

**BLUE CROSS AND BLUE SHIELD ASSOCIATION  
THE BLUE DISTINCTION CENTERS FOR CARDIAC CARE®  
REQUEST FOR INFORMATION FOR 2009 MID-POINT DESIGNATIONS**

General Information

1. Does your facility participate in the Quality Campaigns of the Institute for Healthcare Improvement (IHI) with a commitment to patient safety?       YES     NO

1a. If yes, which of the following interventions does your facility participate in?

- Deploy Rapid Response Teams
- Prevent Central Line-Associated Bloodstream Infection
- Improved Care for Acute Myocardial Infarction
- Prevent Surgical Site Infection
- Prevent Adverse Drug Events (ADE)
- Prevent Ventilator-Associated Pneumonia
- Prevent Harm from High-Alert Medications
- Reduce Surgical Complications
- Prevent Pressure Ulcers
- Reduce Methicillin-Resistant *Staphylococcus aureus* (MRSA) infection
- Deliver Reliable, Evidence-Based Care for Congestive Heart Failure
- Get Boards on Board
- World Health Organization (WHO) Surgical Safety Check List
- Prevent Catheter-Associated Urinary Tract Infections
- Link Quality and Financial Management: Strategies to Engage the Chief Financial Officer and Provide Value for Patients

2. Does your facility publicly report on The Leapfrog Group's Web site via The Leapfrog Group Quality and Safety Hospital Survey?

YES     NO

2a. Please mark your facility's Leapfrog Hospital Survey status for each of the following Leaps?

Leap 1 Computerized Physician Order Entry (CPOE)

- Not Reporting
- In Progress
- Fully Implemented

Leap 2 Intensive care unit managed by intensivists (IPS)

- Not Reporting
- In Progress
- Fully Implemented

Leap 3 High Risk Treatments

Coronary Artery Bypass Graft (CABG)

- Not Reporting
- In Progress
- Fully Implemented

Percutaneous Coronary Intervention (PCI)

- Not Reporting
- In Progress
- Fully Implemented

Leap 4 Safe Practice Score

- Not Reporting
- In Progress
- Fully Implemented

3. If your facility does not publicly report to Leapfrog, indicate which of the following initiatives your facility participates in. This initiative should be one which encourages the sharing of best practices, incorporates data feedback for objective analysis, and promotes collaborative improvement of your facility and its processes.

- Not Applicable, reporting to Leapfrog
- Alabama Hospital Quality Initiative (AHQI)
- Washington State Clinical Outcomes Assessment Program (COAP)
- Coronary Council Meeting of the Midwest
- Northern New England Cardiovascular Disease Study Group
- Pittsburgh Regional Healthcare Initiative (PRHI)
- Pennsylvania Health Care Cost Containment Council (PHC4)
- Pennsylvania Health Care Quality Alliance (PHCQA)
- Puget Sound Health Alliance
- Blue Cross of Idaho's Hospital Quality Pay for Performance Initiative
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
- Other

3a. Name of your facility's other quality, safety, and affordability initiatives?

4. Which of the following healthcare informatics applications does your facility use?

- University Health System Consortium (UHC)
- Premier Clinical Advisor
- None
- Other

4a. Other application (Please specify)

5. Estimate the proportion of your provider groups that have current contracts with the local BlueCross and/or BlueShield Plan. Indicate which category most closely fits by placing an "X" for each Provider Type in the table below.

Provider Type	None	Some	All
Anesthesiology			
Cardiac Surgery			
Cardiology			
Diagnostic Radiology			
Interventional Cardiology			
Pathology			

6. Does your facility participate in the American Heart Association (AHA)'s Get With The Guidelines<sup>SM</sup> (GWTG) - Heart Failure (CHF) Program? (Facility may check more than one checkbox)

YES  NO

6a. Please mark your facility's current level of recognition that has been achieved.

- Participating GWTG-HF Hospital
- Bronze (Initial) Performance Achievement Award
- Silver (Annual) Performance Achievement Award
- Gold (Sustained) Performance Achievement Award

7. Does your facility have a formal continuous quality improvement (CQI) program in place for CARDIAC services?

YES  NO

Please note: You may be required to provide documentation of your process upon request.

