



Reduce the Risk: PCI Bleed

A Campaign of the
American College of Cardiology



ACC REDUCE THE RISK: PCI BLEED

Webinar # 5

USING THE PCI BLEEDING RISK CAMPAIGN TO
AFFECT PATIENT OUTCOMES

August 23, 2018
12:00-1:00pm EST



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Hosted by;

Andrea Price MS, CPHQ, RCIS, AACC

Director- Quality Databases, Indiana University Health

Reduce the Risk PCI Bleed Steering Committee Chair

Sunil Rao MD, FACC

Reduce the Risk PCI Bleed Steering Committee Member



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Agenda

1. ACC Quality Campaign Framework and Design and History
2. Reduce the Risk: PCI Bleed Campaign Goals
3. Campaign Metrics
4. The Change Package/the Campaign Features
5. Getting Started



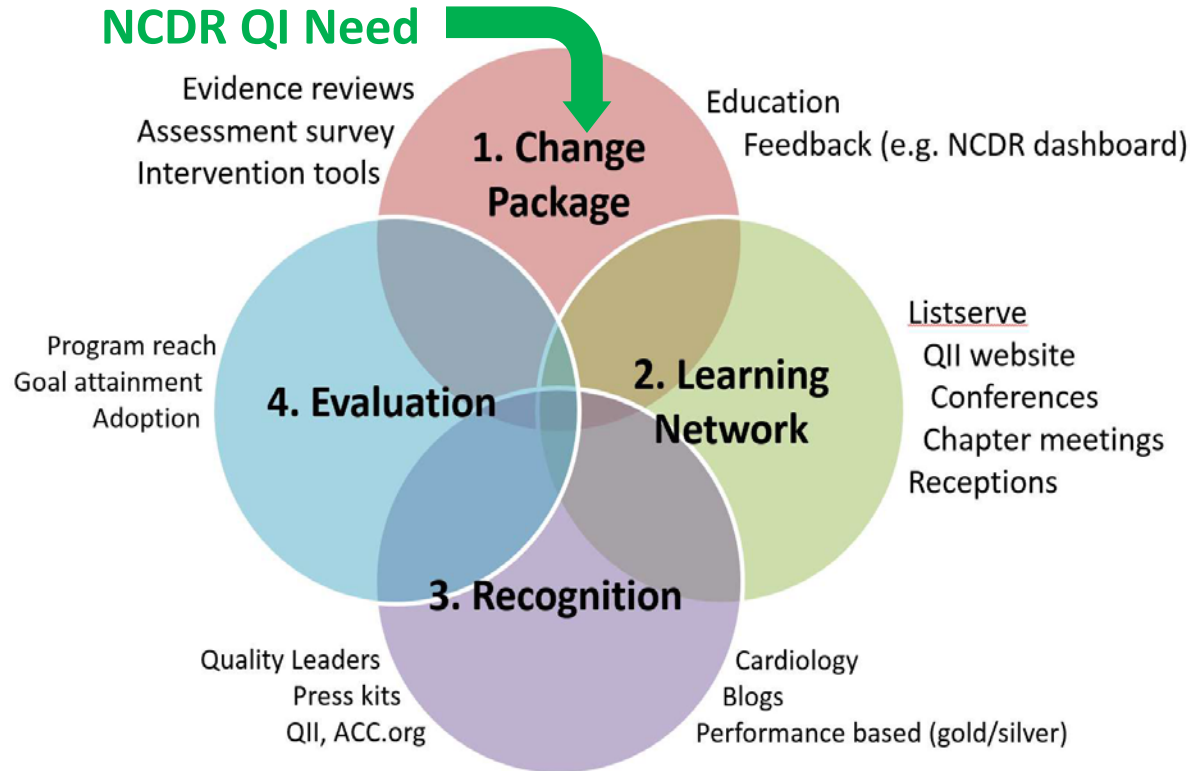
Quality Campaign Goals...

- Help hospitals improve cardiovascular care.
- To improve the quality and value of cardiovascular care and outcomes.
- Leverage evidence-based practices.



