2019 BMC2 Collaborative Quality Initiative Performance Index Supporting Documentation

Measure 1: <u>PCI and Vascular Surgery</u> 2019 Physician Champion Meeting Participation
The PCI physician champion and Vascular Surgery physician champion must *<u>each</u>* attend 2 of the BMC2 meeting opportunities, corresponding to their registry involvement, in 2019 for full P4P points. If the physician champion is unable to attend, the site may send a participating Interventional Cardiologist or Vascular Surgeon in their place to receive credit. <u>Physician Champion meeting opportunities include:</u>

PCI
2/21/19 – PCI Physician Dinner Meeting; Baronette Renaissance, Novi, MI (6-9pm)
5/4/19 – PCI Collaborative Meeting; Baronette Renaissance, Novi, MI (8am-4pm)
11/9/19 – PCI Physician Meeting at MI ACC Conference; Amway Grand, Grand Rapids, MI (Time TBD)
Vascular Surgery
5/8/19 – BMC2/MVS Vascular Surgery Physician Meeting; Amway Grand, Grand Rapids, MI (12-5pm)
11/7/19 – BMC2/MVS Vascular Surgery Collaborative Meeting; (Location TBD, 12-5pm)

Measure 2: <u>PCI and Vascular Surgery</u> 2019 Data Coordinator Expectations
Data coordinators are required to meet expectations in the following areas, corresponding to their registry participation. Some sites participate in both PCI and Vascular Surgery and some participate in only one:

- **<u>PCI & VS:</u> Attendance at most/all meetings and calls**. If a coordinator is unable to attend, they may send someone in their place to receive credit. <u>Data Coordinator meeting opportunities include:</u>

PCI
5/4/19 – PCI Collaborative Meeting; Baronette Renaissance, Novi, MI (8am-4pm)
10/10/19 – PCI Coordinator Meeting; BCBSM Lyon Meadows, New Hudson, MI (8am-4pm)
Vascular Surgery
6/6/19 – Vascular Surgery Coordinator Meeting; BCBSM Lyon Meadows, New Hudson, MI (8am-5pm)
11/7/19 – BMC2/MVS Vascular Surgery Collaborative Meeting; (Location TBD, 12-5pm)

- **<u>PCI & VS:</u> All consecutive cases entered/on time and accurately (based on available data entry).** P4P points will be deducted for evidence that these expectations of data timeliness and accuracy are not being met. If an entire quarter (or more) is missed, it will not be possible to score P4P data dependent performance goals so associated P4P points will also be deducted.
  - <u>PCI Coordinators only:</u> *Specific audit scores will not be used in this calculation while transitioning into the new dataset. Withholding of cases and/or patterns of what appears to auditor to be intentional under reporting of outcomes will result in failure of this measure.*

- **<u>PCI & VS:</u> Demonstration of data use/quality improvement.** Submission of documentation demonstrating use of registry data for <u>at least 2</u> registry-related, quality improvement projects. This can be in an existing site format (i.e. PDCA, Sigma Six, Lean) or the BMC2 provided template. Coordinators no longer need to submit physician attestation forms or meeting minutes as part of the index, as it is assumed physicians and other staff will be involved in quality improvement. <u>If sites fail to submit at least 2 quality projects for each registry they participate in, 2.5 points shall be deducted from this measure.</u> P4P Points will be deducted if 2 documented QI projects are not uploaded to the BMC2.org website by 12/1/19 (falls on a Sunday). ***Upload Deadline for QI projects: December 1, 2019***

- **PCI & VS: Data Coordinator Upload of Case Documentation for Web-based Peer Review.** Coordinators must upload clinical documentation to the designated documentation upload repository for the cases provided by the BMC2 Coordinating Center.
  - Coordinators must upload case review materials for 100% of the provided cases.
  - Coordinators must notify the Coordinating Center of any issues they encounter that may prevent them from providing documentation. See Peer Review Upload Guidelines for detailed information about how to redact, upload and convert files (provided by BMC2 Coordinating Center).
  - All documentation must be completely redacted of PHI and Hospital/site identification. Full and complete redaction will be necessary to receive all P4P points for this measure.

