QualityPath™ Cardiac Bypass (CABG) Maintenance of Designation

Introduction

1. Overview of The Alliance®

   The Alliance moves health care forward by controlling costs, improving quality, and engaging individuals in their health. An employer-owned, not-for-profit cooperative, our more than 260 members provide coverage to about 84,000 people in Wisconsin, Illinois and Iowa. Our robust network lets members choose from more than 90 hospitals, 18,300 professional service providers and 4,100 medical clinic sites in Wisconsin, Illinois and Iowa.

   The Alliance continually pursues higher value on behalf of its members, including strategies such as measuring quality, negotiating pay-for-performance contracts, nurturing patient engagement and collaborating with stakeholders at every level of the health care system. The Alliance provides education and resources to help members design value-based benefit plans and implement employee wellness and prevention programs.

2. The program

   QualityPath identifies high-quality care; uses new ways to pay for care; and rewards patients who choose that care with lower out-of-pocket costs. We worked with providers to develop these programs.

   We started this initiative at the request of some of our members who are interested in developing incentives for their employees and family members to choose high-value providers.

   This program will use evidence-based standards to assess the quality of care provided. Those that meet or exceed thresholds will be publicly recognized for quality. All aspects of this process will be completely transparent.

3. Submission Instructions
   These instructions are intended to provide guidance to respondents and to facilitate fair and objective evaluations of submissions. **Please follow these instructions carefully.**

   a. Contact Point/Responses to Questions
      Please direct all questions, clarifications and inquiries regarding this MoD to QualityPathRFP@the-alliance.org . We will provide a written response to all questions to all respondents to ensure that proposals are based on uniform information.

   b. Responses Format

A separate response needs to be submitted for each individual facility applying, even if multiple facilities are part of the same system. The designation is for a facility and a surgeon practicing at that facility (facility and surgeon specific).

Each criterion has a number in front of it. Where possible, please reference the number in the supporting documentation to assist with cross-referencing criteria and documentation.

c. Response Submission
Please provide an electronic version of your response, signed by the authorized representative of your organization. Submissions should be sent to: QualityPathRFP@the-alliance.org

Final responses are due May 17, 2017, no later than 5 p.m. Central time. Any responses submitted after 5 p.m. may not be considered.

d. Key Dates
- Responses due: Wednesday, May 17, 2017
- Meetings to discuss evaluation results: Mid-July, 2017.

QualityPath™ Cardiac Bypass (CABG) Evaluation Criteria Overview

For easy reference, this section contains a list of criteria and supporting documentation. A more detailed version of the criteria is available immediately following this section. Each item below is linked to the more detailed version.

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1 Facility must participate in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry. 7

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2 Facility must use data from the registry to support quality improvement efforts. 7

Supporting Documentation: Provide a brief description of how your facility uses registry data to work together with surgeons to improve quality. Inclusion of a quality improvement project example is appreciated, but not required. 7

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- Provide a copy of the decision aid. The decision aid must include optimal medical therapy as one treatment option. 13
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Summary of Changes from Previous Version

- Updated links and dates throughout the document.
- Clarified public reporting requirements for Optimal Diabetes Care (# 17) and Optimal Vascular Care (# 18) to more accurately reflect our intent.
- Modified decision support criterion (# 19) to align with joint replacement program requirement.

Registry Participation

Rationale: Facilities and providers need timely, accurate and clinically relevant information to improve patient outcomes, determine appropriate care, engage patients in decision-making and be good stewards of scarce resources.

Resources: http://www.sts.org/national-database

Registry – Facility Criteria

 # 1 Facility must participate in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.

Timing: Every twelve months (Spring Maintenance of Designation), as updated by STS

Fully Meets: Results displayed on STS online reporting website.

Supporting Documentation: None, results available online

 # 2 Facility must use data from the registry to support quality improvement efforts.

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets: Facility demonstrates existing use of registry data for quality improvement efforts **and** demonstrates surgeon involvement in these efforts.

Supporting Documentation: Provide a brief description of how your facility uses registry data to work together with surgeons to improve quality. Inclusion of a quality improvement project example is appreciated, but not required.

Registry – Surgeon Criteria

 # 3 Surgeon must participate in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets: Surgeon participates in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.

Supporting Documentation: Provide a screen shot or PDF export demonstrating surgeon participation in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.

Transparency

Rationale: Consumers have a right to know about differences in cost and quality between health care facilities, surgeons and other clinicians; and a responsibility to educate themselves about these differences as part of making health care decisions. Providers should share this information via public reporting when they have an opportunity to do so. As part of the *QualityPath* program, we will not publicly disclose the individual measure results provided in response to this portion of the RFP. We will be publishing what results and measures were considered as part of the program and which hospital-provider pairs achieve the *QualityPath* quality designation.