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What's in an ACC Quality Campaign? 4 Parts



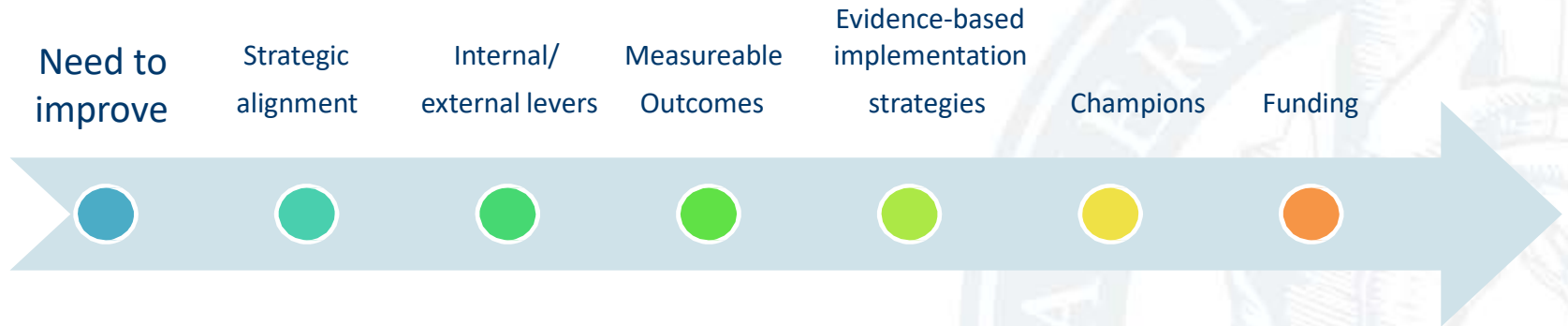
*Key characteristics of a successful QI program

- Influential
- Credible
- Simple
- Strategically aligned for participant
- Offers practical implementation tools
- Offers Networking
- Sets Attainable goals



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Potential Quality Campaign Feasibility Framework



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Reduce the Risk: PCI Bleed–Feasibility Assessment

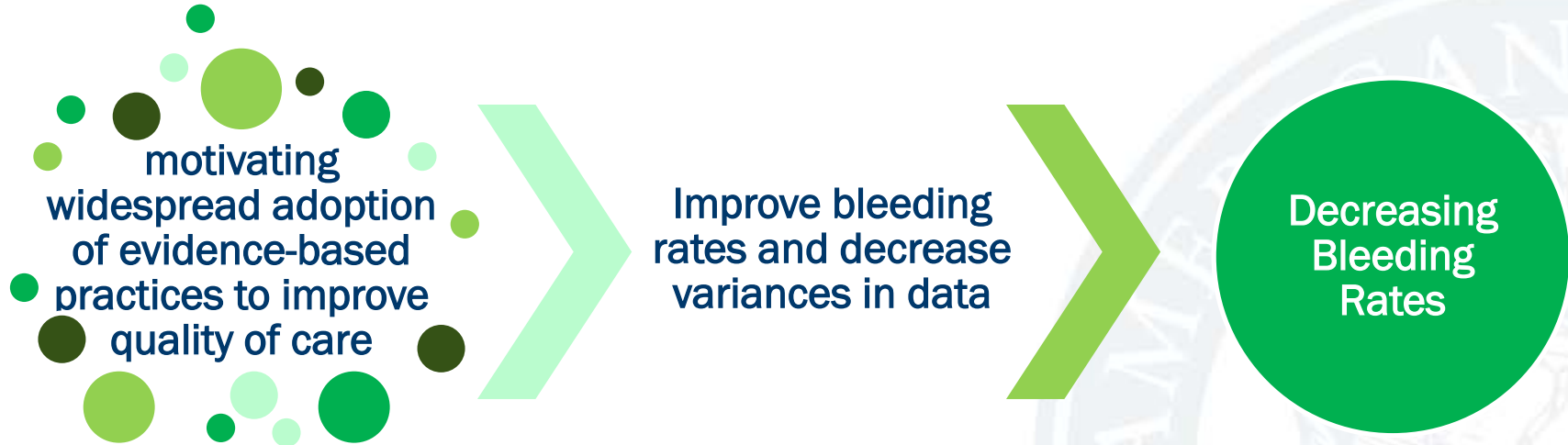
A. Primary Purpose bleeding adverse events	D. Drivers <ul style="list-style-type: none"> • BCBSA • MACRA CPI • NQF • MOC 	G. Evidence based implementation metrics	J. Program champions and experts
B. Aligned with ACC strategic plan and mission	E. Draft QI aim statement(s) widespread adoption of evidence-based practices to improve quality of care.	H. Internal levers <ul style="list-style-type: none"> •CathPCI •ACTION •<u>Guideline references</u> • PCI • DAPT <u>Accreditation</u> •CathLab related standards <u>Tools</u> •PCI bleeding toolkit <u>ACC Quality programs</u> • PMAC pathway 	K. Overall program design <ul style="list-style-type: none"> • Assessment survey • Intervention tools • Education •Feedback <u>Learning Network</u> • Listserv • QII website • Conferences • Chapter meetings •Receptions <u>Recognition</u> • Quality Leader Hospitals •General recognition <u>Evaluation Plan</u> • Program reach • Clinical care • Adoption
C. Evidence of need to improve 2.65% to 9.36% <ul style="list-style-type: none"> • 70% of hospital variability due to unexplained causes <u>Guidelines</u> <ul style="list-style-type: none"> • Evaluate bleeding risk (1C PCI) • ACS treated with DAPT after stent and not high risk of bleeding and no hx of stroke/TIA use prasugrel over clopidogrel (IIA DAPT) <u>NCDR dashboard</u> <ul style="list-style-type: none"> • ½ CathPCI sites have median RAB = 4.16% or higher. • 90th percentile of hospitals have RAB - 1.6% or lower. 	F. Outcome measures pts <ul style="list-style-type: none"> • #1289) Post proc bleeding • (#1602) Bivalirudin w/I 24hrs of all PCI pts • (#1827) Unadjusted bleeding events • (#1871) Post proc bleeding for STEMI pts <u>ACTION</u> <ul style="list-style-type: none"> • (#42) In-hospital RAB 	I. Funding ACC/NCDR at the moment. Pharma: <ul style="list-style-type: none"> •AZ-Brillinta • Daiichi Sankyo/Eli Lilly – Prasugrel •TMC – Bivalirudin Transradial: <ul style="list-style-type: none"> • St. Jude, Medtronic, BSC 	

