An 8-Step Approach to Involving Your Team in Performance Improvement

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Faculty & Commercial Disclosures

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**Commercial Interest**: Nothing to Disclose
ARS Question 1

How would you describe yourself relative to performance improvement (PI) in your organization?

1. Physician leader, (potentially) responsible for organizational PI
2. Individual physician looking for the best way to accomplish PI
3. QA/PI expert / resource (non-MD/DO)
4. Clinical care staff, contributing in other ways to QA/PI efforts
5. Curious bystander
ARS Question 2 – For Physicians

The last time I received credit for MOC Part IV:

1. I completed an ACC PIM product
2. I completed an ABIM PIM product
3. I completed a Completed Project PIM
4. I completed a Self-Directed PIM
5. I’ve never done this before
6. I have no idea what you are talking about
8 Steps for Groups to Obtain MOC Part IV

- Overview of the (new) ABIM Maintenance of Certification (MOC) requirements
- Options for obtaining MOC Part IV (performance improvement project) credit
- Walk through 8 step approach for groups to follow to obtain MOC Part IV credit
- Synopsis
Part I  Licensure & Professional Standing

Part II  Self-Evaluation of Medical Knowledge

Part III  Cognitive Expertise & Examination

Part IV  Self-Evaluation of Practice Performance
Complete an MOC activity every 2 years

Earn total of 100 points every 5 years

20 points
Part II

20 points
Part IV

20 points
Either Part II, III or IV

20 points
Either Part II, III or IV

20 points
Either Part II, III or IV

Patient Safety Module every 5 years
Patient Survey Module every 5 years

Part II = Self-Evaluation of Medical Knowledge modules
Part III = MOC secure “Boards” exam (20 points for 1st exam)
Part IV = Self-Evaluation of Practice Performance modules
Options for Obtaining MOC Part IV Credit

• Documentation of Part IV MOC is via the Practice Improvement Module (PIM)
  – In ABIM parlance, these modules are “products” that you “order” (on your ABIM personal page)

• Structured ABIM products
  – Generic, disease-specific internal medicine PIMs

• Structured ACC products
  – Afib (TEAM-A), Imaging (FOCUS) PIMs

• ABIM framework products
  – Completed Project PIM, Self-Directed PIM
Options for Obtaining MOC Part IV Credit

• Original PIM concept → “products” – designed for individual MD to complete on own time
  – highly prescriptive
  – largely designed for the individual MD – have proven difficult for MDs to address individually
  – most PIM submissions do not leverage group PI activities, hospital-organized PI work

• PI is best accomplished as a team
  – team-based clinical improvement projects eligible for Part IV MOC → 8 Step Approach
## Performance Improvement Process

<table>
<thead>
<tr>
<th>Activity:</th>
<th>Addressing the Question:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement</td>
<td>What is the current state?</td>
</tr>
<tr>
<td>Identify Benchmarks</td>
<td>What is the desired state?</td>
</tr>
<tr>
<td>Gap Analysis</td>
<td>Where is the difference between current and desired states?</td>
</tr>
<tr>
<td>Action Planning</td>
<td>How can we change to meet the desired state?</td>
</tr>
<tr>
<td>Implement Change</td>
<td>Will the change plan work?</td>
</tr>
<tr>
<td>Re-Measure</td>
<td>What is the new current state?</td>
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</table>
8 Step Process for Team-Based PI

How to Organize Your PI Activity to Obtain MOC Part IV Credit for Multiple Team Participants - while keeping the work of the individual physician to a minimum

The “Easy Button” is a registered trademark of Staples the Office Superstore LLC.
8 Step Process for Team-Based PI

1. Create the PI leadership team
2. Champions learn PI principles, MOC process specifics
3. Champions identify potential opportunities for PI (environmental scan, data analysis, etc.)
4. Inaugural team meeting (everyone)
5. Begin ABIM Self-Directed PIM (“order product”)
6. Action planning meeting (everyone)
7. Implement action plan
8. Re-measure and analyze → MOC Part IV credit!
AMA’s PI–CME Process