Transparency – Facility Criteria

 # 4 CABG case volume for the past two calendar years

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Facility has a case volume of 30 cases over the past two calendar years AND has sufficient case volume to allow STS to calculate all STS measures in this section. This requirement is intended to ensure enough cases to reliably measure quality. It is not being used as a proxy for quality. If any measure indicates there were too few cases to calculate a meaningful result, or the STS's equivalent language, a facility is ineligible for the *QualityPath* quality designation.

Does not meet: surgeon has case volume of less than 30 cases over the past two calendar years OR does not have sufficient case volume to allow STS to calculate all STS measures in this section.

Benchmark: Not applicable

Supporting Documentation: Case volume

 # 5 STS CABG Composite Score

Timing: Every twelve months (Spring Maintenance of Designation), as updated by STS

Fully meets: Performance at two or three stars AND results available at STS Reporting Online

Does not meet: Performance at one star or results not available

Supporting Documentation: None, results available online

Resources:

- STS Reporting Online: http://www.sts.org/quality-research-patient-safety/sts-public-reporting-online

 # 6 STS Absence of Operative Mortality

Timing: Every twelve months (Spring Maintenance of Designation), as updated by STS

Fully meets: Performance at two or three stars AND results available at STS Reporting Online

Does not meet: Performance at one star or results not available

Supporting Documentation: None, results available online

Resources:

- STS Reporting Online: http://www.sts.org/quality-research-patient-safety/sts-public-reporting-online

 # 7 STS Absence of Major Morbidity

Timing: Every twelve months (Spring Maintenance of Designation), as updated by STS

Fully meets: Performance at two or three stars AND results available at STS Reporting Online

Does not meet: Performance at one star or results not available

Supporting Documentation: None, results available online

Resources:

- STS Reporting Online: http://www.sts.org/quality-research-patient-safety/sts-public-reporting-online

Transparency – Surgeon Criteria

 # 8 CABG case volume for the past two calendar years

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Surgeon has a case volume of 30 cases over the past two calendars years. This requirement is intended to ensure enough cases to reliably measure quality. It is not being used as a proxy for quality.

Does not meet: Surgeon has less than 30 cases over the past two calendar years.

Benchmark: Not applicable

Supporting Documentation: Case volume

 # 9 In-hospital Mortality (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 10 Operative Mortality (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 11 Morbidity: Any Reoperation (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 12 Morbidity: Permanent Stroke (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 13 Morbidity: Renal Failure (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 14 Morbidity: DSWI (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 15 Morbidity: Prolonged Ventilation (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

 # 16 Combined Morbidity/Mortality Outcomes (risk adjusted)

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Performance as expected or better than expected (see Appendix A for additional information)

Supporting Documentation: Observed and expected rates submitted using the data submission form supplied by The Alliance

Transparency – Affiliated/referring primary care practice(s)

Rationale: Managing cardiovascular risk factors well in patients with known cardiovascular disease decreases their likelihood of suffering serious cardiovascular complications.

Definition of Affiliated/Referring: These are all examples of practices that would be considered affiliated/referring:

- Practices that are part of the same integrated delivery system as the facility applying for the quality designation
- Practices that are part of the same integrated delivery system as the physician applying for the quality designation
- Practices that have a formal agreement or arrangement to refer to either the facility or physician applying for the quality designation
- Practices that participate in a vehicle that allows for joint managed-care contracting with applicant (e.g. IPAs, ACOs, etc.) and refer primarily to applicant.

 # 17 Optimal Diabetes Care (A1c and BP control, aspirin use, not using tobacco, and statin use)

Timing: Every twelve months (Spring Maintenance of Designation), as updated by measure reporting site

Fully meets:

- Reference publicly reported results:
    - Organizations that currently report to Minnesota Community Measurement should refer to results posted publicly on the Minnesota HealthScores (http://www.mnhealthscores.org/)
    - Organizations that belong to the Wisconsin Collaborative for Healthcare Quality (WCHQ) should refer to results posted publicly on the WCHQ site (http://www.wchq.org/)
    - Calculate results using the measure specification in this PDF and display on your system's website: http://mncm.org/wp-content/uploads/2016/11/Optimal-Diabetes-Care-2017-Data-Collection-Guide-FINAL.pdf
- Performance at Wisconsin median (as calculated using WCHQ results) or better

 # 18 Optimal Cardiovascular Disease (CVD) Care (BP control, aspirin use, not using tobacco, and statin use)

Timing: Fully meets at the time of application.