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Reduce the Risk: PCI Bleed Quality Campaign



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- All patients should be evaluated for risk of bleeding before PCI.
- Patients considered high risk for PCI should be part of a collaborative decision to use a **radial** approach.
- In patients with ACS treated with DAPT after coronary stent implantation who are not at high risk for bleeding complications and who do not have a history of stroke or TIA, it is reasonable to continue Clopidogrel for maintenance P2Y12 inhibitor therapy.
- In patients with SIHD treated with DAPT after DES implantation who are at high risk for bleeding complications or develop significant covert bleeding, discontinuation of P2Y12 inhibitor therapy after 3 months may be reasonable.
- In patients with SIHD treated with DAPT after BMS or DES implantation who are not at high risk for bleeding (no history of bleeding on DAPT, coagulopathy, oral anticoagulant use), continuation of DAPT for longer than 1 month in patients treated with BMS or longer than 6 months in patients treated with DES may be reasonable.

What are the ACC/AHA Guidelines Saying

Opportunity for Improvement

40

PCI In-Hospital Risk Standardized Bleeding (all patients)

My Hospital	US Hospitals 50th Pctl	US Hospitals 90th Pctl
2.21	2.81	1.68

Your hospital's risk adjusted rate of bleeding events for patients with PCI procedures using the NCDR® PCI bleeding risk adjustment model. [Detail Line:1822]

2.81%



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Steering Committee Members

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Committee Chair

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#	Program Metric	Metric Description
1	PCI in-hospital risk-standardized rate of bleeding events for all PCI patients	Bleeding complications after PCI are associated with increased morbidity, mortality and costs. This measure is helpful in providing risk-adjusted feedback on bleeding complications, informing clinical decision-making, and directing the use of bleeding avoidance strategies to improve the safety of PCI procedures.
2	Proportion of PCI procedures with transfusion of whole blood or red blood cells	Numerator: Count of PCI procedures with a RBC/Whole blood transfusion procedure. Denominator: Count of PCI Procedures The purpose of this metric is to allow identification of potential overuse of transfusion after PCI procedures. In addition, it points out blood loss, which predicts poor outcomes.
3	Procedures with an observed bleeding event	Count of bleeding event post PCI procedure.
4	Anticoagulation utilization	All Anticoagulants Fondaparinux Low molecular weight heparin (any) Unfractionated heparin (any) Heparin-LMWH/Unfractionated(any) Direct thrombin inhibitors Bivalirudin
5	Access site utilization. Indicate the primary location of percutaneous entry. Code the site used to perform most of the procedure if more than one site was used.	Femoral Brachial Radial Other
6	Method for closure for arterial access site. Indicate the arterial closure methods used in chronological order regardless of whether they provided hemostasis. The same closure method may be repeated	Manual compression Mechanical compression Suture Staple Sealant Patch Other, unspecified device

Performance Measure #40:

A new, hierarchical risk-standardized model

JACC: CARDIOVASCULAR INTERVENTIONS
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NCDR REPORT

An Updated Bleeding Model to Predict the Risk of Post-Procedure Bleeding Among Patients Undergoing Percutaneous Coronary Intervention

A Report Using an Expanded Bleeding Definition From the National Cardiovascular Data Registry CathPCI Registry

Sunil V. Rao, MD,* Lisa A. McCoy, MS,* John A. Spertus, MD, MPH,† Ronald J. Krone, MD,†
Mandeep Singh, MD,§ Susan Fitzgerald, MS, RN,|| Eric D. Peterson, MD, MPH*
Durham, North Carolina; Kansas City and St. Louis, Missouri; Rochester, Minnesota; and Washington, DC

Objectives This study sought to develop a model that predicts bleeding complications using an expanded bleeding definition among patients undergoing percutaneous coronary intervention (PCI) in contemporary clinical practice.

