Dr. ROBERT BREE COLLABORATIVE

Cardiology Topic: Appropriateness of Percutaneous Coronary Interventions

Report & Recommendations

January 31, 2013

Adopted by the Dr. Robert Bree Collaborative on January 31, 2013

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Available at: http://www.hta.hca.wa.gov/bree.html

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Executive Summary

Percutaneous Coronary Intervention (PCI) is a remarkable and valuable tool in the management of both acutely ill and stable patients with coronary artery disease, decreasing mortality and increasing quality of life when used in appropriately selected patients. However, substantial variation exists nationally and among hospitals in Washington State in the proportion of patients who receive PCI for clearly appropriate reasons. This is particularly the case for PCI occurring in nonacute clinical situations despite national criteria. Performing PCIs for nonacute indications with limited or no evidence of appropriateness results in unnecessary care and excess costs, and exposes patients to risks. Complicating this issue is substantial variation in data collection. Data needed to evaluate the appropriateness of PCI for a nonacute indication done in hospitals are incomplete or insufficient, hindering measurement and quality improvement efforts.

The Dr. Robert Bree Collaborative, a consortium of stakeholders from public and private organizations working together to improve health care quality in Washington State, identified appropriateness of PCI as a topic where its unique voice could accelerate well-established quality improvement efforts. To decrease variation and improve appropriate use of PCI, the Bree Collaborative chose to build on the appropriateness of PCI efforts of the Clinical Outcomes Assessment Program (COAP), a neutral, third-party quality improvement program of the Foundation for Health Care Quality in Seattle.

In February 2012, the Bree Collaborative requested public disclosure of hospitals' rates of PCI appropriateness and insufficient data which, historically, have only been available to hospitals. COAP approved the Bree Collaborative's request and is working with hospitals to reduce the amount of missing data and improve hospitals' ability to classify the appropriateness of procedures.

The COAP/Bree Collaborative partnership is precedent-setting and a model for the rest of the nation. Transparency of appropriateness of cardiac procedures by facility will help private and public payers and purchasers, including the State of Washington, purchase high-quality, efficient health care. As a result of this partnership and a push from the State of Washington and other purchasers for transparency and more information on the appropriateness of cardiac procedures, transparency of appropriate use of PCI and measurement of appropriateness of PCI efforts will increase. This shift will improve the value and quality of cardiac care in Washington State.

The Bree Collaborative and its Charge

The Dr. Robert Bree Collaborative (Collaborative) was established in 2011 by Washington State House Bill 1311 as an offshoot of the Washington State Advanced Imaging Management (AIM) project. The purpose of the Collaborative is to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State.[1] (See Appendix A for a list of current Bree Collaborative members.)

Appointed by former Governor Christine Gregoire, the 24-member Collaborative's mandate is to select up to three health care services annually where there is substantial variation in practice patterns or high utilization trends in Washington State. For each health care service, the Collaborative is charged with identifying and recommending evidence-based approaches that "scale up" existing quality improvement efforts aimed at decreasing variation.[2]

At its first meeting in September 2011, the Collaborative heard presentations on a variety of health procedures identified as having high variation in practice patterns and showing the most promise for improvement in health outcomes through appropriate interventions. Collaborative members voted to select obstetric care as the first topic to research and make recommendations for improvement, followed by readmissions, low back pain, and cardiology (appropriateness of percutaneous coronary interventions (PCIs)).

The Collaborative is named in memory of Dr. Robert Bree. Dr. Bree was a pioneer in the imaging field and a key member of the Advanced Imaging Management (AIM) project.

Background on Appropriate Use of PCI and National Standards

Since the 1990s, PCI has been a remarkable and valuable tool in the management of coronary heart and artery disease in both acutely ill and stable patients with coronary artery disease, decreasing mortality and increasing quality of life when used in appropriately selected patients. In appropriate situations, there is both scientific evidence and professional consensus that PCI can improve quality of life for patients with symptomatic angina refractory to appropriate medical therapy. However, performing PCIs for nonacute indications with limited or no evidence of benefit results in unnecessary care and excess costs while exposing patients to risks, and may be considered inappropriate.[i] Nationally, approximately 600,000 PCIs are performed each year, at a cost that exceeds $12 billion.[ii,iii] In Washington State, between 12,000 and 15,000 PCIs are performed annually.[iv]

Recently, PCI appropriateness has received more attention because appropriateness is seen as an emerging quality metric that provides an assessment of anticipated procedural benefit relative to

[1] For more information on the Bree Collaborative, go to: http://www.hta.hca.wa.gov/bree.html.

[2] In the bill, the Washington State Legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the Washington State Legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

the risk of the procedure.[v] Appropriate Use Criteria (AUC) are national standards for determining the appropriate use of PCI and were developed in 2009 by the American College of Cardiology, in partnership with several other professional organizations.[vi] They serve to "quantify" the appropriateness of PCI for a variety of clinical scenarios if the necessary data are available.

