

# COAP Frequently Asked Questions

Revised 12/03

*Please note: This document has been revised to reflect the data collection forms, definitions, and procedures for use with reporting PCIs and CABGs performed on or after January 1, 2004.*

## **DATA DEFINITIONS:**

### **General Information:**

*Q: If we are not sure if the documentation in the chart supports our choice of one of the response items, how should the abstractor answer the question?*

A: What follows is COAP's guidance on selecting your best response: this explicitly recognizes the importance of the abstractor's judgment of the evidence available at time of abstraction. We strongly encourage you to answer every question.

- Select "Yes" (or select from the options provided) if in the judgment of the abstractor there is sufficient evidence in the medical record to demonstrate that the condition is present or the criteria or definitions are met.
- Select "No" if in the judgment of the abstractor there is sufficient evidence in the medical record to demonstrate that the condition has been ruled out or is not present.
- If in the judgment of the abstractor there is insufficient evidence in the medical record to answer either "Yes" or "No" or to select any of the options provided, leave the element blank. If a question cannot be or is not answered, the response will appear in the COAP database as "missing." A high number of missing elements may have an effect on risk-adjustment and/or participation status (see "Data Collection and Submission Logistics" later in this document). There are also two questions with an option for "not measured": Question 21 (pre-procedure stenosis) and question 37 (creatinine)

*Q: If a PCI or CABG is attempted but aborted before completion, should a form be filled out for the procedure?*

A: As of January 1, 2004, COAP is collecting data on all PCIs, regardless of whether the procedure was completed. A form should be completed for all PCIs. If the PCI was completed, select "PCI-based intervention" for Q 1.9. If it was attempted but not completed (guidewire did not cross the lesion), select "Attempted PCI" for Q 1.9. If a CABG is aborted before the revascularization component is performed, it would be reasonable to not complete a form for it.

### **Demographics:**

*Q: What if a patient has no Social Security Number?*

A: This field is used to uniquely identify each patient and avoid duplicate entries of procedures in the database. If there is no SSN, use a unique numeric identifier (such as a hospital ID).

Q: *A patient had a CABG or PCI during the quarter, but was still hospitalized on the day we send our data to the data manager. Should we include this case?*

A: Submit only cases with both an admit and discharge date. If the patient is still in-house, send that case to the data manager when the patient is discharged. Contact COAP's Program Manager for details.

Q: *What is my hospital's site number, and does it change?*

A: Each hospital is assigned a permanent site number from 1 to 35. If you are not sure what your number is, please contact COAP's Program Director. Please note that random identifiers are used on the quarterly and annual reports in order to protect hospital identity, but your site number does not change and should be used on every case submitted.

### **Clinical Risk Factors and History**

Q: *Please explain why questions such as cholesterol status or family history of CAD are not included in this section.*

A: These tend to be risk factors for CAD. Their role in predicting procedural outcomes is not supported in the literature; in order to reduce response burden they were not included.

Q: *How do we answer Q 2 (patient's weight) if there is a significant difference in weight between admit and the procedure?*

A: In some circumstances the patient's weight may change significantly after admit but before the procedure, e.g., a patient with CHF is diuresed. In those cases, record the weight closest to the procedure.

### **Cardiac Risk Factors:**

Q: *If the LVEF is measured more than once (e.g., before and during the procedure), or using more than one source (e.g., one from an echo and one from a cath report), which value should be recorded in Q 20? What if there is a difference in values depending on what source is used?*

A: Record the value and the method closest in time to and prior to the procedure. An LVEF during the procedure itself may reflect issues related to the procedure and

not the patient's preoperative severity of illness. If there is a difference in values due to the source (e.g., echo vs. LV gram), record the worse (lower) value.

*Q: A patient has a PCI and then a second procedure (either PCI or CABG). The stenosis in some major vessel distributions was reduced following the PCI. How do we answer Q 21?*

A: Q 21 asks for the highest degree of stenosis prior to the procedure you are abstracting to this form. Complete a form for each procedure. On the form for the first procedure, indicate the highest degree of stenosis before that procedure. On the form for the subsequent procedure, indicate the highest degree of stenosis before that procedure.

