Disclaimer/Comments

• This summary report is limited to the data request and response submitted to The Foundation of Healthcare Quality COAP-PCI program on January 20, 2017.

• Key points from the data are summarized, with little interpretation.

• Comments are limited to those reported in meeting minutes which have been distributed to all stakeholders identified by the CN staff.

• Refer to COAP reports submitted to CN staff for original data.

• Calculation of 95% confidence intervals was performed by statisticians employed by Virginia Mason Memorial.
Purpose for COAP-PCI data request

• “Goal is high quality outcomes. With the volumes standards that we currently see in Washington facilities, what are some of the clinical outcomes data that might be available?... How do we assure quality outcomes?”*

• “Obtain data from COAP to bring back and analyze from a comprehensive perspective with respect to proposed reduction in volume standards?”*

• “Test COAP; look at Washington outcomes vs Washington Volumes; see if reduction of volumes will have an impact on patient care”*

• Data subcommittee formed: Diane Buelt-Legacy, Chris Thompson-CHI Franciscan, Jody Corona HFPD, James McCabe – UW, Frank Fox-Providence, Tom Park-CHS, Dennis Hoover-VM Memorial, Kathy Hoffman-DOH-CN, Jan Sigman-DOH-CN

*Washington State Certificate of need Program meeting summary – August 3, 2016

• Volume data for each of the reporting 34 hospitals by year.
  • There were 37,912 PCI reported to COAP for the 3 year period
  • Total PCI volume, shows an increasing trend: Up 5.6% over the three year period

• Volumes by hospital were placed into 4 volume categories;
  • Greater than 300 PCIs/year: 16 hospitals
  • 200 to 299 PCIs/year: 6 hospitals
  • 100 to 199 PCIs/year: 6 hospitals
  • Less than 100 PCIs/year: 6 hospitals

• Volumes by PCI acuity
  • STEMI: 7,814 or 20.6%
  • Non-STEMI: 23,180 or 61.1%
  • Non-Acute: 7,017 or 18.5%
Outcome Metrics – Prefacing comments*

• Mortality data is the raw mortality rate and is not risk adjusted

• the numbers are too small to calculate a confidence interval for any one individual type of (non-mortality) adverse event...thus a composite AE was used.

• Mortality and composite adverse events confidence intervals could not be determined for non-acute PCI groupings as the volumes are too small.

• "there’s nothing about the COAP data that could ever show us a difference between 200 and 300 because 200 cases is too few a number of cases to be able to demonstrate a difference."...When looking at an individual hospital.

• The calculation of rates and 95% confidence intervals to the entire data-set allows for comparison of AE’s between hospital volume groups.

• COAP does not provide data on individual providers

PCI Complication Rates Per 1000 Procedures 2013-2015
By Volume of Procedures Performed
With 95% Confidence Intervals
(N=Number of Complications)

Complications: Vascular, New renal failure,
Unplanned CABG, Surgery for other complications,
Tamponade, New cardiogenic shock, Occlusion of
treated lesion, Bleeding with post procedure
transfusion

Annual Volume of PCI Procedures performed
Data Source: COAP_DOH_PCI_Report_01_2017v2
Summary comments

• The COAP-PCI data, reports three years of volume data, from all PCI performing Washington hospitals and reports almost 38,000 PCI cases, showing some increase year over year.

• From the COAP-PCI data, the rate and CI are statistically comparable for mortality and adverse event between a volume of 300 or more cases/year and 200-300 cases/year.

• The COAP data does not contradict the 2013 & 2014 ACCF/AHA/SCAI consensus documents regarding institutional volume standard recommendations.