PCI Appropriate Use Criteria (AUC)

According to AUC, PCI is deemed "appropriate" when the "expected benefits, in terms of survival or health outcomes (symptoms, functional status, and/or quality of life) exceed the expected negative consequences of the procedure."[vii]

AUC were established by interpreting the substantial clinical evidence on risk and benefit in the context of specific, relatively common clinical scenarios, in effect operationalizing the evidence base.

Clinical scenarios account for:[viii]

- Clinical presentation (e.g., ACS, stable angina)
- Severity of angina (CCS classification)
- Extent of ischemia on noninvasive testing and other prognostic factors (e.g., low EF, DM)
- Extent of anti-anginal therapy
- Extent of anatomic disease

Each clinical scenario was classified by experts into one of three categories, which were recently renamed but kept the same definition in the latter two cases:

1. *Appropriate*, where the scientific evidence supports the contention that the procedure benefits clearly outweigh the risks;
2. *May Be Appropriate*, formerly *Uncertain*, where there is limited or conflicting evidence that the benefit outweighs the risks; and
3. *Rarely Appropriate*, formerly *Inappropriate*, clinical scenarios where the expert panel agreed that the risks outweigh any marginal benefit of the PCI.[ix]

COAP and Appropriate Use of PCI

Clinical Outcomes Assessment Program (COAP), a program of the Foundation for Health Care Quality in Seattle, is a national leader in adopting statewide quality improvement efforts in cardiac care. In 2011, COAP started applying the AUC algorithm to its database – which includes data on all interventional cardiac procedures performed at all Washington State hospitals – to measure appropriate use of PCI in Washington State. The intent of measuring and reducing inappropriate use of PCI is to provide more consistent use of PCI across practice settings in the provision of high-quality care; the intent is not to eliminate all procedures that are classified as "rarely appropriate."

Hospitals receive Appropriate Use analyses on their own performance at both the facility and provider level in the form of a risk-adjusted dashboard and descriptive reports to hospitals, quarterly and annually. Patient level reports are provided to each hospital that identify specifically which variables (or the absence of those variables) contributed to that procedure receiving a particular classification. Hospitals also receive comparisons between their performance and the aggregate outcomes for Washington State as well as other individual hospitals identified by name. The collaborative nature of un-blinded data sharing leverages a unique strength of the COAP community and one that sets it apart from membership in the ACC's interventional cardiology registry, which only provides hospital-specific feedback. Collaborative data sharing allows the hospitals to see and respond to practice level variation. This is a key strength, particularly when the goal is to understand and reduce practice variation in the pursuit of higher quality care. Until very recently, hospital-specific data and analyses have not been available to the public.[3]

Appropriate Use of PCI in Washington State and U.S.

A major study on appropriate use of PCI in Washington State was conducted by Bradley and COAP staff in 2011.[x] Using COAP data and AUC, the study authors applied "appropriateness" ratings to all PCI procedures done in 2010 (see Table 1 on next page). The main conclusions from the study were:

- The majority of PCI done for acute indications in Washington State are classified as "appropriate";
- A large number of PCI done for nonacute indications are classified as "rarely appropriate," and the number of PCIs classified as "rarely appropriate" varies significantly by facility; and
- A big problem with measuring appropriate use is incomplete or insufficient data, mostly among nonacute indications. If the data needed to classify the appropriateness of the procedure are not entered, the COAP AUC algorithm does not classify the procedure.

[3] Starting in 2012, COAP started moving towards greater public disclosure and the sharing of outcomes of all its measures and procedures.

Table 1. Appropriate Use of PCI (classified using AUC) in Washington State[4]

Indication	TOTAL (n=13,291)	Appropriate (n=8,734)	May be Appropriate (n=787)	Rarely Appropriate (n=403)	Not Classified (n=3,367)
Acute Indications (acute myocardial infarction or unstable angina with high-risk features)	9,452 (71%)	7,887 (83%)	39 (<1%)	84 (1%)	1,442 (15%)
Nonacute Indications[5] (stable angina)	3,839 (29%)	847 (22%)	748 (20%)	319 (8%)	1,925 (50%)

Source: COAP Data, 2010

Appropriate = The scientific evidence supports the contention that the procedure benefits clearly outweigh the risks as determined by the AUC expert panel.

May be Appropriate = Limited or conflicting evidence that benefit of PCI in these particular clinical scenarios outweighs the risk as determined by the AUC expert panel.

Rarely Appropriate = Risks outweigh any marginal benefit of the PCI as determined by the AUC expert panel.

Not classified = Missing data necessary to calculate appropriateness of PCI.

Appropriate use of PCI nationally mirrors Washington State appropriate use results , as depicted in Table 2.

Table 2. Appropriate Use of PCI Nationally[xi,6]

Indication	Total	Appropriate	May be Appropriate	Rarely Appropriate
Acute Indications (acute myocardial infarction or unstable angina with high-risk features)	355,417	98.6% (350,469)	0.2% (1,055)	1.2% (3,893)
Nonacute Indications (stable angina)	144,737	49% (72,911)	39% (54,988)	12% (16,838)

Source: National Cardiovascular Data Registry (NCDR) CathPCI Registry

[4] Each of these scenarios is given a number ("Appropriate" is a 9, 8, and 7; May be Appropriate" is a 6, 5, and 4; and "Rarely Appropriate" is a 3, 2, and 1).

