ACE Advisor

Table of Contents

What the Pennsylvania Exceptions Committee Decision Means for Interventional Cardiology

A Message from Our CMO
By Bonnie H. Weiner, MD, MSEC, MBA, FSCAI, FACC,
ACE Chief Medical Officer

Congratulations and welcome to all eight of our Commonwealth of Pennsylvania PCI Exception Committee ACE accredited facilities! We believe that you are important in the interventional cardiology quality improvement process in the US. You have utilized ACE accreditation to standardize your cardiac catheterization laboratory (CCL) with quality metrics for all catheterization laboratories, so that your institutions can provide elective percutaneous coronary intervention (PCI) services, without onsite open heart surgery (OHS) to local residents.

This initiative has resonated with other states, and several have responded to the same vision, commitment and capabilities by contacting ACE to discuss how they can work with their low volume or rural CCLs to provide elective PCI services, without onsite OHS to their local residents. Local treatment may also be beneficial for families, because it means that caregivers and relatives of the patient will be able to participate and support their family member at a local facility.

To provide background on this initiative, in January, 2014, the Commonwealth of PA stated that Pennsylvania CCLs without onsite open heart surgery that wish to perform elective

PCI at their facilities must be accredited. In addition, they stated that the accrediting organization must be state department or health-approved with standards at least equal to those of the Accreditation for Cardiovascular Excellence (ACE).

"ACE was selected at UPMC East because of their high standards, their leadership in the industry and because they are sponsored by ACC and SCAI," stated Laurie Rieger, RT (R) (CV), Manager of Cardiovascular Services. "The state has a goal to deliver the highest quality invasive cardiovascular care to Pennsylvania residents. ACE is a partner with our cardiac catheterization lab and the state to set the standard for quality in Pennsylvania."

"We chose ACE for the accreditation process because it is the premier provider of Cath/PCI accreditation. Under the sponsorship of SCAI and ACCF, ACE sets the highest standards of quality in the provision of invasive cardiovascular care," said Al Zoda, MD, FACC, Cardiologist with Mount Nittany Physician Group.

The momentum continues as the seventh and eighth PA PCI programs to achieve ACE accreditation join six other PA hospitals. The first five PA facilities to achieve ACE accreditation earlier this year under the Commonwealth's exception rules include:

- Armstrong County Memorial Hospital (ACMH) in Kittanning, PA
- Monongahela Valley Hospital in Monongahela, PA
- Mount Nittany Medical Center in State College PA
- University of Pittsburgh Medical Center (UPMC) East in Pittsburgh, PA
- UPMC McKeesport in McKeesport, PA

Holy Redeemer Hospital in Meadowbrook, PA, Meadville Medical Center (MMC) in Meadville, PA and Chambersburg Hospital in Chambersburg, PA are the sixth, seventh and eighth PA facilities, respectively, to complete the ACE accreditation process in an effort to expand PCI services under new state regulations. The next step is for Commonwealth of Pennsylvania Exceptions Committee to provide full approval for each facility.

One additional PA facility is completing the final stages of ACE accreditation. To date, 9 of 17 PA facilities -- more than half of those without OHS backup and with the opportunity to expand elective PCI services if they become accredited -- have chosen to partner with ACE. Congratulations and welcome!

Changes at ACE: New PVI Standards, Becker's List of Top 100 Hospitals with Great Heart Programs, Congenital Heart Accreditation

By Mary Heisler, RN, BA, ACE Executive Director

2014 has seen many changes at ACE. New PVI Standards were launched by ACE at the 2014 Vascular Interventional Advances (VIVA 14) Annual Conference in Las Vegas,

NV on November 4, 2014. Along with our current accreditation programs in Carotid Artery Stenting Diagnostic Catheterization and PCI, we announced new accreditation and external quality review services for four catheter-based cardiovascular procedures, including, Electrophysiology, Congenital Heart, Transvalvular Therapies and PV Interventions.

The Role of ACE Accreditation in Peripheral Vascular Disease

Our new video features **Christopher White, MD, MSCAI, FACC, FAHA, FESC, ACE Secretary and Medical Director of the John Ochsner Heart & Vascular Institute at the Ochsner Clinical School in New Orleans, LA**, and explores the value of ACE accreditation for PV Interventions. According to Dr. White, catheterization laboratories should consider peripheral vascular services as essential elements of comprehensive care. "Our patients are symptomatic and they need to be helped," Dr. White said. "ACE acts like a coach," Dr. White explains in the video.**"ACE can coach you to be the best possible team to provide the best possible care for your patients."**

We are proud to be referenced as a pioneer of accreditation standards in the new health policy statement from the American College of Cardiology, American Heart Association, and Society for Cardiovascular Angiography and Interventions (ACC/AHA/SCAI). Download this statement here.