PCI:

- This documentation must include:
  - Angiograms
  - H&P
  - Heart Team/Surgical Consult (include results from the most recent, in cases of multiples)
  - Physician Dictations – If staged procedure, dictation of index procedure also must be included
  - Cardiology post PCI day 1 follow-up note
  - Discharge Summary (physician note, NOT after visit summary)
- These case materials must have been appropriately redacted and submitted as directed to receive full credit.
- ***Upload Deadline for Review Period 2019A:*** **February 9, 2019**
- ***Upload Deadline for Review Period 2019B:*** **September 7, 2019**

Vascular Surgery:

- Details for case documentation will be provided in 2019. This may include CTA or US results, H&P, physician dictation, etc. The case materials must have been appropriately redacted and submitted as directed to receive full credit.
- ***Upload Deadline for Review Period 2019VS: July 13, 2019***
- ***Physician Review Period for 2019VS: August 1, 2019 – August 31, 2019***

- **For Vascular Surgery Coordinators: Completion of 30-day and 1-year follow-up are also included here.** Percentages for 30-day follow-up will be calculated based on Q1-Q3 2019 discharges (or whatever data is available when draft P4P scores are due) with a goal of ≥80%. Percentages for 1-year follow-up will be calculated based on 2017/2018 discharges (depending on data availability) with a goal of ≥80%.

Measure 3: NEW Vascular Surgery Only – Physicians Complete Web-based Cross Site Peer Review of Assigned Cases

Vascular Surgery sites must designate a physician to review cases sent through REDCap from across the collaborative. Case information sent through REDCap by the BMC2 Coordinating Center via email must be reviewed by the designated physician case reviewers at each site. These will be a mix of case types. Reviews must be submitted through REDCap for ≥ 90% of assigned cases to receive full points. No points will be awarded for < 90% submitted reviews. Full details and instructions regarding how to navigate the Redcap system will be provided in 2019. ***Physician Review Period 2019VS: August 1, 2019 – August 31, 2019***

Measure 4: PCI Only – Internal Case Reviews

Internal physician level reviews are to be conducted on the same cases that are submitted for the web-based peer review. The internal reviews must be entered into the REDCap PCI Internal Review Form which is located on BMC2.org under PCI User Documentation (link updated annually) by 12/1/2019. Reviews must be submitted through REDCap for ≥90% of assigned cases to receive full points. No points will be awarded for < 90% submitted reviews. ***Physician Internal Case Review Deadline is December 1, 2019***

Measure 5: <u>PCI Only</u> – Physicians Complete Web-based Cross Site Peer Review of Assigned Cases

PCI sites must designate a physician to review cases sent through REDCap from across the collaborative. Case information sent through REDCap by the BMC2 Coordinating Center via email must be reviewed by the designated physician case reviewers at each site. These will be a mix of case types. Reviews must be submitted through REDCap for 100% of assigned cases to receive full points. No points will be awarded for < 100% submitted reviews.

Physician Review periods will occur twice per year during the following timeframes:

- ***Physician Review Period 2019A:*** **March 1, 2019 – March 31, 2019**
- ***Physician Review Period 2019B:*** **October 1, 2019 – October 31, 2019**

Measure 6: <u>Vascular Surgery Only</u> – Endovascular Aneurysm Repair (EVAR) Length of stay, percent of elective EVAR NOT discharged by post-operative day two < 10% (based on Q1-Q3 2019 data):

Numerator: Number of elective EVAR discharges with a post procedure LOS > 3.

Denominator: Number of elective EVAR discharges.

- ❖ *Excludes fenestrated grafts and EVARs done with concomitant bypass.*

Measure 7: <u>Vascular Surgery Only</u> – Carotid Endarterectomy (CEA) Length of stay, percent of asymptomatic CEA NOT discharged by post-operative day two < 8% (based on Q1-Q3 2019 data):

Numerator: Number of elective CEA discharges that are asymptomatic and have a post procedure LOS > 3.

