to be identified.
 - Completed May 2013.
- Step 4: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington State Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the State. Hospitals had the option to not be identified.
 - Completed June 2013.

For 2012, approximately 28% of PCI cases had insufficient information. In 2013, that was improved to a rate of approximately 23%.

Implementation Survey Results

Our implementation survey addressed three recommendations for hospitals. These included participation in COAP, reporting of necessary information to determine appropriate PCI, and for allowing COAP results to be shared publicly. All of the eight hospitals responding to our survey scored a three on each recommendation, or fully implemented, making this the only topic on our implementation survey with a perfect score. Nonetheless, a significant number of hospitals did not complete the survey, making the ranking less conclusive. More hospital participation is needed to achieve the goal.

More recently, the COAP program has been working through additional reporting challenges. One was to change the “home grown” calculation method for appropriate PCI, and also the calculation of “insufficient data,” to align with national definitions used by the American College of Cardiology (ACC), who sponsors a similar outcomes registry called the National Cardiology Data Registry (NCDR). Changing to the ACC definitions allows streamlined reporting for hospitals, and consistent definitions between the NCDR and SCOAP. These changes, along with SCOAP staff changes, resulted in a temporary “pause” in reporting, while programming and other adjustments are made. The changes are in progress and are expected to be finished soon. Once complete, the COAP program will be able to show a more accurate rate for appropriate PCI as well as insufficient data.

Next Steps

- **Measurement.** Participating hospitals work with the COAP program to explore ways to improve data reporting to track PCI appropriateness.
- **Financial incentives.** Health plans and purchasers consider financial incentives for complete reporting, as well as performing well on appropriate use measures.

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