In October, four ACE-accredited facilities were named in Becker's List of Top 100 Hospitals with Great Heart Programs. For these four hospitals, ACE accreditation is part of a strategic, long-term commitment to best practices in cardiac care, as defined by experts in the field of interventional cardiology and validated by external peer review. The four ACE-accredited hospitals included in the Top 100 list are:

- Carilion Clinic in Roanoke, Virginia
- Emory University Hospital in Atlanta, Georgia
- Northeast Georgia Medical Center in Gainesville, Georgia
- Scott & White Hospital (now Baylor Scott & White Health) in Temple, Texas

As these acknowledgements illustrate, ACE is a consistent presence in the world of

cardiovascular excellence. Is your program next? Facilities seeking ACE accreditation or reaccreditation can obtain more information and complete the application process at http://www.cvexcel.org.

National Trends on Quality Care: CV Summit, ISET, CRT, NCDR, ACC

By Marcia Schallehn, ACE Director, Strategic Marketing

Come visit ACE at several major cardiovascular meetings during the first few months of 2015 to learn about new standards for PVI and national trends on quality cardiovascular care. Members of the ACE team and Board of Directors will be moderating and presenting at multiple sessions on national trends in high-quality care in the areas of cardiac catheterization, peripheral vascular interventions (PVI), congenital heart disease, and other areas of interventional cardiovascular care. Be sure to follow our meeting coverage on Twitter (@ACE_CVEXCEL) and stop by the ACE booth at each meeting for the most current information on quality sessions. ACE looks forward to seeing you there!

Cardiovascular Summit 2015 (CV Summit)

The 2015 Cardiovascular Summit will be held January 22-24, 2015, at the Hilton Orlando Bonnet Creek/Waldorf Astoria in Orlando, Florida. Sponsored by the American College of Cardiology (ACC), the annual Cardiovascular Summit invites all members of the cardiovascular team to discuss and develop strategies to address new challenges in delivering high-quality, cost-effective cardiovascular care.

With the theme of this year's meeting, "Solutions for Thriving in a Time of Change," the 2015 Cardiovascular Summit will focus on 4 key areas:

- Operations and Leadership: Mandatory Strategies for Brutal Times
- Managing to a New Financial Reality: The Unyielding Truth
- Quality and Data: Getting Credit for Doing the Right Thing
- Creating Blueprints for Progress: Combining Operations, Leadership, Data and Quality

Ralph G. Brindis, MD, MPH, MACC, FSCAI, Past President of ACC and ACE Vice Chair, will moderate the special session on quality, "Quality and Data: Getting Credit for Doing the Right Thing." Dr. Brindis will also share his perspective on appropriate use criteria (AUC) in the presentation, "AUC: How Can We Embed This into Our Work Flow?"

Learn more about the 2015 Cardiovascular Summit, and register here:

International Symposium on Endovascular Therapy (ISET) 2015

The 2015 ISET annual meeting will be held January 31-February 4, 2015, at the Diplomat Hotel in Hollywood, Florida. For 27 years, the ISET annual meeting has attracted specialists and support staff trained in vascular surgery, interventional cardiology, and vascular medicine to share new data and best practices related to the delivery of cardiovascular care.

The 2015 ISET annual meeting agenda includes the Nurses and Technologists Symposium: Innovations in Cardiac and Vascular Care, to be held on January 31, 2015.

As the first major vascular meeting of the year, ISET provides a forum for cardiovascular team members to plan the business and clinical goals for the year ahead.

Visit the ISET website for the complete scientific program and more information about the ISET 2015 annual meeting here:

Cardiovascular Research Technologies (CRT)

CRT will take place from February 21 - 24, 2015 at the Omni Shoreham hotel in Washington DC. The conference will feature 13 concurrent meetings in six specialty tracks: Coronary, CRT Valve & Structural, CRT Endovascular, Atherosclerosis & Research, Technology & Innovation, and Nurses & Technologists.