Stage A
- MEASURE
  Identify evidence-based measure(s) and assess practice

Stage B
- CHANGE
  Intervention

Stage C
- RE-MEASURE
  Document Improvement

Effective January 2005 AMA PRA, AAFP, and AOA
Step 1. Create the PI Leadership Team

• Identify Champions:
  - Physician Champion
    - This needs to be an “extra credit” job
  - PI/QI expert (where one exists)
  - Data / performance measures expert (again, where one exists)
  - MOC office / czar? (strongly recommended)
  - And the logical group of aligned physicians who can work together on a MOC Part IV PI project
Step 2. Education of the PI Leader Team

- PI Leadership Team must become informed about:
  - PI theory and practice – choosing an approach, being able to teach PI to the rest of the group
  - MOC specifics – ABIM MOC requirements, Web site
  - Self-Directed PIM process – ordering the “product”, being a logistical resource
  - Concepts of measurement – measure sets, the ABIM Measures Library
    - 500 clinical measures compiled by ABIM in “Measures Library”, structured in groups by setting and specialty
      - www.abim.org/ml
## ABIM Measures Library
### Self-Directed & Completed Project PIMs®
#### Measure Set Groupings

<table>
<thead>
<tr>
<th>Group</th>
<th>Setting(s)</th>
<th>Measure Set(s)</th>
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<tbody>
<tr>
<td>Adolescent Medicine/Pediatrics</td>
<td>Outpatient</td>
<td>Acute Otitis Externa/Otitis Media with Effusion</td>
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<tr>
<td></td>
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<td>Adult Sinusitis</td>
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<td>Asthma</td>
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<td>Atopic Dermatitis</td>
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<td>Substance Use Disorder</td>
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<td>Cardiac</td>
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<td>AMI: Acute Myocardial Infarction</td>
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<td></td>
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<td>CHF: Congestive Heart Failure (inpatient)</td>
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<td></td>
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<td>PCNASR - Stroke Registry</td>
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<tr>
<td></td>
<td></td>
<td>Stroke and Stroke Rehabilitation</td>
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<tr>
<td></td>
<td></td>
<td>VTE: Venous Thromboembolism</td>
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<tr>
<td></td>
<td>Outpatient</td>
<td>Atrial Fibrillation And Flutter</td>
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<tr>
<td></td>
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<td>CAD: Chronic Stable Coronary Artery Disease</td>
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<tr>
<td></td>
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<td>Heart Failure – Outpatient Management</td>
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Structure of ABIM’s Measures Library

**SETTING**
- Inpatient
- Outpatient

**CONDITION**
- Cardiac
- Chronic Illness
- Prevention

**MEASURE SET (# measures)**
- **Inpatient Cardiac**
  - AMI (29)
  - CHF (10)
  - Stroke & Stroke Rehab (17)
  - VTE (11)
  - H-CAHPS Survey (10)
  - AF & Flutter (3)
  - CAD (12)
  - HF (13)
  - VTE - Outpatient Management (6)
- **Outpatient Cardiac**
  - HF - Outpatient Management (13)
- **Outpatient Chronic Illness**
  - HF - Outpatient Management (13)
- **Outpatient Prevention**
  - IVD (9)
  - ABIM Locum Tenens Survey (10)
  - CAHPS Clinical & Group Survey (28)
- **Patient Experience /Satisfaction**
  - ABIM Locum Tenens Survey (10)
  - CAHPS Clinical & Group Survey (28)
  - Primary Prevention of Cardiovascular Disease (13)
Step 3. Environmental Scan

• PI Leadership Team:

  ➢ Evaluates existing sources of data and analyses
  ➢ Identifies candidate clinical practice areas / questions for potential performance improvement
  ➢ Evaluates ABIM performance measures library with respect to candidate areas / questions
  ➢ Puts together teaching materials about PI, MOC to present to the group
  ➢ Compiles all of the above to present to the first all-inclusive team meeting
Performance Data Comes From …