Background New knowledge about the importance of periprocedural bleeding combined with techniques to mitigate its occurrence and the inclusion of new data in the updated CathPCI Registry data collection forms encouraged us to develop a new bleeding definition and risk model to improve the monitoring and safety of PCI.

Methods Detailed clinical data from 1,043,759 PCI procedures at 1,142 centers from February 2008 through April 2011 participating in the CathPCI Registry were used to identify factors associated with major bleeding complications occurring within 72 h post-PCI. Risk models (full and simplified risk scores) were developed in 80% of the cohort and validated in the remaining 20%. Model discrimination and calibration were assessed in the overall population and among the following pre-specified patient subgroups: females, those older than 70 years of age, those with diabetes mellitus, those with ST-segment elevation myocardial infarction, and those who did not undergo in-hospital coronary artery bypass grafting.

Results Using the updated definition, the rate of bleeding was 5.8%. The full model included 31 variables, and the risk score had 10. The full model had similar discriminatory value across pre-specified subgroups and was well calibrated across the PCI risk spectrum.

Conclusions The updated bleeding definition identifies important post-PCI bleeding events. Risk models that use this expanded definition provide accurate estimates of post-PCI bleeding risk, thereby better informing clinical decision making and facilitating risk-adjusted provider feedback to support quality improvement. *J Am Coll Cardiol Intv* 2013;6:897-904. © 2013 by the American College of Cardiology

PCI in-hospital
risk standardized
rate of bleeding events
(all patients)



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Performance Measure #40: What's new

- Hierarchical model
- Fewer patient variables
- Risk relationships within and amongst hospitals
- Absolute Hgb decrease from pre-PCI to post-PCI of 4g/dL (previously 3g/dL)





Performance Measure #40: Model Details

Post-PCI bleeding defined as any ONE of the following:

1. Bleeding event w/in 72 hours OR
2. Hemorrhagic stroke OR
3. Tamponade OR
4. Post-PCI transfusion for patients with a pre-procedure Hgb >8 g/dL and pre-procedure Hgb not missing; OR
5. Absolute Hgb decrease from pre-PCI to post-PCI of ≥ 4 g/dL



Performance Measure #40: Model Details

Patient eligibility:

1. Patient's with a PCI procedure performed during the Episode of Care.
2. Patients with multiple PCI procedures Include only index PCI procedure.
3. Include patient procedures with non-missing values for outcome variables of bleeding event w/in 72 hours AND transfusion.
4. Exclude patients who died on the same day of the procedure.
5. Exclude patients with CABG.



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QII Participant Change Package

Assessment

Includes benchmarking data, and is designed to identify opportunities for improvement.

[Read More...](#)



Toolkit

Specific tools and strategies designed to address one general topic area for improvement.

[Read more...](#)



Calls & Webinars

Listen to community calls and on-demand webinars that review evidence based toolkits and lessons learned.

[Read more...](#)



Listserv

Collaborate and interact with others on a listserv who share best practices and lessons learned.

[Read More...](#)



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Overall Score (43 of 62 possible points)

69%

Success Metric 1: PCI in-hospital risk standardized rate of bleeding for all patients

(29 possible points) 18

Success Metric 2: Proportion of PCI procedures with transfusion of whole blood or red blood cells

(5 possible points) 4

Success Metric 3: Procedures with an observed bleeding event

(8 possible points) 6

Success Metric 4: Anticoagulation utilization

(8 possible points) 4

Success Metric 5: Access site utilization

(4 possible points) 4

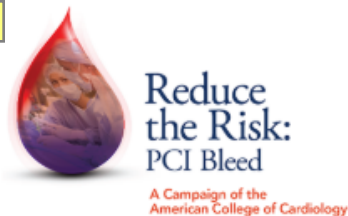
Success Metric 6: Method for closure for arterial access site

(8 possible points) 7

Campaign Assessment Tool

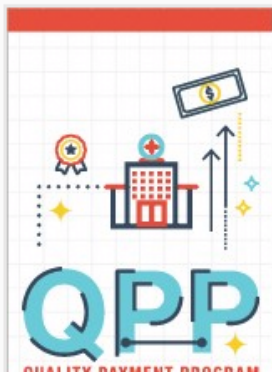


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- ▶ About Reduce the Risk
- ▶ Getting Started
- ▼ Reduce the Risk Features
 - Assessment
 - Toolkit
 - Webinars
 - Reduce the Risk Listserv
- Reduce the Risk - PCI Bleed Participation Certificate

ADVERTISEMENT



Reduce the Risk: PCI Bleed Toolkit

The ACC has curated evidence-based tools to help you decrease PCI bleeding at your facility. Click on each section to find targeted tools for each Campaign metric:

Metric 1: in-hospital risk-standardized rate of bleeding events for all PCI patients.

