

Innovation in Use of Data to Improve Care for Patients with AMI

The Problem: As the Leadership Saves Lives guiding coalitions began to try to understand and improve care for patients with AMI, they uncovered a problem. Although they were swimming in data, they needed better ways to integrate and communicate data across the care continuum to foster improvement.

The Response: Coalitions began to work together to develop processes and templates for synthesizing and communicating data for improvement projects, first in the root cause analysis stage, and then in the intervention/improvement stage. We present two case examples.

Case Study 1: Holistic mortality review

As one of their first activities together, guiding coalitions from LSL hospitals embarked upon a holistic root cause analysis to identify opportunities to improve outcomes for patients with AMI. Traditional approaches to mortality review provided little useful data to guide improvement. One LSL hospital set out to change this, adapting the Mayo Clinic Mortality Review System to systematically and proactively capture opportunities for improvement. We describe their rationale, the resulting approach, and lessons learned from the implementation experience.

[illegible]

MISSION: REFINED

Referral Hospital: XXXX
Transport Agency: Ground ALS
ECG post PCI to RCA

Case Synopsis: (Sine arrived at Billings Clinic, patient lanes directly to cath lab emergently due to continued chest pain w/lyr theocody administration. Left heart cath demonstrated a critical mid-segment occlusion of the distal portion of the RCA prior to the posterior descending and posterolateral infarctions. First attempts at reperfusion were unsuccessful due to calcified tortuous lesion, but was ultimately intervened with angioplasty and placement of a drug-eluting stent. Patient recovered in ICU immediately post procedure and transferred to CCU the following morning. Echo on 9/21 demonstrated an LVEF of 55-65% with no evidence of wall motion abnormalities and normal apical function. Grade 1 diastolic dysfunction was noted alongside a mildly dilated atrium. He was discharged home on day 2 in stable condition with a cardiac regimen of Bileta 90 mg twice daily x 1 year, aspirin 81 mg daily indefinitely, metoprolol tartrate 25 mg twice daily, HCTZ 12.5mg/20mg daily and pravastatin 40mg at bedtime. W/ follow up with cardiologist in 2-3 weeks and enroll in cardiac rehab.

Percent call 911: No	ED Arrival 15:59	First ECG 16:02	Transporting Agency Called 16:10	Lyrits Admin Time: 16:15	Door Dash from Floor 10: 16:18
		32min 10 Minutes	Arrived to Billings Clinic Time: 52 Minutes	Total Transfer Time: 17:49	Arrival to Cath: 17:49
					PCI Time: 18:09
					Disch/28 1:00 Minutes

Case Study 2: Case feedback to the full care team

High quality care for patients with AMI requires engagement of healthcare professionals from across the care continuum (from prehospital emergency providers to community based cardiac rehabilitation programs). Once a patient has moved to the next step, it can be difficult to systematically circle back to share outcomes or opportunities for improvement. Several LSL hospitals set out to improve case feedback loops, including more complete immediate feedback on patients with STEMI, and more comprehensive quarterly case review with all ACS care Providers.

In this toolkit

The toolkit includes an editable PowerPoint deck on each of the two case studies, including rationale for the approach, the resulting tool, reflections on implementation experience, and a note about the importance of tailoring this approach to your local hospital context.



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