[5] Excluding the "not classified" cases, the proportion of PCIs for nonacute indications classified as "appropriate" was 44%; "may be appropriate" at 39%; and "rarely appropriate" at 17%.

[6] Note: Unclassified PCI are not counted in the denominators in this study.

Variation in Appropriate Use of PCI and Missing Data for Nonacute Indications, Across Facilities

In Washington State and nationally, variability of appropriate use of PCI is seen mostly with nonacute indications, across facilities.[xii] For example, in Washington State the percentage of PCI procedures for nonacute indications classified as "rarely appropriate" ranges from 9% to 24%, with a median of 14%. (See Appendix C for a bar graph.)

There is also wide variation of missing or insufficient data used to determine appropriate use of PCI in nonacute indications among hospitals. The percentage of nonacute indications "not classified" by facility varies from approximately 25% to 100%. (See Appendix B for a bar graph.) The statewide average for the percentage of "not classified" for nonacute PCI in 2011 (see Appendix C for a bar graph) and in the first quarter of 2012 (see Appendix D for a bar graph) was approximately 47%. Hospitals have begun working on ways to reduce the amount of insufficient data in nonacute cases ever since COAP has brought this issue to light; however, overall improvement has not yet been realized and significant variation still exists.

Causes of Variation of Appropriate Use of PCI for Nonacute Indications and Insufficient Data

PCI appropriateness signals whether PCI procedures are performed for necessary clinical reasons, or the benefits of the procedure outweigh the risks.[xiii] Variation in the proportion of "rarely appropriate" PCI procedures performed in patients with nonacute indications signals what appears to be substantial variation in practice pattern across hospitals.[xiv]

Data show that process of care and data collection deficiencies are the main causes of the large number and variability of unclassified cases for nonacute indications.[xv] A high proportion of nonacute PCI were performed without documentation of preprocedural tests. These noninvasive tests (walking stress tests and imaging stress tests) are evidence-based means of stratifying patients into minimal, low, medium, and high risk categories for subsequent cardiovascular events. In a stable low risk patient without significant angina or other clinical factors, AUC expert consensus states that the procedural risks outweigh any minimal benefit. Missing noninvasive stress test results account for most of the "not classified" cases (57%).[xvi]

Lack of documentation is the result of one or two issues: 1) the preprocedural test was not performed; or 2) some hospitals may not routinely collect or reliably document all of the information necessary in order to evaluate whether a procedure can be classified as "appropriate." For instance, a patient may have received screening tests at an outpatient facility and results were not available to the abstractor at the hospital performing the PCI; this also means that these salient test results were not included in the operator's clinical documentation either prior to or for the PCI.

Bree Collaborative and COAP

The Collaborative invited the medical director of COAP to present data on appropriate use of PCI at the January, March, and May Collaborative meetings. Appropriate use of PCI was identified as a topic where the Collaborative's unique voice could accelerate well-established quality improvement efforts. Purchasers, in particular, were interested in this issue because they want more quality information and performance data to create high-quality and high-value networks for their employees and families.

During the first part of 2012, Collaborative staff and members along with COAP staff worked together to identify ways the Collaborative could help increase appropriate use of PCI and better data collection practices. No formal cardiology workgroup was formed; instead, the Collaborative relied on the clinical expertise of COAP staff, the COAP management committee, special advisors to COAP, and a small informal group of Collaborative members and representatives for clinical advice and recommendations. Five Bree Collaborative members serve on the COAP management committee or as special advisors to COAP, providing a strong linkage between both initiatives.

The COAP management committee consists of twelve clinicians with cardiac and quality expertise, including two Collaborative members. (See Appendix E for a list of COAP management committee members.) Representatives from the Washington State Health Care Authority and the Puget Sound Health Alliance also served as advisors.

Collaborative Recommendations: Increase Measurement and Reporting of Appropriateness of PCI

The Collaborative in February 2012 asked the COAP management committee to allow hospitals' insufficient information reports and appropriateness of PCI results to be made available to the public. The strategy behind publicly posting hospitals' appropriateness of PCI results is that they will incent hospitals to improve appropriateness of PCI procedures, data collection, and documentation. This shift will likely lead to a reduction in the amount of missing or insufficient information and improve transparency.

The COAP management committee in February 2012 approved the Collaborative's request and agreed to provide technical assistance to hospitals to reduce the amount of missing data and improve the ability to classify the appropriateness of procedures.

To create a forum for cardiac clinicians to hear directly from the Collaborative about its request, a few Collaborative members including representatives from The Boeing Company, Regence Blue Shield, and the Puget Sound Health Alliance attended a breakout session on appropriateness of PCI at the annual COAP meeting in May 2012. Collaborative members stressed the importance of transparency of quality information. They also emphasized that employers need quality information to make smart purchasing decisions, and in the future will not contract with hospitals that do not make their performance on cardiac procedures publicly available.