Ralph G. Brindis, MD, MPH, MACC, FSCAI, Past President of ACC and ACE Vice Chair, will moderate and participate in several sessions at CRT:

CRT Valve and Structural II Track -Monday, February 23, 2015

- 3:31 pm Panel Discussion - TAVR Clinical Trials

FDA Town Hall Track Tuesday, February 24, 2015:

- 8:35 am Panel Discussion: What are Priorities for FDA? If These Were Met, Would Sponsors do Their Studies in the U.S?
- 9:51 am Panel Discussion: What has Changed within the FDA and How Will this Impact Clinical Research and Device Evaluation?
- 11:13 am Public Reporting: What You Need to Know
- 11:34 am Panel Discussion: How to Improve the Efficiency of Clinical Trials in the U.S.
- 12:30 pm Lunch Symposium with Industry and Academia - Impact of ACA on Cardiology
- 1:20 pm Panel Discussion with Audience Q&A
- 1:43 pm Session IV: Challenges To Device Innovation: Rapid Fire Hot Topics For FDA
- 1:44 pm Hot Topic I: LAA Closure Lessons From The Pivotal Studies And 3 Advisory Panels

Mary Heisler, RN, BA, ACE Executive Director, will speak and participate as a panelist in the Cardiovascular Professionals' Symposium for Nurses & Technologists

SESSION V - Improving For Today and Tomorrow - Sunday, February 22, 2015

- 4:25 pm Cath Lab Accreditation and Quality
- 4:35 pm Panel Discussion

For more information, click here.

The National Cardiovascular Data Registry (NCDR.15) 2015 Annual Conference

The 2015 NCDR annual conference will be held March 12-13, 2015, at the Sheraton San Diego Hotel & Marina in San Diego, California. NCDR.15 is geared toward physicians, administrators, and other staff interested in cardiovascular quality improvement.

The NCDR.15 program agenda will include updates and practical insights from key NCDR registries, including the CathPCI Registry® and the Peripheral Vascular Intervention (PVI) Registry®. NCDR investigators will also present new data from the IMPACT Registry®, which focuses on pediatric and adult congenital heart disease patients. Attendees will discover new tools and techniques for incorporating NCDR registry findings into quality-improvement initiatives within their own hospitals and cardiac catheterization laboratories.

Visit the NCDR website to learn more about the 2015 annual meeting. Of note, hospitals participating in the NCDR will receive one complimentary registration to NCDR.15 for each NCDR registry joined or renewed for 2015.

American College of Cardiology (ACC.15) 2015 Scientific Sessions

ACC.15 will be held March 14-16, 2015, at the San Diego Convention Center in San Diego, California. Each year, the ACC attracts the world's leading cardiovascular professionals to present state-of-the-art clinical advances with immediate and practice-changing relevance for cardiovascular care. The ACC.15 program includes specialty tracks for all members of the cardiac catheterization team: physicians, nurses, technicians, administrators, and support staff.

Several members of the ACE Board of Directors will moderate sessions and present their own insights on cardiovascular quality at ACC.15.

- Christopher J. White, M.D., FACC, MSCAI, FAHA, FESC, ACE Secretary, will moderate the session, "Appropriate Use and Quality Initiatives in Vascular Medicine and Intervention," on March 14, 2015, at 2:00 pm.
- Dr. Brindis will present the James T. Dove Lecture, "What Will a "Valuable" Cardiologist Have to do by 2020?" on March 14, 2015, at 12:25 pm.
- Gregory J. Dehmer, MD, FACC, FACP, FAHA, MSCAI, ACE Board Chair, will moderate the session on "Appropriate Use Criteria for Ischemic Syndromes," on March 15, 2015, at 3:45 pm.
- Dr. Dehmer will also present "Pitfalls in Assessing Valvular Disease in the Cath Lab," on March 16, 2015, at 12:50 pm.

Other programs of interest at ACC:

March 14, 2015 - 10:00 am: Congenital Heart Disease: Quality & Outcomes
March 15, 2015:

- 8:00 am: Transforming Care: Innovations in Delivery and Payment Systems for Cardiovascular Care
- 12:30 pm: Coming Attractions: Guidelines, Registries and Quality

March 16, 2015 -12:30 pm: Vascular Team Based Care: What Are the Essential Components for Success?

Visit the ACC website to learn more about the ACC.15 program, explore the online program planner, and plan your trip to ACC.15.

Why an FPPE and OPPE Quality Review from

ACE can Work for your Cardiac Cath Lab

By Sheree Schroeder, MSN, RN, RDCS, FASE
ACE Director, Quality Review Programs

The processes of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) are parts of a program introduced in 2007 by the Joint Commission (JCAHO) to make the decision of privileging by hospital management an objective and ongoing process. In addition, OPPE and FPPE offer important guidelines that cardiac cath lab management can actively implement to support performance improvement initiatives. In his blog, Paul Ziaya, MD, the Field Director for JCAHO, points out that OPPE metrics can be segmented for focused improvement. Dr. Ziaya provides the example of examining post-op infection rates, to evaluate practices and provide a baseline for data collection to support future programs aimed to lower infection rates.