7a. Please mark your facility's CQI program components

- Written Plan  YES  NO
- Specific to cardiology/cardiac surgery  YES  NO
- Multidisciplinary team  YES  NO
- Quarterly team meetings with minutes  YES  NO
- Indicators for the improvement of processes for treatment of emergent patients  YES  NO

8. Does your facility maintain a summary report of Quality Improvement (QI) initiatives including documentation of outcomes, e.g., dashboard?

YES  NO

9. Does your facility obtain and evaluate overall patient satisfaction?

YES  NO

10. Does your facility obtain and evaluate patient satisfaction specific to CARDIAC CARE with the results reported to the cardiac team?

YES  NO

11. Does your facility, or the facility you refer cardiac rehab patients to, have the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) Cardiac Rehabilitation Program Certification?

YES  NO

12. Does your facility track transitions of care for patients discharged from an inpatient setting to another setting, (e.g., home, cardiac rehab facility) using a formal method? (e.g., NQF 3-Item Care Transition Measure [CTM-3])

YES  NO

13. Does your facility accept the Association of American Medical Colleges' (AAMC) Principles for Protecting Integrity in the Conduct and Reporting of clinical trials?

Information can be found at the Association of American Medical Colleges (AAMC)'s Web site

<http://www.aamc.org/research/clinicaltrialsreporting/start.htm>.

YES  NO

13a. Which of the following consensus principles for clinical trials does your facility follow?

Publication and Public Availability of Research Results

Registration of Clinical Trials

Have a lead investigator and steering committee to represent the full body of investigators

Establish a publication and analysis committee

Follow AAMC guidelines for individual publication

Follow AAMC guidelines for authorship

14. Does your facility participate in the Action Registry<sup>®</sup>-Get With The Guidelines<sup>™</sup> (GWTG) – Coronary Artery Disease (CAD) Registry?

YES  NO

15. Are implantable cardioverter defibrillators (ICDs) being placed at your facility?

YES  NO

16. Does your facility participate in the NCDR™ ICD Registry™ for ALL patients that receive implantable cardioverter defibrillators?

YES  NO

17. Does your facility use a formal credentialing process for ICD implantation privileges based on generally accepted credentialing criteria from a credible expert or national organization? (e.g., Heart Rhythm Society 2004 Clinical Competency Statement: Training Pathways for Implantation of Cardioverter Defibrillators (ICD) and Cardiac Resynchronization (CRT) Devices).

YES  NO

18. Please complete the following table by physician type with the number of physicians performing ICD implantations at your facility and the volume of ICD procedures performed by each physician type for the timeframe of January 1, 2008 through December 31, 2008. Physicians should be entered only once within this table. Enter "0" for any physician types that do not perform ICD implantations. Enter "Unknown" in each data entry field if physician types who perform ICDs are not known and proceed to question 19.

	Physicians with subspecialty training in Electrophysiology	Physicians with subspecialty training in Thoracic or cardiothoracic Surgery	Physicians without formal training	Total for facility
Total number of physicians by category				
Total volume of procedures performed by physician category for timeframe of January 1, 2008 through December 31, 2008.				

19. If you provided numerical values for question 18, please enter N/A in the fields below. If you entered "Unknown" for any part of question 18, then please complete the following table with the TOTAL number of physicians performing ICD implantations at your facility and the TOTAL volume of ICD procedures performed for the timeframe of January 1, 2008 through December 31, 2008.

	Total for Facility
Total number of physicians performing ICD implantations	

Total volume of ICD procedures performed for timeframe of January 1, 2008 through December 31, 2008.	
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20. Provide your facility's volume for the timeframe of January 1, 2008 through December 31, 2008 for the following procedures. (If this procedure is not performed, enter "0" in each data entry field).

Diagnostic cardiac catheterizations	<input type="text"/>
Electrophysiology diagnostic studies (e.g. EP Study – Tilt Table Test)	<input type="text"/>
Electrophysiology therapeutic procedures (e.g. Pacemaker Implantation, ICD Insertion, Cardiac Ablation)	<input type="text"/>
Ventricular Assist Devices (VADs)	<input type="text"/>
Heart Transplantation	<input type="text"/>

### Cardiac Medical

**Complete questions 21-27 regarding your Acute Myocardial Infarction (AMI) patients.**

21. Does your facility have or refer patients to a STRUCTURED PROGRAM on Smoking Cessation for patients diagnosed with AMI? (e.g., Nicotine Anonymous, North American Quitline Consortium, American Cancer Society's Quitline®, <http://www.smokefree.gov>, National Network of Tobacco Cessation Quitlines, American Legacy Foundation's Great Start).