Metric 2: Proportion of PCI procedures with transfusion of whole blood or red blood cells.

Metric 3: Procedures with an observed bleeding event.

Metric 4: Anticoagulation utilization.

Metric 5: Access site utilization.

Metric 6: Method for closure for arterial access site.

➤ Preprocedural (Tools to address Metric #1 and 6)

➤ Intraprocedural (Tools to address Metric #1, 5, and 6)

➤ Postprocedural (Tools to address Metric #1, 5, and 6)

➤ Pharmacotherapy (Tools to address Metric # 1, 2, 3, 4, 5, 6)

➤ EHR Integration (Tools to address Metric #1, 4, 5, and 6)



Reduce the Risk: PCI Bleed Toolkit

▼ Preprocedural (Tools to address Metric #1 and 6)

Metric	Tools
Metric 1: in-hospital risk-standardized rate of bleeding Metric 3: Procedures with an observed bleeding event	CathPCI Bleeding Risk Calculator App
Metric 1: in-hospital risk-standardized rate of bleeding events for all PCI patients Metric 6: Method for closure for arterial access site	Pre PCI-Procedure Orders
Metric 1: in-hospital risk-standardized rate of bleeding Metric 3: Procedures with an observed bleeding event	The Universal Protocol from the Joint Commission
Metric 1: in-hospital risk-standardized rate of bleeding events for all PCI patients Metric 4: Anticoagulation utilization Metric 5: Access site utilization	Risk-Concordant Framework for Bleed Avoidance Strategies



Toolkit Aligned to Metrics

PCI BLEEDING RISK CHECKLIST

Use this table to identify common problems and possible solutions.

COMMON PROBLEM	POSSIBLE SOLUTION
Procedure Performance Issue Improper Performance of Procedure	Tools <ul style="list-style-type: none"> Risk Factors that Increase Vascular Complications Indications For PCI in STEMI Pre-PCI Procedure Orders Arterial Access Protocol for PCI
Protocol Issues Lack of Protocol to Prevent Postoperative Bleeding	Tools <ul style="list-style-type: none"> Post-PCI Procedural Recommendations Post-PCI Procedure Groin Bleed Post-PCI Procedure Orders Post-PCI Sheath Removal Protocol Post-PCI Sheath Removal Checklist Competency Assessment for Arterial Access
Lack of Knowledge About Patient Factors That Can Contribute to Risk of Postoperative Bleeding	Tools <ul style="list-style-type: none"> Risk Factors That Increase Vascular Complications
Failure to Identify Early Warning Signs of Postoperative Bleeding	Tools <ul style="list-style-type: none"> Early Warning Signs of A Vascular Complication
Medication Management Issues Improper Preoperative, Intraoperative, and Postoperative Medication Management	Tools <ul style="list-style-type: none"> Risk Factors That Increase Vascular Complications General Considerations For Use of Antithrombotic Therapy Recommendations for Anticoagulation University of Wisconsin Health: Perioperative Antithrombotic Therapy – Implications for the CathPCI Patient Blue Cross Blue Shield Anticoagulation Management Surviving MI for Broad Engagement
Communication Issues Lack of Communication Among Clinicians	Tools <ul style="list-style-type: none"> Surviving MI Barriers and Solutions Surviving MI Characteristics
Failure to Communicate Early Warning Signs of Postoperative Bleeding to the Patient	Tools <ul style="list-style-type: none"> Institute for Healthcare Improvement Situation, Background, Assessment, Recommendation (SBAR) Communication Tool

CathPCI Bleeding Risk Calculator

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Early Warning Signs of a Vascular Complication After PCI

Multiple factors can lead to a bleed after a PCI. This table provides the most common vascular site complications.