Fully meets:

- Reference publicly reported results:
    - Organizations that currently report to Minnesota Community Measurement should refer to results posted publicly on the Minnesota HealthScores (http://www.mnhealthscores.org/)
    - Organizations that currently belong to the Wisconsin Collaborative for Healthcare Quality (WCHQ) should refer to results posted publicly on the WCHQ site (http://www.wchq.org/)
    - Calculate results using the measure specification in this PDF and display on your system's website: http://mncm.org/wp-content/uploads/2016/11/Optimal-Vascular-Care-2017-Data-Collection-Guide-FINAL-v1.pdf
- Performance at Wisconsin median (as calculated using WCHQ results) or better

Supporting Documentation: Indicate location where results are publicly available.

Standardized Clinical Processes

We do not have separate criteria for facility and physician use of standardized clinical processes. We recognize that different workflows will work for different organizations and it is not our intent to be prescriptive. Wherever these processes fit in the physician-hospital workflow, they need to be well-defined, repeatable, and reliable.

 # 19 Decision Support for Ordering High-Tech Diagnostic Imaging Tests (HTDI) (CT, MRI)

Rationale: Decision support for diagnostic imaging provides immediate help determining the best test based on a patient's indication and available evidence and best practice. It helps physicians order the right test the first time, saving the cost of unnecessary or low utility tests. We are looking for a process that provides up-to-date, evidence-based information to providers at the point of order. The process needs to allow for data gathering to evaluate how the process is working and to provide feedback to ordering

providers on their ordering patterns. The scope of the process should include the surgery practice and affiliated/referring primary care practice (using the same definition of affiliated as in the Transparency section).

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: System is fully implemented for the full patient population and reports are being generated and shared.

Supporting Documentation: A feedback report, demonstrating the ability to provide feedback results at an aggregate facility level and allow for drill-down by practice and clinician. The intent is not for these to be different reports, but one report that can be rolled-up and down to help evaluate and improve both the process and individual provider ordering utility. The report should cover all high-tech diagnostic imaging and all "appropriateness levels" assigned in the decision support system. At a minimum, it should include the rates for the facility, affiliated/referring clinics, and surgeons applying.

 # 20 Shared Decision Making

Rationale: Shared decision making using a standard, high-quality decision aid ensures that patients are informed of all options for treating their condition prior to the procedure, that they understand the risks and benefits of each option, and that they want to proceed with a CABG. We are looking for a process that engages all patients considering elective CABG in shared decision making using a high-quality decision aid.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Process fully implemented for all patients undergoing elective CABG.

Preferred: Shared decision making happens prior to the patient meeting with the surgeon.

Supporting Documentation:

- Provide a description of the shared decision making process.
- Provide a copy of the decision aid. The decision aid must include optimal medical therapy as one treatment option.
- Provide percentages, numerators, and denominators of patients participating in shared decision making broken out by surgeon, practice, and by facility. Denominator is all patients receiving elective CABG. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark. See example report in Decision Making Quality below.

 # 21 Decision Quality Assessment

Rationale: Assessing the quality of shared decision making prior to CABG helps identify gaps in the patient's understanding and the extent to which the patient was actively engaged in deciding to have CABG. Performing this assessment prior to the CABG provides the opportunity to resolve gaps in understanding.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Process fully implemented for all patients participating in the shared decision making process.

Supporting Documentation:

- Provide a description of the process for assessing the quality of shared decision making using the publicly available assessment tool: http://www.massgeneral.org/decisionsciences/research/DQ_Instrument_List.aspx
- Provide percentages, numerators, and denominators of patients participating in an assessment of shared decision making broken out by surgeon, practice, and by facility. Denominator is all patients undergoing elective CABG. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark.

For example:

	Patients having a procedure	Participated in Shared Decision Making	Participated in Decision Quality Assessment
Physician A	1000	900 / 1000 = 90%	450 / 1000 = 45%
Clinic A	2000	1800 / 2000 = 90%	900 / 2000 = 45%
Hospital A	4000	3600 / 4000 = 90%	1800 / 4000 = 45%

 # 22 Conversation About Future Care Needs

Rationale: Spelling out what kind of medical care we want if we are too ill or hurt to express our wishes is a way of telling our wishes to family, friends, and health care professionals to avoid confusion later on.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets:

- Process in place to ensure a conversation about future care needs is documented in an Advanced Directive.
- Proportion of patients with a conversation documented in an Advanced Directive is tracked and shared with *QualityPath*. Denominator is all patients undergoing elective CABG.

Benchmark: None.

Supporting Documentation:

- A description of the process for ensuring a conversation about future care needs.
- Provide percentage of patients with conversation documented in an Advanced Directive. We are looking for evidence of process implementation.

Disclose Potential Conflicts of Interest

Rationale: Full disclosure of industry payments is important to identify and manage potential conflicts of interest.