YES  NO

22. What is your facility's current 30 day Risk-Adjusted AMI Mortality rate as reported by your Quality Improvement Organization (QIO) for the Centers for Medicare and Medicaid Services (CMS) (e.g., The Joint Commission, QualityNet, and Hospital Compare)?

\_\_\_\_\_ %

*Data provided in questions 23-27 are based on Acute Myocardial Infarction (AMI) patients' included within the National Hospital Quality Measures as described on CMS' Web site Hospital Compare ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)).*

23. Report the number of AMI patients who received aspirin at ARRIVAL (within 24 hours before or after hospital arrival) for the most current reported timeframe (AMI-1).

Number of AMI patients who received aspirin at ARRIVAL  
(within 24 hours before or after hospital arrival) \_\_\_\_\_

Total number of eligible AMI patients \_\_\_\_\_

24. Report the number of AMI patients who were prescribed aspirin at hospital DISCHARGE for all patients discharged for the most current reported timeframe (AMI-2).

Number of AMI patients who were prescribed aspirin at DISCHARGE \_\_\_\_\_

Total number of AMI eligible patients \_\_\_\_\_

25. Report the number of AMI patients prescribed Angiotensin-Converting Enzyme (ACEI) or Angiotensin-Receptor Blockers (ARB) for left ventricular systolic dysfunction (LVSD) at facility DISCHARGE for all patients discharged for the most current reported timeframe (AMI-3).

Number of AMI patients prescribed ACEI or ARB for LVSD at DISCHARGE \_\_\_\_\_

Total number of eligible AMI patients with LVSD \_\_\_\_\_

26. As of April 1, 2009, CMS retired measure AMI-6, known as, "Acute myocardial Infarction patients without beta-blocker contraindications who received a beta-blocker within 24 hours after hospital arrival." While this data was collected and scored in the BDC for Cardiac Care 2008 RFI cycle, it will not be collected nor scored in the BDC for Cardiac Care 2009 Mid-Point RFI cycle. The one point for this has been relocated to Question #14 regarding participation in the NCDR™ ACTION Registry™. Please check YES, indicating that you have read this statement.

YES  NO

27. Report the number of AMI patients who were prescribed a Beta Blocker at DISCHARGE for all patients discharged for the most current available timeframe (AMI-5).

Number of AMI patients prescribed a Beta Blocker at DISCHARGE \_\_\_\_\_

Total number of eligible AMI patients \_\_\_\_\_

**Complete questions 28-32 regarding your Heart Failure (HF) patients.**

28. Does your facility have or refer patients to a STRUCTURED PROGRAM on Smoking Cessation for patients diagnosed with Heart Failure? (e.g., Nicotine Anonymous, North American Quitline Consortium, American Cancer Society's Quitline®, <http://www.smokefree.gov>, National Network of Tobacco Cessation Quitlines, American Legacy Foundation's Great Start).

YES  NO

29. What is your facility's current 30 day Risk-Adjusted Heart Failure Mortality rate as reported by your Quality Improvement Organization (QIO) for CMS (e.g., The Joint Commission, QualityNet, and Hospital Compare)?

\_\_\_\_\_ %

Data provided in questions 30-32 will be based on Heart Failure (HF) patients' National Hospital Quality Measures as described on CMS' Web site Hospital Compare ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)).

30. Report the number of HF patients prescribed Angiotensin-Converting Enzyme (ACEI) or Angiotensin-Receptor Blockers (ARB) for Left Ventricular Systolic Dysfunction (LVSD) at facility DISCHARGE for all patients discharged for the most current reported timeframe (HF-3).

Number of HF patients prescribed ACEI or ARB at DISCHARGE \_\_\_\_\_

Total number of HF patients with LVSD \_\_\_\_\_

31. Report the number of HF patients with documentation in the facility record that Left Ventricular Systolic (LVS) Function was evaluated before arrival, during hospitalization, or is planned for after discharge for all patients discharged in the most current reported timeframe (HF-2).

Number of HF patients with documented assessment of LVS function \_\_\_\_\_

Total number of HF patients \_\_\_\_\_

32. Report the number of HF patients with documentation that they or their caregivers were given written discharge instructions or other educational material addressing ALL of the following: a. Activity level, b. diet, c. discharge medications, d. follow-up appointment, e. weight monitoring, and f. what to do if symptoms worsen for all patients discharged in the most current reported timeframe (HF-1).