• **Data sources for a Self-Directed PIM:**
  
  - National payment systems (e.g. PQRS)
  - Local, regional or national registries (e.g. NCDR®)
  - Large reputable quality initiatives (e.g. Bridges to Excellence)
  - Chart abstraction (paper records or EHR abstraction)
Performance Measures Must Be …

• PI principles require measures to be:
  ➢ SMART:
    o Specific, Measurable, Actionable, Relevant, Time-bound

• ABIM requires measures to be:
  ➢ From ABIM’s Measures Library

  OR:

  ➢ Evidence-based, rooted in practice guidelines, nationally endorsed
    ➢ ACC Performance Measures
    ➢ The Joint Commission
    ➢ National Committee for Quality Assurance
Choosing Performance Measures from ABIM’s Measures Library

• Do the following:
  ➢ Search for relevant conditions or groups in the library (including Cardiac, Chronic Illness, Patient Satisfaction, Prevention)
  ➢ Click “+” to expand group and show names of performance measures
  ➢ Click “i” to review the measure definitions
  ➢ Select two or three measures from one group – or if there are no applicable measures, then author your own
Search the Measures Library

CHOOSE A MEASURE SET FROM THE LIBRARY

Measures are organized into sets that often appear together on a quality report. Search the library to find a set that includes the same measures as those on your report. A measure set may be selected already. To search for a different measure set, select Search a condition or use the Search by keyword option.

1. Select a condition
   - Cardiac

2. Expand sub-topic
   - Perioperative Care
     - Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)
     - Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)

3. View measures
Measures Library

**CHF: Congestive Heart Failure - Inpatient Management**

- 30-Day Mortality Rate - Heart Failure
- ACE or ARB for LVSD
- Adult Smoking Cessation Advice/Counseling
- Anticoagulant at Discharge for HF Patients with Atrial Fibrillation
- Discharge Instructions
Variation in Measure Definition - Minor

ACEI or ARB for LVSD

ABIM Measures Library (Cardiac; Inpatient; AMI)
Definition: “Percentage of AMI patients with Left Ventricular Systolic Dysfunction who are prescribed an Angiotensin Converting Enzyme Inhibitor (ACEI) or Angiotensin Receptor Blockers (ARB) at discharge.”

ICD Registry National Outcomes Report (Executive Summary)
Definition: “Proportion of patients with left ventricular systolic dysfunction who were prescribed ACE-I or ARB therapy.”
Variation in Measure Definition - Significant

Chronic Anticoagulation Therapy

ABIM Measures Library (Cardiac; Outpatient; AF & Flutter)

Definition: Percentage of patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter at high risk for thromboembolism who were prescribed warfarin during the 12 month reporting period.

PINNACLE Registry National Outcomes Report (Executive Summary)

Definition: Prescription of warfarin, or another oral anticoagulant drug that is FDA-approved for the prevention of thromboembolism, for all patients with nonvalvular AF or atrial flutter at high risk of thromboembolism according to CHADS$_2$ risk stratification.
Measurement Questions

• Do you collect this information systematically as data?

• Will the abstraction of the data be **manual** (i.e., FTE to manually perform chart abstraction) or **electronic** (i.e., FTE to write code to export the data)

• Will you need to complete and submit one of ABIM’s **Non-Approved Measures Application Forms**?
Step 4. Inaugural Team Meeting (Everyone)

- Champion convenes all members of PI Project Team:
  - Physicians who need MOC Part IV points
  - PI/QI resource
  - Data and measures expert
  - Other members of the multi-disciplinary team familiar with potential areas for improvement
Step 4. Inaugural Team Meeting (cont.)