### **Procedure Variables:**

*Q: A patient has an IABP inserted after the stent placement or vessel dilation. Is Q24 Yes or No?*

A: An IABP inserted in the procedure room before the surgery has begun or the cath has been inserted is 'prior to initiation of the actual procedure' and the answer is Yes. An IABP inserted after stent placement is not pre-procedure and the answer would be No.

*Q: A Patient has a stent without PCI; how would this procedure be indicated in question 29, PCI Procedure Table?*

A: A stent without a balloon is considered a stent only

*Q: A flow wire is passed across the lesion, and it is determined that a PCI is not required. Do we fill out a form for this procedure?*

A: A form would not be completed for this procedure.

*Q: In counting grafts, would a skip graft count as two anastomoses?*

A: A skip graft would count as two (or more) distal anastomoses for either arterial or venous grafts in Q 27 and Q 28.

*Q: In Q 29, if the guidewire crossing is unsuccessful, should we answer any additional questions?*

A: Yes; even if the attempt is unsuccessful, answer the following questions if possible: % stenosis pre-procedure; was lesion treated before in the current or prior hospitalization; was lesion treated before with a drug eluting stent; was lesion treated before with brachytherapy; if lesion in a graft, indicate type of graft.

Q: *Please provide guidance on how to answer Q 30.0, 31.1, and 30.2 if patient was admitted directly from the physician's office to the cath lab with a STEMI and had a PCI.*

A: Q 30 asks if the procedure was performed or attempted for treatment of AMI, so you would answer Yes. Since the patient was a direct admit from the physician's office—not through the ER—do not answer Q 30.1 or 30.2, as they are to be answered only for patients presenting to the ER with STEMI. Similarly, if an inpatient had a STEMI and was taken to the cath lab for intervention, Q 30.1 and 30.2 would not be answered. The reason for this is to capture (and report back to hospitals) only the “ER door to intervention time” cleanly and consistently.

### **Post-Procedure Events:**

Q: *What is the rationale for changing the questions about intra- and post-procedure procedures and events (Q 35, 36, and 43)?*

A: These questions were changed to incorporate ACC and STS definitions and to differentiate ‘expected’ events from those considered to be true complications . The new definitions in Q43 allow COAP to determine total “return to OR” rate and differentiate them from events that can reasonably be considered complications of the CABG or PCI.

Q: *A patient has a fall two days post-CABG and is taken to the OR for a hip pinning. It's not apparently related to the cardiac procedure. How should Q 43 be answered?*

A. If the patient is taken to the OR for any reason, the response to Q 43 is Yes. In this example, none of the CABG choices (43.4, 43.5) applies, so leave blank.

Q: *A patient has a PCI and later goes to the cath lab for a second PCI. We fill out a form for each procedure. Is the answer to Q 44 Yes for both procedures or just for the first one?*

A: “Following the procedure” refers to the procedure described in the data form. In this example, the answer to Q 44 is Yes for the first procedure and No for the second procedure.

Q: *How are ventilation hours rounded?*

A: Round ventilation hours to the nearest whole number, using this statistical convention: odd numbers are rounded down, and even numbers are rounded up. For example, 3.6 hours would be recorded as 4 hours; 3.9 hours would be recorded as 3 hours.

Q: *A patient is extubated following CABG and then reintubated and extubated several times during the hospital stay. How many hours would be entered in Q 42?*

A: Provide the total number of hours of intubation from the end of the procedure until discharge. If there are unusual circumstances that lead to multiple reintubations and the resulting total length of time is quite long, the hospital can conduct a record review to determine the reasons.

Q: *There are various ways of recording blood products, especially platelets. How should they be indicated in Q 45?*

A: Platelet packs are multiples of single units. A “six-pack” of platelets would be recorded as 6 units, two six-packs as 12 units, etc. If one administration of pooled platelets is equivalent to 6 units, record it as 6 units. This would apply to platelet pheresis also. Enter “0” if no blood products are used. Do not leave it blank; this is recorded as “missing”.