Complication	Definition
Hematoma Incidence: 5-23%	<p>The localized blood-filled soft tissue swelling is the most common vascular access site complication.</p> <p>It may happen if puncture is below the femoral bifurcation.</p> <p>Occurs with blood loss at arterial and/or venous access site or arterial/venous perforation</p>
Retroperitoneal Hemorrhage Incidence: 0.15-0.44%	<p>Bleeding posterior to the serous membrane lining (the retroperitoneum) the abdominal wall and pelvis that may result from puncture below inguinal ligament leading to suprainguinal arterial or posterior wall perforation</p>
Pseudoaneurysm Incidence: 0.5% - 9%	<p>A disruption and dilation of the arterial wall creating a communicating tract between tissue layers. Often occurring between one of the weaker femoral artery walls leading to blood flowing into the tissue</p> <p>May result from arterial cannulation dysfunction, inadequate compression after sheath removal, impaired hemostasis and femoral puncture below the bifurcation</p>
Arteriovenous Fistula	A direct connection between an

This tool is a part of the Bleeding Risk Toolkit available at <https://www.ahajournals.org/doi/10.1161/aha.116.395555>

Post PCI Sheath Removal Protocol

Inappropriate sheath removal after a PCI can lead to adverse events for the patient, including vascular complications and additional surgical procedures. The following protocol can be used in a hospital setting to address this.

Adapted with permission from the Blue Cross Blue Shield of Michigan Cardiovascular Collaborative (BMC2) Best practice protocols available at <https://bmc2.org/system/files/private/best-practice-protocols-5-20-14.pdf>.

A dedicated sheath pulling team that has met competency requirements may be the best organizational structure to minimize vascular complications.

1. Confirm with recovery RN that:

- Patient is ready for sheath pull.
- Atropine available for vaso vagal response.
- Pertinent history: special considerations (i.e. previous groin complications).

Catheter/Sheath Type	Special Instructions
Femoral gortex graft access site.	Manual hold only, no clamp.
New iliac stent (same side approach) or less than 6 months old.	Manual hold only, no clamp.
New iliac stent (opposite side approach)	None
Old iliac stent (more than 6 months old)	Manual hold only, no clamp.
Antegrade approach	Manual hold only, no clamp.
Cardiac biopsy sheath	Must be removed in lab.
Brachial sheath	Monitor with pulse oximeter.
Radial sheath	Use of Hemo-band. Hemo-band may be adjusted and/or removed on unit (see Hemo-band policy).
Markedly obese	None. Manual hold preferred.
Aortic insufficiency	Will require longer hold time. If need longer hold, consider Compression Assist Device.
SBP > 180 mm Hg	Must be treated prior to removal.

2. Assess the patient for sheath pull.

- BP greater than 160 systolic and greater than 100 diastolic, contact attending or fellow.
- BP less than 90 systolic and heart rate less than 45 bpm (contact attending or fellow if BP is high or low).
- ACT less than 180 seconds when measured on the Hemochron Junior Signature.
- Active chest pain.
- Visualize and assess the sheath insertion site.