In July 2012, the Collaborative outlined its request in a letter to the COAP management committee. The letter outlined a four-step process with target completion dates to reduce insufficient information and share the results publicly on a quarterly basis, which is below. The proposed process allows time for hospitals to improve their documentation and employ methods for improvement before appropriateness results are posted on the website. (See Appendix F for a copy of the letter sent from the Collaborative to COAP.)

Step 1: An appropriate use insufficient information report (2012 data) by hospital will be posted on the COAP members-only section of the COAP website. *Target date: August 1, 2012.*

Step 2: COAP will provide feedback to hospitals and tools for reducing the amount of insufficient information in their data. *Target date: August – December 2012.*

Step 3: An updated appropriate use insufficient information report (based on 4th Quarter 2012 data only), by hospital, will be given to the Collaborative and hospitals to review. Hospitals will have the option to not be identified. *Target date: April 15, 2013.*

Step 4: Once hospitals have been given a chance to employ methods for improvement, and any corrections they might have made have been incorporated, an updated report (based on 4th Quarter 2012 data only) will be posted on the public section of the COAP website. The Collaborative will also ask the Puget Sound Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the Puget Sound region, on a quarterly basis. Hospitals will have the option not to be identified. *Target date: May 1, 2013.* (See Appendix D for a sample report of how the un-blinded data will be presented; note: "Hospital 1..2..3", etc, will be replaced with the hospital name once the report is finalized and prior to posting on the website. Hospitals that choose not to participate in the report will have their names listed with no data).

At its July meeting, the COAP management committee approved the process and target dates.

Status of Collaborative Recommendations

Step 1 was completed in August, and Step 2 is in process. To date, COAP staff has met with several hospitals that have requested assistance. The patient level reports for each hospital, which identify the specific reasons the hospital had either inappropriate or insufficient data for evaluation, have been released and will be used to help hospitals reduce the number of cases that fall into this category. In addition, COAP staff reached out to each hospital before the end of December 2012 to review what the public report would look like.

According to COAP staff, most hospitals are supportive of increased transparency and agree to be identified in appropriate use of PCI and insufficient information reports. However, some are not and have not agreed for their results to be published. A few hospitals are resistant to making data public because they do not see the relevance, question the definition of appropriate use, or for other reasons.

Ways that Hospitals, Payers, and Purchasers, including the State of Washington, Can Support Collaborative Recommendations

There are steps that hospitals, payers, and purchasers including the State of Washington can take to support and reinforce the Collaborative's recommendations. Hospitals (with clinician support) should participate in COAP, a neutral, third-party quality improvement program; submit all necessary data requested by COAP for community-wide analyses; and allow COAP to publish their appropriate use and insufficient information results.

Payers and purchasers, including the State of Washington, can take similar steps through contracting by requiring individual hospitals to:

- Participate in COAP, a neutral, third-party quality improvement program;
- Submit complete data requested by COAP for community-wide analyses;
- Allow COAP to publish their appropriate use and insufficient information results;
- Demonstrate that they have taken sufficient steps to reduce the amount of insufficient data related to appropriateness of PCI; and
- Create an action plan if PCI appropriate use and insufficient or "not classified" data exceed benchmark rate.

Future Efforts to Promote Measurement and Transparency of Cardiac Interventions and Procedures

COAP and Collaborative staff will continue to meet to discuss additional ways that the Collaborative can support and incent improved measurement and transparency of additional COAP cardiac measures.