Denominator: Number of elective CEA discharges that are asymptomatic.

- ❖ *Excludes cases concurrent with CABG and Urgent Cardiac Surgery within 30 days.*

Measure 8: NEW <u>PCI Only</u> – Pre or Post PCI Intravenous fluid administration (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage", and symptomatic heart failure NYHA 2,3, or 4) ≥ 96% of all patients should have intravenous fluid administered pre and/or post PCI

Numerator: Number of procedures noted to have intravenous fluid administered pre and/or post PCI (BMC2 Hydration-Intravenous field utilized)

Denominator: Total procedures. Excluding patients presenting with any of the following NCDR field #'s: #4560 "Currently on Dialysis" =yes, #4630 "Cardiac Arrest Out of Healthcare Facility" =yes, #4635 "Cardiac Arrest at Transferring Healthcare Facility" =yes, #7340 "Cardiac Arrest at this facility" =yes, #7410 "Cardiovascular instability" = yes, #7800 "PCI" status=salvage, #4001" Heart Failure" =yes, #4011 "NYHA Class" = II, III, IV).

Measure 9: NEW <u>PCI Only</u> – Documentation of Surgical Consultation (#7815) for all patients with severe left main artery disease or 3 vessel CAD with proximal LAD involvement (excludes prior CABG, shock, arrest and STEMI) ≥ 90% of patients with severe LM and/or 3 vessel disease with proximal LAD disease should have a documented surgical consult

Numerator: Number of procedures with surgical consultation documented "yes." (NCDR #7815)

Denominator: Procedures with severe left main (LM) disease (NCDR #7507 segment 11a, 11b, 11c, with

NCDR #7508 documented >=50%) **or** 3 vessel disease with proximal LAD involvement (NCDR field#7507 segments 12, 18,19,19a,1,2,3, 28 with NCDR #7508 documented ≥70% and/or NCDR#7511= "yes" with child field #7512 ≤0.8 or child field #7513 ≤0.86). Excluding patients presenting with any of the following: NCDR field #'s 4515 "Prior CABG" =yes, #7410 "Cardiovascular instability" =yes, #4630 "Cardiac Arrest Out of Healthcare Facility" =yes, #4635 "Cardiac Arrest at Transferring Healthcare Facility" =yes, #7340 "Cardiac Arrest at this facility" =yes, #7825 "PCI Indication" =STEMI-Immediate PCI for Acute STEMI, STEMI-Stable, STEMI-Unstable, STEMI post successful full dose lytics, STEMI-Rescue".

Measure 10: NEW PCI Only – ACE/ARB Low EF ≥98% patients with LVEF < 40% shall be prescribed an ACE or ARB at time of discharge

Numerator: Number of discharges prescribed ACE and/or ARB at discharge (NCDR #10205)

Denominator: Discharges with discharge status of "alive" (NCDR #10105) with LVEF of <40% (BMC2 "LVEF Assessment this admit", if "no" then NCDR #7061 "LVEF during Dx LHC", if "no" then NCDR #5111 "LVEF Assessed Pre-Procedure") without documented contraindication (NCDR #10205=No-medical reason/No-patient reason).

- *Please note that discharges with the following discharge locations (NCDR #10110 and #10115) are excluded from the numerator and denominator: "Other acute care hospital", "Hospice", Left against medical advice"*

Measure 11: NEW PCI Only – ACE/ARB if Diabetic with Hypertension ≥ 85% patients with diagnosis of diabetes and hypertension shall be prescribed ACE and/or ARB at discharge.

Numerator: Number of discharge prescribed ACE and/or ARB at discharge (NCDR #10205)

Denominator: Discharges with discharge status of "alive" (NCDR#10105) with diagnosis of HTN (NCDR #4615) and diabetes mellitus (NCDR #4555) without documented contraindication (NCDR#10205=No-medical reason/No-patient reason).

- *Please note that discharges with the following discharge locations (NCDR #10110 and #10115) are excluded from the numerator and denominator: "Other acute care hospital", "Hospice", Left against medical advice"*