• **Meeting Actions:**

  - Share ABIM’s MOC requirements
  - Educate about basics of PI process
  - Review findings of environmental scan / analyses (baseline data)
  - Review applicable performance measures
  - Instruct MDs on logistics of navigating ABIM site and signing up for Self-Directed PIM
  - Assign homework – study the candidate performance measures, identify / prioritize the ones that would be suitable for the actual PI project
Step 5. Begin ABIM’s Self-Directed PIM

- Direct all physicians to ABIM’s website to:
  - Register as an MOC diplomate
  - Order the Self-Directed PIM product
  - All physicians review:
    - **Part A – Orientation**
  - All Physicians review (but do not complete):
    - **Part B – Measures and Data** (review of ABIM Measures Library)
6. Action Planning Meeting(s)

- **Meeting Action:**
  - Discuss the homework, finalize the selection of three measures to be addressed in the PI project, distribute relevant data for input onto the ABIM site.
  - Discuss / create the plan to change / improve the selected measures, assigning responsibilities for executing the components of the plan.
  - Assign responsibility for completing the Action Planning document (to redistribute back to the group).
  - All physicians complete:
    - *Part B – Measures and Data*
    - *Part C – Action Plan*
Download and Complete an Action Plan

DOWNLOAD/PRINT AND COMPLETE AN ACTION PLAN GUIDE (PDF)

Download and print this step-by-step guide, then complete it with your improvement-project team. We recommend you print a copy for every member of your team and review it together. Some teams find it helpful to meet more than once to answer the questions as a group.

Guide for Creating Your Action Plan—Inpatient Setting

Next Step: Once you have completed the guide, return to this page and click the box below to record your responses on the following pages.
Requesting Use of Other Performance Measures

• If you do not see all three of the performance measures you wish to use in the same group, or you want to use measures which do not appear in the library:
  
  - You must request approval from ABIM
    - Click on “Submit your measures for approval”
    - Complete and submit one of ABIM’s *Non-Approved Measures Application Forms*
Example of one of ABIM’s four Non-Approved Measures Application Forms (Page 1 of up to 5)
Non-Approved Measures Application Form

The following information may be required:

- Title of each measure
- Description of each measure
- Name of clinical practice guideline from which each measure was derived
- Guideline citations
- Grade or level of evidence
- Sample size
- Baseline performance rate
Step 7. Implement Action Plan

- Implement intervention over three to six months where data available quarterly
  - ACC NCDR Executive Summary

- Implement over one to three months where data available monthly
  - NCDR dashboards
  - EHR abstraction or data export

- Allow time for action plan implementation to affect data
Step 8. Re-Measurement and Credit

• Reassess performance
  ➢ Use same performance measure data used in the measurement phase

• Discuss results
  ➢ Codify new processes into policies and procedures

• Reflect on what has been learned

• All physicians complete:
  ➢ *Part D – Completion and Credits*

• Physicians claim 20 MOC Part IV credits
Complete a Survey and Claim Credit

CLAIM CME CREDIT, IF APPLICABLE

The Perelman School of Medicine at the University of Pennsylvania designates this educational activity for a maximum of 20 AMA PRA Category 1 Credits™. If you have already received CME credit for the project you reported on in this module, please select the second option below.

- I want to claim CME credit for this PIM.
- I already have received CME credit for this activity.
Resources

- MOC czar – if you don’t have one, you need one
  - Most likely hospital-based
  - Patient experience surveys – qualifying surveys (e.g., Press Ganey) are already being done by your hospital – no need to repeat!
  - Patient safety activity – options being developed …

- [www.cardiosource.org/PartIV](http://www.cardiosource.org/PartIV)
- [www.ncdr.org](http://www.ncdr.org)
- [www.abim.org](http://www.abim.org)
QA/PI PRINCIPLES AND METHODOLOGIES
WHAT DO I NEED TO KNOW?
“The ultimate goal is to manage quality. But you cannot manage it until you have a way to measure it, and you cannot measure it until you are able to monitor it.”