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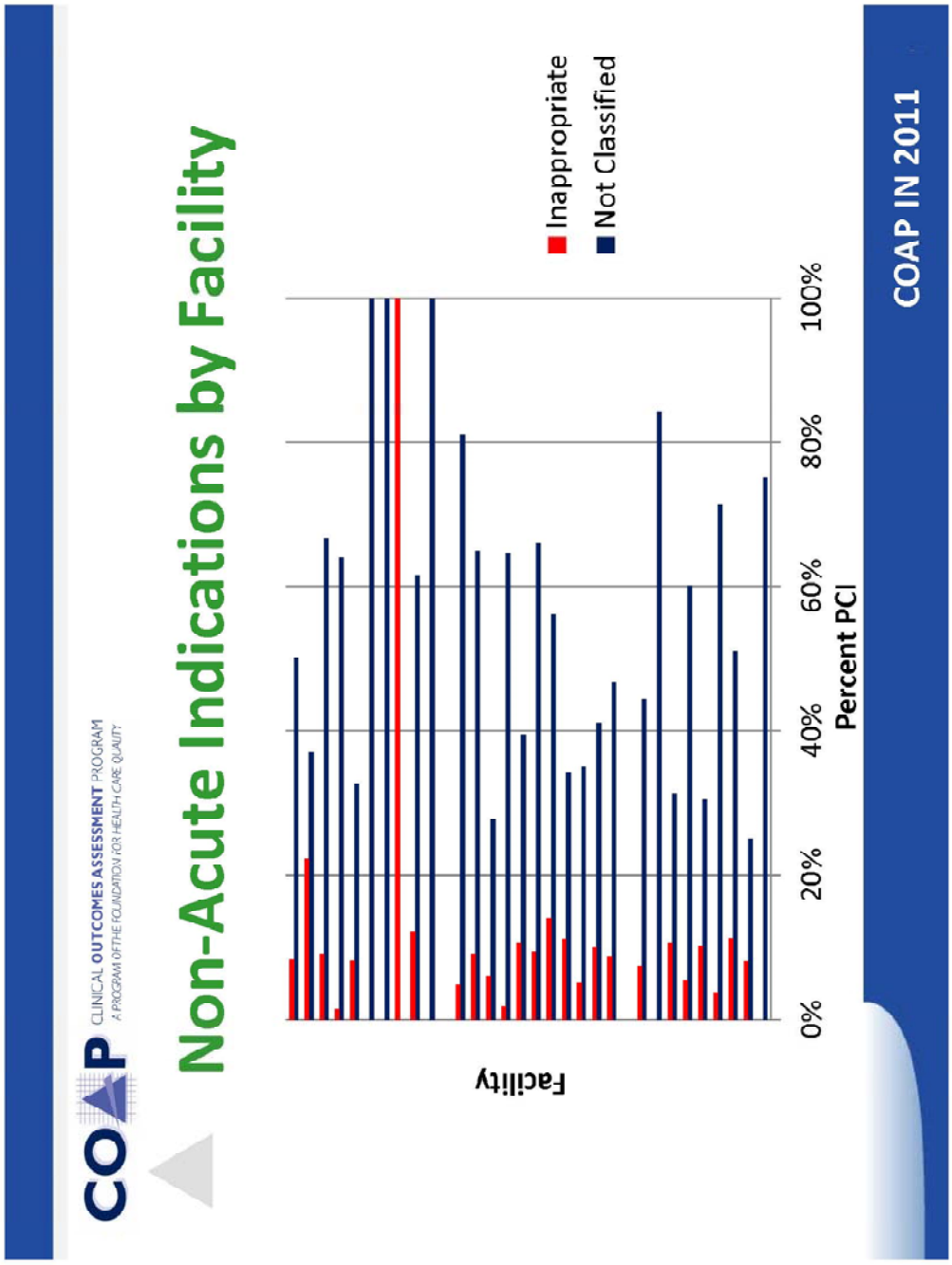
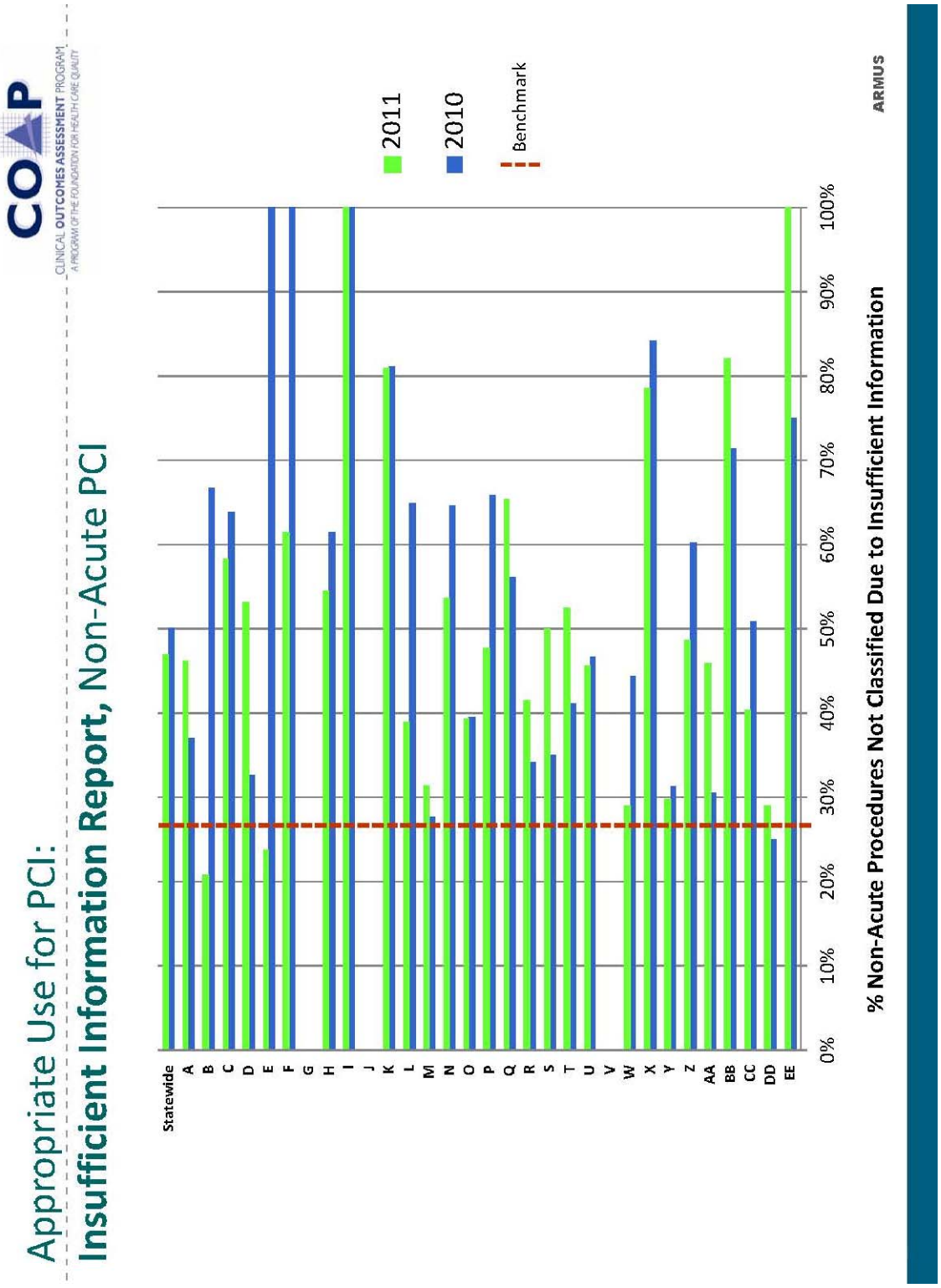
Appendix A – Bree Collaborative Membership