#### **DATA COLLECTION AND SUBMISSION LOGISTICS:**

Q: *How should my hospital collect and submit the COAP elements?*

A: Each hospital determines what processes work best, given its own resources, expertise, and experience. For example, hospitals may collect the data retrospectively, concurrently, or a combination; enter onto a paper form, use a Web-based tool, or export from another cardiac registry. Because data entry from paper forms has more opportunity for entry error and is more labor-intensive (and thus more expensive), COAP encourages all hospitals to use the Access database if possible; an Access db for COAP users is available free of charge. If you are considering changing to an electronic method, or are planning any change, please notify COAP’s Program Manager to discuss transition issues.

COAP strongly recommends that data NOT be emailed: password-protection is not considered to be sufficient protection of the hospital and patient information, and COAP does not condone email as an acceptable option. Electronic data should be transferred to disk and should be sent via 2-day air with a tracking number. Similarly, paper records should be sent via any method with a tracking mechanism (e.g. FedEx, UPS, USPS)

Q. *Why are some data elements ‘required?’ What happens if we can’t provide them to COAP?*

A: COAP has selected 42 data elements considered essential to building and maintaining a useful registry of cardiac revascularization procedures and outcomes. These data elements include patient demographics to permit tracking and linking of patients; predictive clinical factors; procedure type, the post-procedure events or outcomes; and key information to risk-adjust for severity of illness.

A high percentage of missing or invalid required elements can affect hospitals' data and annually-assessed participation status: missing elements required for risk adjustment may be "normalized," which may make patients appear not as sick as they may actually be; in addition, if a threshold of missing elements is reached, it may not be possible to risk-adjust hospital data, and the hospital's participation status may be adversely affected.

Where feasible, quarterly and annual reports will be prepared for hospitals submitting datasets without the required elements. All missing data are reflected in the reports as "% missing." Each hospital should monitor its reports and work to improve the completeness of the data submitted to COAP.

Please contact the COAP Program Manager or Director for more information.

**POLICY:**

*Q: Please provide guidance on how to protect COAP information and how it can be shared appropriately.*

A: Documents in two formats are available for your information and use in discussions of this important topic. Denise Dominik, RN, Douglas Stewart, MD, and Lois Catts, RN have developed a PowerPoint presentation; please credit the authors when you use this presentation. In addition, the information in the slides has been summarized as a Word .doc and an Adobe .pdf document. These documents, and the PowerPoint presentation, are available on the COAP web site.

*Q: How did COAP originate?*

A: COAP officially began in 1993 when the Washington State Health Care Authority, in an effort to promote quality while reducing costs, released a Request for Information aimed at selective contracting for CABG services. Based on the uniformly negative response from the provider community, the HCA chose to pursue a more collaborative approach to working with the medical community with the goal of quality improvement. A pilot project was conducted in 1995 and 1996, which demonstrated that a collaborative relationship between the state and medical community was feasible and that important information could be gained through such an effort. Based on the success of this pilot program, COAP has been launched as a physician-led program, in partnership with other stakeholders, designed to promote data driven quality improvement activities across Washington.

*Q: What is the relationship between COAP and the State of Washington?*

A: State agencies across the nation are increasingly requiring the collection of outcomes data, especially in cardiac care, and using the data to generate public report cards. Washington State has elected to pursue a different approach. The central premise of COAP is that quality of care can best be enhanced through collaborative, not punitive, mechanisms. Based on the well-organized leadership demonstrated by the cardiac physicians in this state, the Health Care Authority has delegated the responsibility of this quality improvement program to a physician-led management committee. Under the terms of COAP's contract with the state, no state agency will be authorized to review patient-, physician- or hospital-identified data without appropriate consent from the respective party. Instead, the COAP Management Committee will share with the State blinded data reports demonstrating general trends in cardiac care, and will outline how it has responded to any concerns about quality of care. The HCA continues to provide strong support to COAP by requiring that health plans contract with hospitals that participate in COAP and by contributing to program planning and development in an advisory role.