-Florence Nightingale
Continuous Process Improvement
Borrowed from Business and Industry

- Kaoru Ishikawa and the fishbone diagram
- Lean Six Sigma
  - Defects, Overproduction, Waiting, Non-Utilized Talent, Transportation, Inventory, Motion, Extra-Processing
- Pareto principle
  - 80/20 or principle of factor sparsity. 80% of effects come from 20% of causes.
Principles in Healthcare Settings

- Emphasis on systems and processes
- Focus on patients
- Focus on teamwork
- Focus on collection and use of data
Principles in Healthcare Settings

- Emphasis on systems and processes
- Focus on patients
- Focus on teamwork
- Focus on collection and use of data
Emphasis on Systems and Processes

Resources
- People
- Infrastructure
- Materials
- Information
- Technology

Activities
- What is done
- How is it done

Outcomes
- Health services delivered
- Change in health status
- Patient satisfaction

Understand your organization
Principles in Healthcare Settings

• Emphasis on systems and processes
• Focus on patients
• Focus on teamwork
• Focus on collection and use of data
Focus on Patients

- Patient access
- Evidence based practice
- Patient safety
- Care coordination
- Patient participation
Principles in Healthcare Settings

• Emphasis on systems and processes
• Focus on patients
• Focus on teamwork
• Focus on collection and use of data
Focus on Teamwork

- Complex systems rarely involve one person in care delivery
- Cross-discipline needs
- Reliance on staff requires commitment across team
- Identify stakeholders and leaders of the team
Principles in Healthcare Settings

• Emphasis on systems and processes
• Focus on patients
• Focus on teamwork
• Focus on collection and use of data
Focus on Collection and Use of Data

- Distinguish between what is thought to be happening and what is actually happening
- Establish a baseline (starting low is okay)
- Put in place monitoring
- Value in both quantitative and qualitative data
Putting It All Together

**Analysis**
1. Stakeholder involvement
2. Situational analysis
3. Health goals

**Strategy**
4. Quality goals
5. Choose interventions

**Implementation**
6. Implementation
7. Monitoring
CQI PROJECT:
SCAI QIT AS A TEMPLATE
Quality is defined as:

A. The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

B. Prevention of recurrent MI

C. < 20% residual stenosis, TIMI 3 flow after coronary stenting

D. Something intangible, but I know it when I see it
CQI Project

• What is “quality”?
• SCAI QIT
• Proposed projects
Domains of Quality

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

- Structure
- Process
- Outcomes
Domains of Quality

- “Structure” relates to having the ingredients necessary to deliver quality care
- “Process” measures refer to the application of evidence based diagnostic and therapeutic measures
- “Outcomes” are consequences of the applied measures
  - Markers of disease progression (e.g. mortality)
  - Health status (e.g. QOL)
  - Costs
  - Appropriate use
Performance Measures

• Represent a meaningful outcome to patients and society
• Be valid, reliable, and readily measured
• Have the ability to be adjusted for patient variability
• Be modifiable through improvements in care processes
• Be practical to measure

What’s In This for Me?

Are You an Invasive Cardiologist?

Yes
Learn about Tools to Help You Improve the Quality of Care Provided in your Cardiac Cath Lab

No
Learn about Tools to Help You Improve the Quality of Care for Patients That You’re Thinking About Referring to the Cardiac Cath Lab

Slide courtesy of Kalon Ho MD

http://img2.wikia.nocookie.net/__cb20101031233306/winniethepooh/images/2/2f/Pooh_and_Piglet,_Thinking.jpg
SCAI is inviting you to join the interventional cardiology community in tackling continuous quality improvement (CQI) in the cardiac cath lab. SCAI's Quality Improvement Toolkit (SCAI-QIT) features several tools focused on:

- Guidelines;
- Peer review conferences;
- Random case selection;
- National database participation;
- Pre-procedure checklists;
- Data collection; and
- Inventory management

The beauty of SCAI-QIT is that it is flexible and can be customized for each user. Even better, you will lead the way at your own institution, using its practical tools to document your strengths, identify opportunities for improvement, and prepare for government-mandated "Pay-for-Quality" initiatives.