Robert Bree Collaborative	
Steve Hill, Chair	Former Director, Dept of Retirement Systems
Roki Chauhan, MD	Senior Vice President & Chief Medical Officer, Premera Blue Cross
Susie Dade, MS	Deputy Director, Puget Sound Health Alliance
Gary Franklin, MD, MPH	Medical Director, Labor and Industries
Stuart Freed, MD	Medical Director, Wenatchee Valley Medical Center
Thomas Fritz	Chief Executive Officer, Inland Northwest Health Services
Joseph Gifford, MD	Chief Strategy and Innovation Officer for Western Washington, Providence Health & Services
Richard Goss, MD	Medical Director, Harborview Medical Center - University of Washington
Mary Gregg, MD, FACS, MHA	Director, Quality and Patient Safety, Swedish Health Services, Seattle
Tony Haftel, MD	VP Quality & Associate Chief Medical Officer, Franciscan Health Systems
Beth Johnson	VP, Provider Services, Regence Blue Shield
Gregory Marchand	Director Benefits Policy and Strategy, The Boeing Company
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions, Virginia Mason Medical Center
Carl Olden, MD	Family Physician, Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill, MD, MBA	Chief Medical Officer PNW, CIGNA
Robyn Phillips-Madson, DO, MPH	Dean and Chief Academic Officer, Pacific NW University of Health Sciences
John Robinson, MD, SM	Chief Medical Officer, First Choice Health
Terry Rogers, MD	CEO, Foundation for Health Care Quality
Eric Rose, MD	Physician, Fremont Family Medicine, Seattle
Kerry Schaefer	Strategic Planner for Employee Health, King County
Bruce Smith, MD	Physician, Group Health Physicians
Jay Tihinen	Assistant Vice President Benefits, Costco Wholesale
Jeffery Thompson, MD, MPH	Chief Medical Officer, Health Care Authority
Peter Valenzuela, MD, MBA	Medical Director, PeaceHealth Medical Group