Webinar #1: September 18, 2018

Webinar #2: November 7, 2018

Webinar #3: January 23, 2019

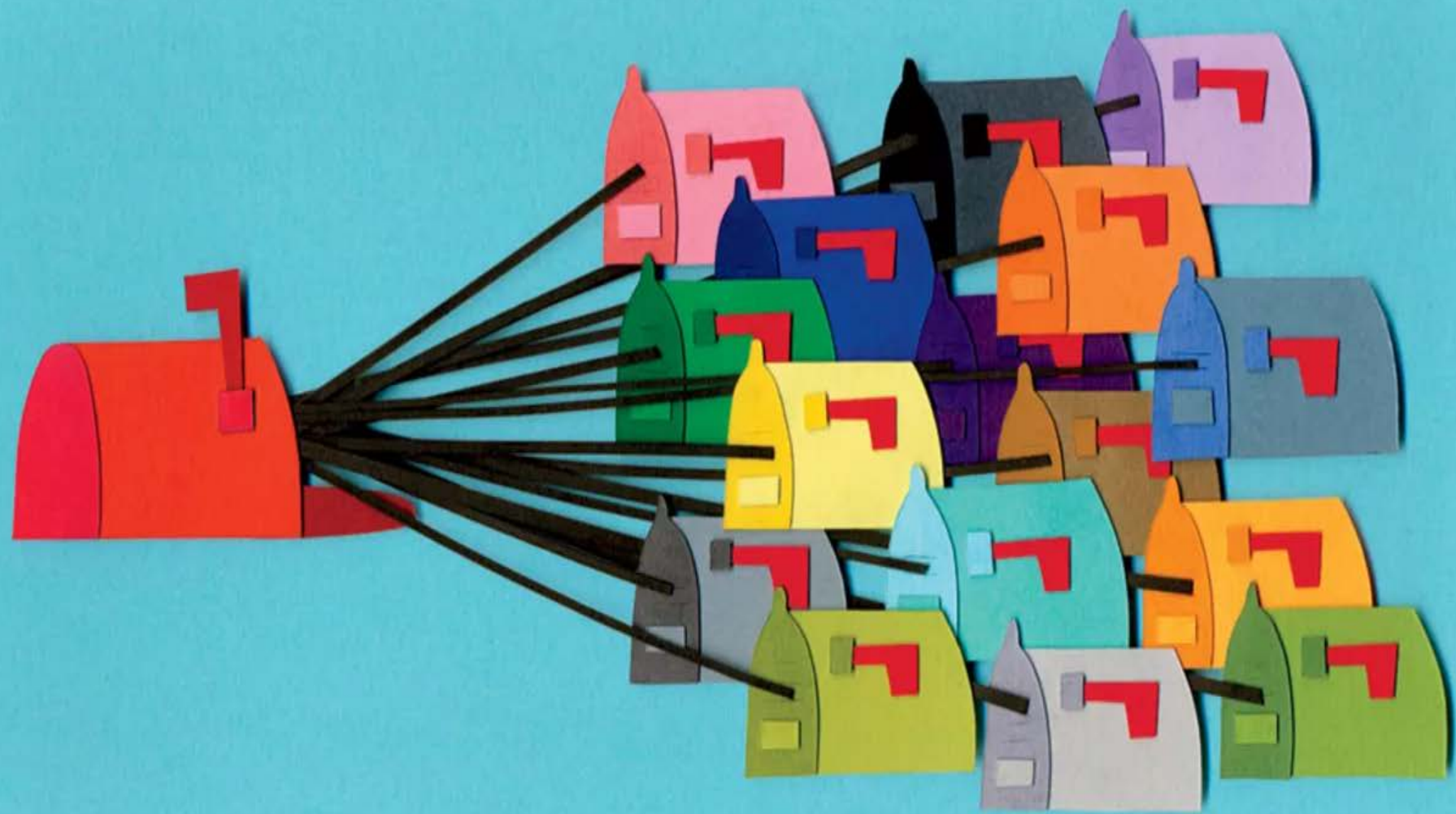
Webinar #4: May 22, 2019

Webinar #5: August 23, 2019

Webinar #6: November 6, 2019



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The Campaign Dashboard



*This is a draft



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Dashboard Example

Facility Name and PID #			2017Q2			2017Q3			2017Q4			2018Q1			My Hospital R4Q			US Vol Group Pts R4Q		US Registry Pts R4Q	
CathPCI Quality Campaigns > Reduce the Risk PCI Bleed Campaign			G			G			G			G									
			Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	%	Num	%
	Metric Key	Description																			
Metric 1	4934	PCI In hospital risk- standardized rate of bleeding events	1,000			435			406			416			2,257			315,333		1,467,135	
Metric 2	4288	Proportion of PCI procedures with transfusion of whole or RBC	934	1,000	93.4	383	435	88.1	345	406	85.0	341	416	82.0	2,003	2,257	88.8	295,309	93.7	1,410,930	96.2
Metric 3	4928	Procedures with an observed bleeding rate	445	1,000	44.5	435	435	100.0	406	406	100.0	416	416	100.0	1,702	2,257	75.4	184,405	58.5	735,584	50.1
Metric 4		Anticoagulation Utilization	1,000	1,000	100.0	43	435	9.9	44	406	10.8	23	416	5.5	251	2,257	11.1	66,285	21.0	313,113	21.3
	4466	All anticoagulants	374	1,000	37.4	381	435	87.6	342	406	84.2	341	416	82.0	1,438	2,257	63.7	160,615	50.9	666,023	45.4
	4467	Fondaparinux	5	1,000	0.5	2	435	0.5	3	406	0.7	0	416	0.0	10	2,257	0.4	3,766	1.2	13,418	0.9
	4468	Low molecular weight heparin	451	1,000	0.5	446	435	102.5	414	406	102.0	426	416	102.4	1,737	1,702	102.1	190,288	103.2	758,264	103.1
	4469	Unfractionated heparin	50	1,000	0.1																
	8944	Heparin-LMWH/Unfractionated	50	1,000	0.1																
	4471	Bivalirudin	374	1,000	37.4	381	435	87.6	342	406	84.2	341	416	82.0	1,438	2,257	63.7	160,615	50.9	666,023	45.4
Metric 5		Access site utilization																			
	4159	Femoral access site	1,000	1,000	100.0	43	435	9.9	44	406	10.8	23	416	5.5	251	2,257	11.1	66,285	21.0	313,113	21.3
	4161	Brachial access site	374	1,000	37.4	381	435	87.6	342	406	84.2	341	416	82.0	1,438	2,257	63.7	160,615	50.9	666,023	45.4
	4163	Radial access site	5	1,000	0.5	2	435	0.5	3	406	0.7	0	416	0.0	10	2,257	0.4	3,766	1.2	13,418	0.9
	4165	Other access site	451	1,000	0.5	446	435	102.5	414	406	102.0	426	416	102.4	1,737	1,702	102.1	190,288	103.2	758,264	103.1
Metric 6		Method for closure for arterial access site																			
	4167	Manual compression	934	1,000	93.4	383	435	88.1	345	406	85.0	341	416	82.0	2,003	2,257	88.8	295,309	93.7	1,410,930	96.2
	4169	Mechanical compression	445	1,000	44.5	435	435	100.0	406	406	100.0	416	416	100.0	1,702	2,257	75.4	184,405	58.5	735,584	50.1
	4171	Suture closure method	1,000	1,000	100.0	43	435	9.9	44	406	10.8	23	416	5.5	251	2,257	11.1	66,285	21.0	313,113	21.3
	4173	Staple closure method	374	1,000	37.4	381	435	87.6	342	406	84.2	341	416	82.0	1,438	2,257	63.7	160,615	50.9	666,023	45.4
	4175	Sealant closure method	5	1,000	0.5	2	435	0.5	3	406	0.7	0	416	0.0	10	2,257	0.4	3,766	1.2	13,418	0.9
	4177	Patch closure method	451	1,000	0.5	446	435	102.5	414	406	102.0	426	416	102.4	1,737	1,702	102.1	190,288	103.2	758,264	103.1