*Q: Who is paying for this program?*

A: Funding for this program is multifaceted. Support of the "start-up" phase was provided by several sources: the Health Care Authority (on behalf of its contracted health plans) contracted with COAP to organize and facilitate a secure and confidential statewide quality improvement program for cardiac revascularization services; the Foundation for Health Care Quality, under whose auspices COAP operates, has been generous in providing essential infrastructure and development costs. With the ending of the HCA's direct financial support as of January 2001, ongoing funding is provided by annual user fees and per-case fees. Efforts to secure grants and contracts will continue.

*Q: What happens if an institution chooses not to participate?*

A: Participation in COAP is a QI/QA requirement defined in the contracts between the Health Care Authority and the health plans. Should an institution choose not to participate, the initial response would be an effort by COAP to meet the needs of the institution through cooperative measures, and thereby facilitate participation. Beyond that, the consequences of non-participation would be based on contractual mechanisms between the Health Care Authority, the Health Plan(s), and the non-participating cardiac program(s)—possibly jeopardizing access to state-funded patients. An important goal of COAP is to avoid such coercive measures and create an atmosphere of collaboration and partnership in an effort to better serve patients in this state.

In its Quality Improvement Plan, the Management Committee provides additional definition of "participation" in COAP; please see the Plan for further detail. A list of hospitals that are "full participants" in COAP is posted on this web site and will be

updated to reflect any future changes in status. The Management Committee makes any changes in participation status.

## **RESEARCH AND REPORTING:**

*Q: Who gets the COAP reports at each hospital?*

A: As one of its methods to protect hospital-specific information from accidental disclosure, COAP distributes a limited number of reports: reports are sent to the individual at each hospital who signed the contract between COAP and that hospital, and to others as requested in writing by that individual. Each hospital determines how to distribute the reports or share the information internally according to its own quality improvement policies and mechanisms. Please contact the Program Director with any questions about or requested changes to report distribution.

*Q: Will publicly released report cards be generated from these data?*

A: No. Unlike other states that have collected cardiac outcomes data with the goal of producing report cards, COAP has been designed as a mechanism for internal quality improvement activities. COAP is protected under state law from discoverability as a quality improvement activity (RCW 43.70.510). No identified data may be released by COAP without written consent from the respective party.

*Q: Will the reporting system lead some physicians to refuse to perform procedures on high-risk cases out of fear of looking bad in the reports?*

A: Among the foremost objectives of the program is how to optimize treatment outcomes for patients with coronary artery disease. If high-risk patients are turned down for a procedure, the provider's procedure-specific mortality rate may indeed be reduced. However, if that treatment was the best option for those patients, more patients may unnecessarily die or do poorly. By examining multiple modalities of revascularization, physicians will have tools to help assess the optimal approach to the treatment of coronary disease, including those in the highest risk groups. Using credible, risk-adjusted information from the COAP registry to augment clinical decision-making, physicians are expected to experience improved outcomes for patients with coronary artery disease.

*Q: Will physicians have access to data collected through the institutions?*

A: Yes. An important lesson learned from other statewide models is that credibility among physicians is paramount. COAP has approached this through developing a physician-led program, where the needs and concerns of the physician community are addressed in partnership with other stakeholders. Physician access to meaningful data is integral to a viable and credible data collection effort. Physicians will have access to COAP data through their respective institutions as

defined in the contract between COAP and the institutions. In addition, for an additional fee physicians may request reports directly from COAP either to review their own patient-specific elements to confirm validity, or to examine their aggregate results compared to peer group norms.

*Q: Will hospitals that perform procedures on high-risk cases or cases turned down by other physicians look bad in the reports?*

A: Effective quality improvement can only occur if analyses are perceived as fair and credible. If well accepted and validated risk-adjustment techniques prove unable to account for case-mix, the physician-led Management Committee will be charged with the responsibility of working collaboratively to identify appropriate alternatives. Physicians and institutions need not be penalized for electing to take on the most challenging cases.

*Q. What is the future of COAP?*

A. COAP's Management Committee has developed a Strategic Plan for the next several years, with a major focus on proactive quality improvement. COAP has developed and distributed additional reports of selected risk-adjusted CABG and PCI indicators to help hospitals identify trends, and will work closely with the hospitals to support actions to correct any opportunities for improvement.