Cardiology Quality Improvement Summary
March 22, 2016 – DRAFT

**Division Quality Leads**
Kim Eagle
Jim Froehlich

**QI Priorities**
- Risk adjusted outcomes for heart failure and myocardial infarction (specifically, accurate coding)
- 30 day readmissions, including transition to home
- Cost of care, specifically understanding what high cost drivers are
- Using data to refocus efforts on areas that matter

**Highest Volume Conditions**

*Inpatient Only*
1. Acute and chronic coronary artery disease
2. Heart failure
3. Cardiac arrhythmia conduction disorders

*All Patients (Inpatient and Outpatient)*
1. Atrial fibrillation
2. Heart failure
3. Atherosclerosis
4. Valvular disorders

**Quality Projects**

**Current Work**
- Reducing unnecessary variation in ECHO
  → Lead: Ted Kolias
- Atrial fibrillation guideline implementation
  → Lead: Jim Froehlich with Tom Crawford
- Quality, safety, and efficiency for interventional cardiology
  → Leads: Stan Chetcuti and Hitinder Gurm
- Quality, safety, and efficiency of arrhythmia procedures
  → Lead: Hakan Oral
- Safety quality efficiency of peripheral vascular interventions
  → Lead: Mike Grossman
- Quality of anticoagulation
  → Lead: Jim Froehlich
- Inpatient outcomes
  → Lead: Hitinder Gurm
- Patient and family centered bedside rounding
  → Lead: Kim Eagle
- Outpatient quality measures
  → Leads: Todd Koelling (HF), Mel Rubenfire and Kim Eagle (coronary disease), Mike Grossman (CVC Clinic)
- Transitions to home pilot using mobile technology
  → Lead: Todd Koelling
- Improving clinic access
  → Lead: Jim Froehlich
- Reducing unnecessary variation in ECHO
- Assessment of right ventricular size and function
  → Lead: Ted Kolias
- MOC Part II three times per year modules
  → Lead: Kim Eagle and Mike Shea

**BCBS Collaborative Quality Initiatives**
- BCBSM Cardiovascular Consortium – Percutaneous Coronary Intervention
- BCBSM Cardiovascular Consortium – Vascular Interventions Collaborative
- Michigan Anticoagulation Quality Improvement Initiative

**Quality Groups and Committees**
- Monthly M&M for inpatient, catheterization, and electrophysiology
- David Pinksy and Kim Eagle review each inpatient death

**Institutional Quality Roles with Division Lead**
- Assistant Chair for Quality and Innovation
  → Leads: Jim Froehlich

**Potential Projects**
- TBD
Measurement

Peer Review

Rate-Based Indicators
• Covered in regularly review data

Case-Based Indicators
• Covered in regularly review data

Registries
• IRAD (CMS)
• TAVR
• NCDR ICD (CMS)
• PCI (BCBS)
• Peripheral vascular intervention (BCBS)
• Pace makers
• Right heart catheterization and RV biopsy (internal)
• Atrial fibrillation ablation (internal)
• NCDR STS/TVT
• NCDR CathPCI

Regularly Reviewed Data

PACE
• ALOS, readmissions

QMP
• Working to make left ventricular ejection fraction and NY heart association class regularly available in MiChart
• Working to have regular reports on adjusted mortality for heart failure and myocardial infarction
• Working to have reliable cost data
• Meet quarterly with Steve Bernstein

Dashboards and Regular Reports
• CVC dashboard (managed by Jamie Beach)
• Quarterly EP and Cath reports
• Interventional cardiology (Quarterly)
• Arrhythmia (Quarterly)
• Echo (choose a problem to work on quarterly)
• Heart failure

Choosing Wisely
1. Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
2. Don’t perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.
3. Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
4. Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
   → Status: #4 is mandated by many payers, faculty are covering each of these carefully (covered in grand rounds twice in last year)

Barriers and Challenges
• Accurate data: difficult to obtain and understand what is has and has not been adjusted for. Would like to be able to regularly review and disseminate to faculty with action plans for improvement.
• Cost: do not know what the cost of providing care is, which makes it difficult to reduce costs.

Of the high volume and specialty conditions listed above, are there any gaps that should be addressed based on current performance or do you have any of interest in enhanced quality improvement activities?
• Always have an interest in QI activities. See current gaps as risk adjusted mortality for HF and AMI, readmissions, and cost.

Are there other quality issues of concern not captured in this document (e.g., patient satisfaction, overuse of diagnostic testing, etc.)?
• No