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Earn “**High**” weighted
credit for this MACRA
MIPS Improvement
Activity!

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Opt in today!

To become a Reduce the Risk: PCI Bleed facility”

1. Log into NCDR
2. Go to your CathPCI Registry® home page
3. Click “Start Here” on the left navigation bar
4. Opt in!

The Registry Site Manager will be required to log in to opt your facility into the program.



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Quality Improvement
for Institutions

<https://cvquality.acc.org>

Reduce the Risk: PCI Bleed

Anticipate. Prepare. Save Lives.

The ACC's **Reduce the Risk: PCI Bleed** Quality Campaign is focused on minimizing PCI-associated bleeding risks and saving patient lives through widespread adoption of evidence-based best practices.

Building on the ACC's proven track record in helping hospitals and cardiovascular professionals take advantage of key strategies to close gaps in guideline-recommended care, **Reduce the Risk: PCI Bleed** leverages the power of the [CathPCI Registry®](#) to help hospitals and clinicians anticipate, prepare and save lives.



Reduce
the Risk:
PCI Bleed

A Campaign of the
American College of Cardiology

Join the Reduce the Risk: PCI Bleed Campaign

Join **Reduce the Risk: PCI Bleed** and be recognized for your commitment to Quality! Participation is easy and no additional cost to CathPCI Registry participants!

Opting in Link

**NCDR**
NATIONAL CARDIOVASCULAR DATA REGISTRY

CathPCI Registry® Switch Registry ▼

Veronica Wilson | American College of Cardiology | Logout

CathPCI Registry / Home / Announcements

Home

START HERE

Dashboard

Corporate Dashboard

Chapters Dashboard

▶ Data

▶ Resources

▶ Control

Public Links

Quality Improvement for Institutions Home

NCDR Home

Welcome CathPCI Registry Participants

Locate the v5 Pending Data Dictionary Updates

As dynamic, real-world scenarios are captured in the v5 dataset areas for improvement are rapidly being identified! Please locate the document: v5 Dynamic Lists and Definitions with Pending Data Dictionary Updates on the resource page. This document will support accurate data capture and be updated as needed until the Data Dictionary can be amended. Thank you for checking the announcement page frequently!

Posted Jun 11, 2018

NCDR.18 Annual Conference: Sessions on Demand (recordings)

Thank you again for attending the NCDR.18 Annual Conference in Orlando, Florida earlier this year.

For those of you who purchased the NCDR.18 Sessions on Demand (recordings) already, we received some feedback that the session titles did not completely mirror the ones used onsite. We appreciate your feedback and are happy to inform you that all session titles have now been updated. If you have not yet received your login credentials to access the recordings, please contact us at ncdr@acc.org or 800-257-4737.

If you have not purchased the NCDR.18 Sessions on Demand and wish to do so now, please use the following link: <http://www.conferencemedia.net/stores/ncdr/>

We look forward to seeing you at NCDR.19 in New Orleans!

Posted Jun 11, 2018

NCDR Orientation 101 Webinar Occurs Tuesday June 12th 2018

Please join us on June 12th 2018, from 1pm – 3pm Eastern Time as we walk you through getting started with NCDR. We'll arm you with information about website navigation, business processes, available resources and much more!

Participants will be muted in this session, and are welcome to ask questions via the Q-and-A functionality displayed on the screen during the session. The NCDR Clinical Quality Advisor Team will lead this session, and will answer as many questions as possible!

[Click Here to Join the April 10th 2018 Webinar!](#)



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