Number of HF patients with documented discharge instructions \_\_\_\_\_

Total number of HF patients discharged to home or home care \_\_\_\_\_

### Cardiac Catheterization Services

33. Does your facility participate in the American College of Cardiology's (ACC) D2B (Door to Balloon) Alliance™?

YES  NO

34. Does your facility track and trend rates of normal or insignificant Coronary Artery Disease (CAD) (i.e., <50% stenosis) results on diagnostic cardiac catheterizations for each physician?

YES  NO

35. Does your facility report to the ACC NCDR™ CathPCI registry®, Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC<sup>2</sup>) registry, or the New York State Percutaneous Coronary Interventions Reporting System (PCIRS) for the indicated timeframes? (Please Note: The NCDR

CathPCI has removed “PCI procedure Success”, Executive Summary #6, as a metric. This Executive Summary metric received one core point in the Cardiac Care 2008 RFI. This metric has been removed from the Cardiac Care 2009 Mid-Point RFI, and the point from this question has been reallocated to Question #13 – AAMC Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials).

YES. Please ATTACH the appropriate data registry report as indicated below:

- Attach ACC NCDR™ CathPCI Registry® 2009Y1 Report (April 1, 2008 through March 31, 2009) or 2009Y2 Report (July 1, 2008 through June 30, 2009) and answer Questions 35a through 35g with the data from this report.

OR

- MICHIGAN facilities reporting to BMC<sup>2</sup> MUST attach the BMC<sup>2</sup> report for April 1, 2008 through March 31, 2009, and answer Questions 35a through 35g. (Please note that questions 35a and 36 are not included in the BMC<sup>2</sup> report. For these questions, enter the requested data tracked by the facility for the same time frame noted in the submitted BMC<sup>2</sup> report). IF your facility reports to both the ACC NCDR™ CathPCI Registry® and BMC<sup>2</sup>, then ONLY attach the BMC<sup>2</sup> report for April 1, 2008 through March 31, 2009, and answer Questions 35a through 35g. IF your facility does not report to BMC<sup>2</sup> or does not have the BMC<sup>2</sup> report, then attach the ACC NCDR™ CathPCI Registry® 2009Y1 (or 2009 Y2) Report and answer questions 35a through 35g with the data from this report.

OR

- NEW YORK State facilities should attach the NCDR™ CathPCI Registry® 2009Y1 (or 2009Y2) Report. If the NCDR™ CathPCI Registry® Report is not available, then attach the facility’s New York State PCIRS report for the data available for the most recent 12 month period, and answer Questions 35a through 35g.

NO, my facility does not report to any of the listed registries.

35 a. Provide the proportion of non-obstructive CAD at your facility (NCDR Executive Summary #9).  
(Note: if a vessel is not assessed, then stenosis is assumed as 0).

Sum of all vessels with percentage of stenosis < 50% \_\_\_\_\_

Sum of Diagnostic Catheterization procedures with Left Heart Catheterization \_\_\_\_\_

Proportion of patients having a left heart catheterization where all coronary branches have < 50% stenosis \_\_\_\_\_% Column

35b. Report the number of primary (ST Segment Elevation Myocardial Infarction - STEMI) PCI patients with door to balloon (D2B) time ≤ 90 minutes (NCDR Executive Summary #1).

Total number of patients that had PCI \_\_\_\_\_

Percentage of primary (STEMI) PCI patients with D2B  $\leq$  90 minutes. \_\_\_\_\_%

35c. Report risk adjusted PCI mortality rate (elective and emergent) (NCDR Executive Summary #2)

\_\_\_\_\_%

35d. Report the number of PCI patients with at least one incidence of vascular complication (NCDR Executive Summary #3).

Total number of patients receiving PCI \_\_\_\_\_ Percentage of Incidence of Vascular Complications \_\_\_\_\_%

35e. Report number of PCI patients who received any type of stent and had thienopyridine (such as clopidogrel or ticlopidine) prescribed at discharge (NCDR Executive Summary #4).