Help SCAI Improve Quality of Care One Cath Lab at a Time

Join the Interventional Cardiology Community in Launching the SCAI Quality Improvement Toolkit (SCAI-QIT)

SCAI is inviting you to join the interventional cardiology community in tackling continuous quality improvement (CQI) in the cardiac cath lab. SCAI's Quality Improvement Toolkit (SCAI-QIT) features several tools focused on:

- Guidelines;
- Peer review conferences;

Get to Work on Quality! Sign Up to Be a SCAI Quality Champion Now

It's time to get to work on Quality. It only takes a minute to get started!
Aims of the SCAI-QIT Syllabus

- Develop QI programs in catheterization laboratories
- Maintain existing QI programs
- Allow labs to tailor QI programs to local environments
Outline

Defining Quality in the Cath Lab
Operator and Staff Requirements
Procedural Quality
  – Benchmarking
  – Key conferences
Cath Lab Best Practices
Facility and Environmental Issues
Care Coordination with Referring Physicians
Sign Up to be a SCAI Quality Champion

Benefits include:

• Listserv—Receive guidelines, standards and position papers when published
• Receive Monthly SCAI-QIT Tips of the Month
• Notification of webinars and educational opportunities
• Venue for questions to the QI Committee with personalized or published answers
• Opportunities to participate in development of new SCAI-QIT tools, comment on new data standards and guidelines
• Public recognition of your commitment to Continuous Quality Improvement
Webinar Archives

• Navigating the New 2012 Appropriate Use Criteria for Diagnostic Cardiac Catheterization
• What the 2012 Cath Lab Standards Update Has to Offer for Quality Improvement
• Navigating the New 2012 Revascularization Appropriate Use Criteria
• Navigating the Revised 2011 Guidelines to PCI
• SCAI-QIT: Defining Quality in the Cath Lab, Facility and Environmental Issues Tools, and Accreditation for Cardiovascular Excellence
• SCAI-QIT: Operator and Staff Requirements
• SCAI-QIT: Procedural Quality and Cath Lab Best Practices

Upcoming Webinars

• PCI without Surgical Backup, with Greg Dehmer, 18 Mar 2014
• CathPCI Registry – Tools That Work, with Skip Anderson, 21 Mar 2014
• Documentation Module, with Kirk Garratt
• Care Coordination, with Hank Jennings

Slide courtesy of Kalon Ho MD
Download SCAI’s Quality Improvement Toolkit (SCAI-QIT) Cath Lab Guidelines & Appropriate Use Criteria (AUC) App to join the interventional and invasive cardiology community in tackling continuous quality improvement (CQI) in the cardiac cath lab and implement the SCAI’s Quality Improvement Toolkit in your practice.

To Begin the Online App, Please Click on the Specific Guideline or Appropriate Use Criteria Below:

**ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 Appropriate Use Criteria for Coronary Revascularization Focused Update**

**Coming Soon**

**Additional Guidelines & Appropriate Use Criteria**

**2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention**
Potential CQI Projects*

- Documentation of radiation exposure during angiography and PCI
- Reduction in contrast use during angiography and PCI
- Documentation of appropriateness of procedures

*Measures other than those listed by the ABIM need approval
ACTION PLAN DEVELOPMENT
ARS Question 4

Which one of the following is most closely associated with your clinical practice?
A. Percutaneous coronary intervention
B. Peripheral arterial angioplasty
C. ICD implantation
D. Inpatient cardiovascular management
E. Outpatient cardiovascular management
Performance Improvement: Action Plan: Development

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ACE = angiotensin converting enzyme
ARB = angiotensin receptor blocker
CAD = coronary artery disease
CHF = congestive heart failure
LV = left ventricular
LVEF = left ventricular ejection fraction
NYHA = New York Heart Association

Drug therapy:
1) Aspirin use in CAD patients
2) ACE-I/ARB use in patients with LVEF <0.40
3) Beta-blocker use in patients with LVEF <0.40

Source: National Cardiovascular Data Registry - ICD Registry (Individual data)
### Drug therapy