In his article, Dr. Ziaya notes that providing data to individual physicians (especially when matched to peer or benchmark data) results in improved physician engagement in using the data for self-evaluation and practice modification. He notes that institutions which provide ongoing data access have found that many physicians will review their own data on a regular basis and begin the process of making changes to their practices on their own.

In addition, Dr. Ziaya writes that most physicians will make necessary changes when presented with data showing they are not performing at the same level as their peers. He notes that some practitioners (hopefully a small percentage) do not take appropriate action, even after reviewing the OPPE feedback. Hospitals can utilize OPPE and FPPE processes in these cases to provide records and tools for making necessary privileging decisions.

ACE provides the tools for healthcare institutions to collect meaningful data to support OPPE and FPPE over the long term. Our Quality Review program is a catalyst for positive change that is critical to the Continuous Quality Improvement (CQI) effort. ACE can customize its Quality Review services with a collaborative, success-focused approach that engages the full cardiac cath lab team.

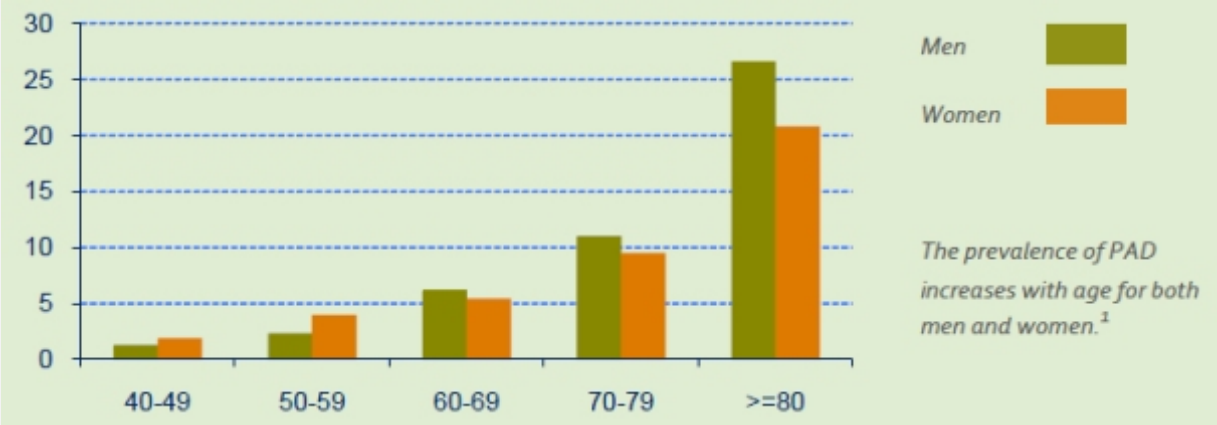
SCAI Expert Consensus Series Treatment of PAD

Excerpt from the SCAI Fall 2014 Newsletter

SCAI
The Society for Cardiovascular Angiography and Interventions Foundation

It is estimated that 8 million US patients have peripheral artery disease (PAD). Patients older than 60 represent 12-20% of this population. Overall, population awareness of PAD is estimated at 25%

Prevalence of PAD (%) by Age Group (years)



While the incidence of peripheral artery disease (PAD) is growing, there has been little expert guidance on the treatment and management of common forms of the disease. A series of expert consensus documents has been written by SCAI's Peripheral Vascular Disease (PVD) Committee and e-published this summer in Catheterization and Cardiovascular Interventions (CCI). "We are seeing an increase in PAD," states, Christopher White, MD, MSCAI, FACC, FAHA, FESC, ACE Secretary and Medical Director of the John Ochsner Heart & Vascular Institute at the Ochsner Clinical School in New Orleans, LA. According to Dr. White, catheterization laboratories should consider peripheral vascular services as essential elements of comprehensive care. "Our patients are symptomatic and they need to be helped,"

The series includes four expert consensus documents on common forms of PAD, including aorto-iliac, femoropopliteal, infrapopliteal and renal artery stenosis (RAS). **"Those of us who commonly treat patients with PAD know it can have a significant impact on quality of life, including pain and risk of limb loss or organ damage," states PVD Committee Co-chair Bruce Gray. DO, FSCAI.** Today we have safe and effective endovascular treatments to treat a greater number of patients who previously may have had few options. "These papers help interventional cardiologists better understand which patients will benefit from treatment and those for whom treatment may not be optimal."