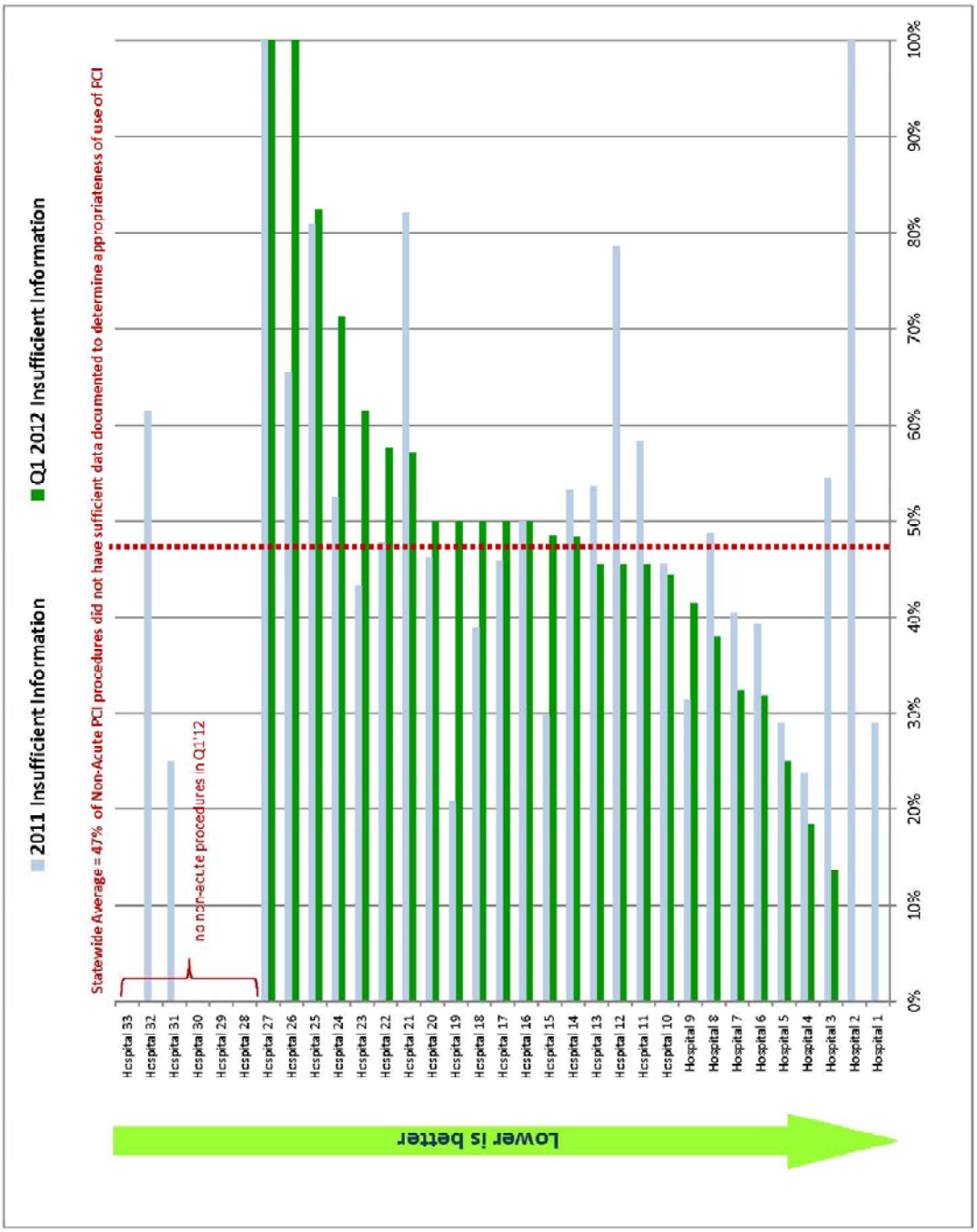
Appendix B – Nonacute Indications by Facility, Based on COAP 2010 Data



Appendix C – Insufficient Information Report, Non-Acute PCI, Comparing COAP 2010 and 2011 Data



Appendix D - Insufficient Information Report, Non-Acute PCI, Comparing COAP 2011 and Q1 2012 Data



Appendix E – COAP Management Committee Roster

Management Committee

Cass Bilodeau, RN, BSN
STEMI Coordinator/Regional Clinical Liaison
Kadlec Medical Center
Richland, WA

David Dreis, MD
Medical Director, Clinical Outcomes
Virginia Mason Medical Center
Seattle, WA

J. Richard Goss, MD, MPH
Director, Quality Improvement; Medical Director
Harborview Medical Center
Seattle, WA

Mary Gregg, MD, FACS, MHA
VP Quality & Patient Safety Medical Affairs , Cherry Hill Campus
Director, Quality and Patient Safety
Swedish Health Services
Seattle, WA

Geoff Harms, MD
Interventional Cardiology
Central WA Medical Center
Wenatchee, WA

G. Gilbert Johnston, MD
Cardiovascular Surgery
St. Joseph Cardiothoracic Surgeons
Tacoma, WA

Eric J. Lehr, MD, PhD
Cardiovascular Surgery
Swedish Medical Center
Seattle, WA

Julie McDonald, RN, BSN, CPHQ (chair)
Director, Clinical Analytics
Providence Regional Medical Center, Everett
Everett, WA

Chelle Moat, MD, MPH
Medical Director, Care Management
Premera Blue Cross
Mountlake Terrace, WA

Michael E. Ring, MD, FACC, FSCAI
Medical Director Cardiac Services Line and Cardiac Catheterization Laboratories
Providence Sacred Heart Medical Center
Spokane, WA

Mark Sollek, MD
Retired (medical director, 3rd party payor)
Seattle, WA

Mandya Vishwanath, MD
Cardiovascular Surgery
Northwest Heart & Lung Surgical Assoc.
Spokane, WA

Richard W. Whitten, MD, MBA, FACP
Carrier Medical Director, Medicare B
Noridian Administrative Services
Kent, WA

Special Advisors

Susie Dade, MS
Director, Quality Improvement & Administration
Puget Sound Health Alliance
Seattle, WA

Nancy Fisher, RN, MD, MPH
Chief Medical Officer
Center for Medicare & Medicaid Services, Region X
Seattle, WA

Charles Maynard, PhD
COAP Statistician
Research Professor
University of Washington
Seattle, WA

Richard C. Phillips, MD, MS, MPH
Cardiac Surgeon, Retired
Everett, WA

Terry Rogers, MD, FACP
CEO
Foundation for Health Care Quality

Gyula Sziraczky
President
ARMUS Corporation
San Mateo, CA

Jeff Thompson, MD, MPH (replacement TBA)
Chief Medical Officer
WA State Health Care Authority
Olympia, WA