Definitions:

- Direct industry payments: Payments or items of value given directly to a health care provider by a manufacturer of drugs, medical devices, biologicals, or other medical supplies when made directly to a health care provider for purposes other than payment for providing medical treatment.
  - Examples (for clarification, not intended to be all-inclusive)
    - Payment from a drug manufacturer to a physician to fund research.
    - Royalties from a device manufacturer to a physician.
- Indirect industry payments: Payments or items of value given to a health care provider by a third-party, where the third-party has received the funds from a manufacturer of drugs, medical devices, biologicals, or other medical supplies with the direction to provide payment to the health care provider.
  - Example (for clarification, not intended to be all-inclusive)
    - Payment from a drug manufacturer to a non-profit to fund a provider speaking at an industry event.

 # 23 Disclose Potential Conflicts of Interest – Facility

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets:

- Facility has a policy in place that includes full disclosure of industry conflict of interest to patients.
- Facility must track all direct and indirect payment.

Supporting Documentation

- Disclosure of conflict policy
- An example of how disclosure of conflict information is provided to patients
- Provide total direct and indirect payments, broken out by payer, to *QualityPath*

 # 24 Disclose Potential Conflicts of Interest – Surgeon

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets:

- Surgery practice has a policy in place that includes full disclosure of industry conflict of interest to patients.
- Surgery practice must track all direct and indirect payment.

Supporting Documentation

- Disclosure of conflict policy

- An example of how disclosure of conflict information is provided to patients
- Provide total direct and indirect payments, broken out by payer, to *QualityPath* for each surgeon applying for *QualityPath* quality designation.

Appendix A – Submission of surgeon-level CABG data.

Follow the steps outlined in the STS's "Guide to Using Risk Adjustment Locally" which can be found in the Risk Adjustment Supplement to the results report.

Use the O/E Ratio re-calibration multiplier from the most recent year available. For instance, if reporting data from 6/2014 – 6/2016 and the most recent re-calibration multiplier available is for 2015, use the 2015 multiplier. If 2016 is available, use 2016. If reporting 6/2014 – 6/2015, use the 2015 multiplier.

Download the CABG Data Submission spreadsheet available on this page: http://www.the-alliance.org/Providers/QualityPath/Coronary_Artery_Bypass_Graft/

Complete the spreadsheet.

Indicate in row 4 which year's multiplier was used.

Submit data for past 24 months, broken out into year one, year two, and then combined, in the format on the next tab.

Indicate in row 3 the time frame included in each period (e.g. Year one = 6/1/2015 - 6/1/2016)

Data submission should include all surgeons with facility data during the two-year submission period and needs to identify the surgeons by name.

Appendix B – Summary Table of Timing for Maintenance of Designation Elements

Criterion	Inclusion in Maintenance of Designation Cycles	
	Spring	**Fall**
# 1 Facility must participate in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.	Yes	No
# 2 Facility must use data from the registry to support quality improvement efforts.	Yes	No
# 3 Surgeon must participate in the Society of Thoracic Surgeons Adult Cardiac Surgery Registry.	Yes	No
# 4 CABG case volume for the past two calendar years (facility)	Yes	No
# 5 STS CABG Composite Score (facility)	Yes	No
# 6 STS Absence of Operative Mortality (facility)	Yes	No
# 7 STS Absence of Major Morbidity (facility)	Yes	No
# 8 CABG case volume for the past two calendar years (surgeon)	Yes	No
# 9 In-hospital Mortality (risk adjusted) (surgeon)	Yes	No
# 10 Operative Mortality (risk adjusted) (surgeon)	Yes	No
# 11 Morbidity: Any Reoperation (risk adjusted) (surgeon)	Yes	No
# 12 Morbidity: Permanent Stroke (risk adjusted) (surgeon)	Yes	No
# 13 Morbidity: Renal Failure (risk adjusted) (surgeon)	Yes	No
# 14 Morbidity: DSWI (risk adjusted) (surgeon)	Yes	No
# 15 Morbidity: Prolonged Ventilation (risk adjusted) (surgeon)	Yes	No
# 16 Combined Morbidity/Mortality Outcomes (risk adjusted) (surgeon)	Yes	No
# 17 Optimal Diabetes Care (A1c and BP control, aspirin use, not using tobacco, and statin use)	Yes	No
# 18 Optimal Cardiovascular Disease (CVD) Care (BP control, aspirin use, not using tobacco, and statin use)	Yes	No
# 19 Decision Support for Ordering Diagnostic Cardiac Imaging Tests	Yes	Yes
# 20 Shared Decision Making	Yes	Yes
# 21 Decision Quality Assessment	Yes	Yes
# 22 Conversation About Future Care Needs	Yes	Yes
# 23 Disclose Potential Conflicts of Interest – Facility	Yes	No
# 24 Disclose Potential Conflicts of Interest – Surgeon	Yes	No