Key Recommendations

In the first paper of the series, aorto-iliac PAD endovascular treatment, the expert panel found that patients have a success rate greater than 90% and a low mortality rate. According to the second paper in the series, revascularization with surgery or endovascular treatment is an option for those with severe infrapopliteal arterial disease, but not treating patients who are asymptomatic or mildly symptomatic. In the third paper, the expert panel noted balloon angioplasty continues to be a valid treatment option for patients with femoropopliteal disease, but it has suboptimal long-term results in some patients with areas of total occlusion or long stenoses, critical limb ischemia or diabetes. The fourth and final paper in the series discusses renal artery stenting (RAS) as an option for many patients who have historically been excluded from clinical trials, including those whose condition could not be managed with optimal medical therapy. RAS may be an option for patients with cardiac disturbance syndrome or flash pulmonary edema, patients with uncontrolled hypertension and those with significant stenoses whose blood pressure cannot be controlled with medication. "The series fills a void for expert guidance on PAD and renal artery management and is part of SCAI's ongoing commitment to help interventional cardiologists provide the best possible care for each patient's individual symptoms and condition," said Michael R. Jaff, DO, FSCAI, who chairs SCAI's PVD Committee. All four papers are available online at SCAI.org/Guidelines.

Source: Roger VL, et. al. Heart Disease and Stroke Statistics 2011 Update: A Report From the AHA Circulation 2011;123:e18-e209.

What Are You Doing With Your Registry Data?

The synopsis of this article is by courtesy of ACC

By Robert N. Vincent, MD, CM, FACC,
Chair of the ACC's IMPACT Registry Steering Committee

The ACC's IMPACT Registry is a vehicle to collect data on all pediatric and adult patients with congenital heart disease undergoing diagnostic and interventional catheterization procedures. Its key objective is to collect data to identify variability in procedures amongst institutions and operators, link variability to outcomes, assess performance, provide benchmarks and implement quality improvement initiatives. The intent is to improve the care and outcome of patients with congenital heart disease undergoing cardiac catheterization.

Quarterly reports consisting of the last 12 months of data are distributed to participating institutions. They contain center-specific data and aggregate data for all metrics and data elements. Individual institutions are able to compare their data and outcomes to aggregate data, but not to other specific institutions. We recommend centers consider the five "W's" below when evaluating the quarterly report.

Who: Who is looking at them? Unless all involved personnel are present (physicians, nurses, technicians, administrators, etc.) and active in the discussion of the report, there won't be a meaningful discussion about quality improvement. Good data are dependent on good data entry. Who is responsible for data entry and data oversight?

What: What are you looking at? Are you looking at the quality metrics and analyzing what these numbers really mean to you and your institution? Do they reflect what is happening within your institution? Are the data correct or have there been data entry errors? They can be fixed. If you identify a problem within the registry outcomes report that you think results from a programming issue, this needs to be relayed to the NCDR. Hospital feedback enhances the quality of reporting.

When: Are there regularly scheduled meetings; do all relevant parties attend? Is there a discussion and exchange of ideas or just a review of the report? Are you comparing your results to previous results and looking at areas with declining performance as well as areas showing improvement, or just comparing to benchmarked data? The intent of a regularly scheduled meeting is to keep quality on everyone's mind.

Where: Does the meeting location have access to all information needed for discussions that might occur? It is important to have access to the quarterly report, EMR, quality score cards, as well as catheterization, CT, echocardiogram, MRI reports and images, etc. When questions about specific issues are raised, is the meeting located where you can retrieve the information to answer them?

Why: Why quality improvement? The answer should be to provide patients with the best cardiovascular care possible. You should be comparing yourself to aggregate data for benchmarking, but more importantly to yourself for improvement.

It is not uncommon for centers to look at the data, compare themselves to the benchmark, see that they fall within the expected ranges, and be happy with that. An alternative is to pick one or two areas that you wish to improve and analyze these internally to see how you are doing. Quality improvement occurs over time and must be evaluated along a continuum so that these data become reflective of what is truly happening in your institution. This is particularly true for rare events that occur in uncommon cases (which are the majority of the cases that we do in congenital cardiology).

For more information about the IMPACT Registry, visit NCDR.com/IMPACT.

Join Our Mailing List!

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