Total number of PCI patients that received stents \_\_\_\_\_

Percentage of Eligible PCI patients who received any type of stent and had thienopyridine (such as clopidogrel or ticlopidine) prescribed at discharge \_\_\_\_\_%

35f. What is the mean total length of hospital stay (in days) for all patients having at least one PCI during admission (NCDR Executive Summary #7)? \_\_\_\_\_ Days

35g. What is the mean number of stents per PCI procedure at your facility (NCDR Executive Summary #8)? \_\_\_\_\_ stents

36. Provide the proportion of vascular complications at your facility (NCDR Executive Summary #10).

Sum of any Vascular Complication \_\_\_\_\_

Sum of Diagnostic Catheterization procedures (excluding PCI) with Left Heart Caths \_\_\_\_\_

Proportion of patients having a diagnostic catheterization procedure with at least one vascular complication \_\_\_\_\_%

37. Does your facility have a policy which provides 24/7 primary PCI staff coverage?

YES  NO

37a. What is the stated response time in your facility's policy for the 24/7 on-call surgical team to provide PCI staff coverage?

Response time 30 minutes or less

\_\_\_\_\_

\_\_\_\_\_

Response time 31 to 60 minutes

Response time  $\geq$  61 minutes

38. Report number of cardiologists at your facility that are currently performing PCI, who are board certified in interventional cardiology.

Total number of cardiologists certified in interventional cardiology currently performing PCIs \_\_\_\_\_

Total number of cardiologists currently performing PCI's \_\_\_\_\_

39. Report number of cardiologist at your facility that are currently performing at least 75 PCI procedures per year (may count PCI's performed outside your facility).

Number of Cardiologist performing  $\geq$  75 PCI's/year \_\_\_\_\_

Total number of cardiologists currently performing PCI's \_\_\_\_\_

40. Report total number of readmissions within 30 days on patients that have received a PCI from January 1, 2008 through December 31, 2008. Example: A patient who received a PCI on January 1, 2008 and who subsequently was admitted on January 5, 2008, January 10, 2008, and January 15, 2008 for ANY reason would be calculated as 3 readmissions for 1 patient that had a PCI. (Please enter NA if your facility does not track this data).

Number of PCI readmissions within 30 days January 1, 2008 through December 31, 2008 \_\_\_\_\_

Total number of patients receiving PCI January 1, 2008 through December 31, 2008 \_\_\_\_\_

### Cardiac Surgical Services

41. Report the number of surgeons at your facility that are currently performing a minimum of 75 cardiac surgical procedures a year (May count cardiac surgeries performed by surgeon outside your facility).

Number of surgeons performing minimum 75 cardiac surgeries/year \_\_\_\_\_

Total number of surgeons that are currently performing cardiac surgeries \_\_\_\_\_

42. Report the number of surgeons that are currently performing cardiac surgical procedures that are board certified in cardiothoracic surgery.

Number of surgeons certified in cardiothoracic surgery \_\_\_\_\_

Total number of surgeons that are currently performing cardiac surgeries \_\_\_\_\_

43. Report the number of readmissions within 30 days on patients that have received an isolated CABG for the timeframe of January 1, 2008 through December 31, 2008. Example: A patient who received an isolated CABG on January 1, 2008 and who subsequently was admitted on January 15, 2008, January 20, 2008 and January 25, 2008 for any reason would be calculated as 3 readmissions for 1 patient who had a CABG. (Please enter NA if your facility does not track this data).

Number of readmissions within 30 days of CABG January 1, 2008 through December 31, 2008 \_\_\_\_\_

Total number of patients receiving CABG January 1, 2008 through December 31, 2008 \_\_\_\_\_

44. Does your facility have a policy which provides for a 24/7 on-call surgical team to perform emergency cardiac surgery (CABG)?

YES  NO

44a. What is the stated response time in your facility's policy for the 24/7 on-call surgical team to provide emergency cardiac surgery (CABG) staff coverage?

- Response time of 60 min or less
- Response time 61 to 120 min
- Response time  $\geq$  121 min

45. Is your facility able to provide a Facility-Level or Participant-Level Society of Thoracic Surgeon's (STS) Composite Quality STAR rating for the 3<sup>rd</sup> Harvest (July 1, 2008 through June 30, 2009) or for the timeframe of January 1, 2008 – December 31, 2008? The most recent data in the 3<sup>rd</sup> Harvest is preferred, but full year 2008 will be accepted.

YES  NO

45a. If YES, please attach the one page containing the Composite Quality STAR rating. If both facility-level and participant-level reports are available, please attach the one page Composite Quality STAR rating from the facility-level report.

46. Please describe any additional program strengths or innovative approaches to Cardiac Care services that you would like to share with us. Utilize this space for any comment, additional information, or attachment that you were not able to submit in the Survey.