Staff
Chris Bryson, MD, MS
Medical Director

Kristin Sitcov
Program Director

Appendix F - Copy of the Letter Sent from the Collaborative to COAP Management Committee

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS
P.O. Box 48380 • Olympia, WA 98504-8380 • (360) 664-7000 • Toll Free 1-800-547-6657 • www.drs.wa.gov

July 3, 2012

COAP Management Committee
Foundation for Health Care Quality
Seattle, WA

Dear Members of the COAP Management Committee:

The Bree Collaborative would like to thank you for approving our request to allow COAP data on appropriate use of percutaneous coronary interventions (PCI) to be un-blinded and shared publically, including facility-level results and the clear identification of missing documentation. Your commitment to transparency is commendable, and a necessary step towards improving the quality of care delivered in Washington State.

To achieve transparency with COAP data, the Bree Collaborative recommend a standardized process and timeline be established to share PCI results publically on a quarterly basis. To start the process, we propose four steps with target completion dates:

1) An appropriate use insufficient information report (based on rolling four quarter report, Q2 2011 through Q1 2012), by hospital, will be posted on the COAP members-only section of the COAP website.

   Target date: August 1, 2012

2) COAP will provide feedback to hospitals and tools for reducing the amount of insufficient information in their data.

   Target date: August – December 2012

3) An updated appropriate use insufficient information report (based on 4th Quarter 2012 data only), by hospital, will be given to the Bree Collaborative and hospitals to review. Hospitals will have the option to not be identified.

   Target date: April 15, 2013

4) Once hospitals have been given a chance to employ methods for improvement, and any corrections they might have made have been incorporated, an updated report (based on 4th Quarter 2012 data only) will be posted on the public section of the COAP website. The Bree Collaborative will also ask the Puget Sound Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the Puget Sound region. Hospitals will have the option to not be identified, on a quarterly basis.

   Target date: May 1, 2013

COAP Management Committee
July 3, 2012
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Attached is a sample report to help you envision how the un-blinded data would be presented. Again, thank you for your commitment to transparency and improving the quality of cardiac care in Washington State. Representatives from the Bree Collaborative are willing attend the next COAP management committee meeting on July 18th to discuss the proposed process and answer any questions you may have.

Sincerely,

Steve Hill
Chair, Bree Collaborative, on behalf of the Bree Collaborative

Attachment

cc: Chris Bryson, MD, COAP, Foundation for Health Care Quality (FHCQ)
Kristin Sitcov, COAP, FHCQ
Rachel Quinn, Bree Collaborative, FHCQ

Members of the Bree Collaborative

Roki Chauhan, MD, Premera Blue Cross
Susie Dade, Puget Sound Health Alliance
Gary Franklin, MD, WA State Labor and Industries
Stuart Freed, MD, Wenatchee Valley Medical Center
Tom Fritz, Inland Northwest Health Services
Joe Gifford, MD, Regence Blue Shield
Rick Goss, MD, Harborview Medical Center
Mary Gregg, MD, Swedish Medical Center
Anthony Haftel, MD, Franciscan Health Systems
Steve Hill, Bree Collaborative Chair
Jodi Joyce, RN, Legacy Health
Theresa Helle, The Boeing Company (for Greg Marchand)
Robert Mecklenburg, MD, Virginia Mason Medical Center
Robyn Phillips-Madson, Pacific NW University of Health Sciences
Carl Olden, MD, Pacific Crest Family Medicine
Mary Kay O'Neill, MD, CIGNA
John Robinson, MD, First Choice Health
Terry Rogers, MD, Foundation for Health Care Quality (FHCQ)
Eric Rose, MD, Fremont Family Medical
Kerry Schaefer, King County
Bruce Smith, MD, Group Health Cooperative
Jay Tihinen, Costco
Jeff Thompson, MD, WA Health Care Authority
Peter Valenzuela, MD , PeaceHealth

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[vi] Patel MR, Dehmer GJ, Hirshfeld JW, Smith PK, Spertus JA. ACCF/SCAI/STS/AATS/AHA/ASNC 2009 appropriateness criteria for coronary revascularization. J Am Coll Cardiol 2009;53(6):530-552.

[vii] Ibid.

[viii] Ibid.

[ix] Ibid.

[x] Bradley SM, Maynard C, Bryson CL. Appropriateness of Percutaneous Coronary Interventions in Washington State. *Circ Cardiovasc Qual Outcomes*. 2012; published online.

[xi] Ibid.

[xii] Chan PS, Patel MR, Klein LW, Krone RJ, Dehmer GJ, Kennedy K, Nallamothu BK, Weaver WD, Masoudi FA, Rumsfeld JS, Brindis RG, Spertus JA. Appropriateness of percutaneous coronary intervention. *JAMA*. 2011;306:53–61.

[xiii] Bradley SM, Maynard C, Bryson CL. Appropriateness of Percutaneous Coronary Interventions in Washington State. *Circ Cardiovasc Qual Outcomes*. 2012; published online.

[xiv] Ibid.

[xv] Ibid.

[xvi] Ibid.