1. **Aspirin use in CAD patients**
2. ACE-I/ARB use in patients with LVEF <0.40
3. Beta-blocker use in patients with LVEF <0.40

### Baseline data: 11/12 (91.7%)
Performance Improvement: 
Action Plan: Development

<table>
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<tr>
<th>LVEF (%)</th>
<th>Beta-blocker?</th>
<th>ACE-inhibitor/ARB?</th>
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Drug therapy
1) Aspirin use in CAD patients
2) ACE-I/ARB use in patients with LVEF <0.40
3) Beta-blocker use in patients with LVEF <0.40

Baseline data (ACE-I/ARB): 15/16 (93.8%)
Baseline data (beta-blocker): 14/16 (87.5%)
### Performance Improvement: Action Plan: *Implementation*

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline performance</th>
<th>Target performance</th>
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<tr>
<td>Aspirin use in CAD patients</td>
<td>11/12 (91.7%)</td>
<td>&gt;95%</td>
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<tr>
<td>ACE-I/ARB use in patients with LVEF &lt;0.40</td>
<td>15/16 (93.8%)</td>
<td>&gt;95%</td>
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<tr>
<td>Beta-blocker use in patients with LVEF &lt;0.40</td>
<td>14/16 (87.5%)</td>
<td>&gt;95%</td>
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</table>

**Action plan:**

1. Review, documentation and initiation of pharmacotherapy in outpatient ICD referral patients (including drug contraindications/intolerance) at the time of visit or implantation
2. Review, documentation, and initiation of appropriate drug therapy in inpatient ICD recipients (including drug contraindications/intolerance)
3. Communication with primary cardiovascular caregiver regarding details of pharmacotherapy
4. **Re-measurement** of selected metrics using above action plan
Performance Improvement: Action Plan: Implementation

Enter Performance Data

Enter the source of your data.
- Medical Society

Describe your quality improvement (QI) project for this PIM.
- Beginning a new QI project
- Reporting on a recently completed QI project

Is this a new (i.e. just beginning) or recently completed QI project? Click the appropriate button.

If this is a completed QI project, enter the beginning dates and end dates for the data you will be using.

Enter the target condition you are reporting on.
- CAD

What is the first measure you will be using? You will have to report on a minimum of 5 measures. Many cardiologists use the measures from the CathPCI executive summary.

What is the guideline or consensus statement on which this measure is based?

What guideline or consensus statement? Almost all the measures are based on ACC/AHA guidelines.

You can obtain this data from your NCDR report. See sample below.
## Performance Improvement: Action Plan: *Implementation*

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<tr>
<td>LVEF &lt;0.40, ACE-I/ARB?</td>
<td>91.6%</td>
<td>99.3%</td>
<td>98.3%</td>
<td>98.5%</td>
<td>97.9%</td>
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<td>82.8%</td>
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<td>LVEF &lt;0.40, beta-blocker?</td>
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<td>97.9%</td>
<td>100%</td>
<td>99.5%</td>
<td>100%</td>
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<td>4.5%</td>
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<td>7.3%</td>
<td>4.5%</td>
<td>8.4%</td>
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**Suggested metrics:**
- Evidence-based, guideline-directed
- Collected by registry
- “Multi-purpose” metrics
- Capable of process improvement/intervention

**Suggested interventions:**
- Improved documentation
- Improved chart review
- Communication with all caregivers
- Involvement of all care team elements

*Source: National Cardiovascular Data Registry - ICD Registry (Institutional data)*
Which one of the following is most closely associated with your clinical practice?

A. Percutaneous coronary intervention → Cath PCI Registry
B. Peripheral arterial angioplasty → PVI Registry
C. ICD implantation → ICD Registry
D. Inpatient cardiovascular management → ACTION Registry (ACS/NSTEMI)
E. Outpatient cardiovascular management → PINNACLE Registry
Performance Improvement:
Action Plan: Available Registries

Registry benefits

• Systematic data collection
• Standardized variables
• Comparison within and between practices/institutions
• Applicable in multiple arenas